Hawke's Bay Clinical Council Meeting

Date: **Wednesday, 8 March 2017**

Meeting: **3.00 pm to 5.30 pm**

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

Council Members:

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

Apologies: Dr Mark Peterson, Dr John Gommans

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

PUBLIC MEETING

Item	Section 1 – Routine	Time (pm)
1.	Apologies / Welcome	3.00
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	
5.	Clinical Council Workplan	
6.	Review Progress on Annual Plan 2016/17 Objectives (from Feb Mtg)	3.10
	Section 2 – For Discussion and Information	
7.	HB Palliative Care Strategy – Mary Wills 7.1 Live Well, Stay Well, Die Well – Palliative Care in Hawke's Bay	3.20
8.	Clinical Committees Review (from Feb Mtg) – Kate Coley / Ken Foote	3.40
9.	Travel Plan Update – Andrea Beattie	4.00
10.	Draft Annual Plan Report – Tim Evans / Tracee Te Huia / Carina Burgess 10.1 Draft Annual Plan 2017-18	4.10
	Section 3 – Monitoring	
11.	Te Ara Whakawaiora / Breastfeeding (national indicator) – Chris McKenna	4.20
	Section 4 – Reporting Committees	
12.	Maternity Clinical Governance Group Update – Chris McKenna / Jules Arthur	4.30
13.	Falls Minimisation Committee Update – Chris McKenna	4.35
14.	**Section 5 – Recommendation to Exclude the Public**	

PUBLIC EXCLUDED

Item	Section 6 – Routine	
15.	Minutes of Previous Meeting	4.40
16.	Matters Arising - Review Actions - Nil	
	Section 7 – For Information / Discussion	
17.	High Level Budget Review Presentation - Tim Evans / Peter Kennedy	4.45
	Section 8 – General	
18.	Topics of Interest – Member Issues / Updates	5.00

NEXT MEETING - Wednesday, 12 April 2017

Interests Register

Hawke's Bay Clinical Council

Mar-17

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 Care)	Taradale Medical Centre	Shareholder and Director	General Practice - now 20% owned by Southern Cross Primary Care (a subsidiary	Yes	Low
	Royal New Zealand College of General Practitioners	Board member	GP training and standards	Yes	Low
	City Medical Napier	Shareholder	Accident and Medical Clinic	Yes	Contract with HBDHB
	Daughter employed by HBDHB from November 2015	Post Graduate Year One	Will not participate in discussions regarding Post Graduates in Community Care	Yes	Low
	PHO Services Agreement Amendment Protocol (PSAAP)	"Contracted Provider" representative	The PHO services Agreement is the contract between the DHB and PHO. PSAAP is the negotiating group that	Yes	Representative on the negotiating group
	Health Hawke's Bay Limited (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
	Council of Medical Colleges	Royal New Zealand College of General Practitioners representative and Council of Medical Colleges Executive	May impact on some discussions around medical training and workforce, at such times interest would be declared.	Yes	Low
Dr John Gommans (Chief Medical Officer - Hospital)	Stroke Foundation Ltd	Chairman of the Board of Directors	Provides information and support to people with a stroke. Has some contracts to the MOH	Yes	Low
	Internal Medicine Society of Australia and New Zealand (IMSANZ)	Immediate Past President and a current Director of IMSANZ	The IMSANZ represents the interests of specialist General Internal Medicine physicians throughout Australia and New Zealand	Yes	Low
	Royal Australasian College of Physicians (RACP), Adult Medicine Division Committee (AMDC)	Member and Chair elect of NZ Committee	RACP represents Physicians in all Adult Medicine specialties across Australasia; the NZ AMD representing those based in NZ	Yes	Low
William Allan (Chief Pharmacist)	Pharmaceutical Society of New Zealand	Executive member	Pharmacy advocacy, professional standards and training	Yes	Low
	Pharmaceutical Management Agency (PHARMAC)	Member, Tender Medical Subcommittee of PTAC (Pharmacology & Therapeutics Advisory Committee)	Provide advice to PHARMAC on the clinical suitability of tenders for subsidised medicines for inclusion in the Pharmaceutical Schedule and Hospital Medicines List (HML)	Yes	Low. Influences the cost of subsidised medicines to the DHB's combined pharmaceutical budget
	Executive User Group for eMedicines programme (ITHB/HQSC)	Member (Central Region's representative)	Provide leadership and guidance to the HITB and HQSC on the eMedicines (Hospital) programme (electronic prescribing & administration; eMedicines	Yes	Low
	Pharmacy Steering Group (MoH)	Member	Provide advice to the Ministry on the utilisation of pharmacists within the health workforce	Yes	Low
Jules Arthur (Midwifery Director)	National Midwifery Leaders group	Member	Forum for national midwifery and maternity issues	No	
	Central Region Midwifery Leaders report to TAS	Member	Regional approach to services	No	
	National Maternal Wellbeing and Child Protection group	Co Chair	To strengthen families by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner.	No	
	NZ College of Midwives	Member	A professional body for the midwifery workforce	No	
	Central Region Quality and Safety Alliance	Member	A network of professionals overseeing clinical governance of the central region for patient quality and safety.	No	
Dr Kiri Bird (General Practitioner)	Te Timatanga Ararau Trust (Iron Maori)	Partner (Lee Grace) is a Trustee	Health and Wellbeing	Yes	Low - Contract with HBDHB
	Gascoigne Medical Raureka	General Practitioner	General Practice	Yes	Low
	Royal NZ College of General Practitioners	Member	Health and Wellbeing	No	
	Royal NZ College of General Practitioners	Lead Medical Educator in HB	Health and Wellbeing	No	
	Te Ora Board (Maori Doctors)	Deputy Chair	Health and Wellbeing	No	

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**
	Te Akoranga a Maui (Maori chapter for RNZCGP)	Member	Health and Wellbeing	No	
David Warrington (Nurse Director - Older Persons)	The Works Wellness Centre	Wife is Practitioner and owner	Chriopractic care and treatment, primary, preventative and physiotherapy	Yes	Low
	National Directors of Mental Health Nursing	Member		No	Low
Dr Tae Richardson (GP and Chair of Clinical Quality Advisory Committee)	Loco Ltd	Shareholding Director	Private business	No	
	Dr Bryn Jones employee of MoH	Husband	Role with Ministry of Health as Chief Advisor in Sector Capability and	Yes	Low
	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.
	National Advisory Committee of the RNZCGPs	Member	Health and Wellbeing	No	
	Health Hawke's Bay (PHO)	Medical Advisor - Sector Development	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues in this area relating to the PHO.
Debs Higgins (Senior Nurse)	Eastern Institute of Technology (EIT)	Lecturer - Nursing	Education.	No	
	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
Anne McLeod (Senior Allied Health Professional)	Aeotearoa NZ Association of Social Workers	Member		Yes	Low
	HB DHB Employee Heather Charteris	Sister-in-law	Registered Nurse Diabetic Educator	Yes	Low
	Directions Coaching	Coach and Trainer	Private Business	Yes	Low: Contracts in the past with HBDHB and Hauora Tairawhiti.
Dr Robin Whyman (Clinical Director Oral Health)	NZ Institute of Directors	Member	Continuing professional development for company directors	No	
	Australian - NZ Society of Paediatric Dentists	Member	Continuing professional development for dentists providing care to children and advocacy for child oral health.	No	
Dr Russell Wills	HBDHB Community, Women and Children and Quality Improvement & Patient Safety Directorates	Employee	Employee	Yes	Potential, pecuniary
	HBDHB employee Mary Wills	Spouse	Employee	Yes	Potential, pecuniary
	Paediatric Society of New Zealand	Member	Professional network	No	
	Association of Salaried Medical Specialists	Member	Trade Union	Yes	Potential, pecuniary
	New Zealand Medical Association	Member	Professional network	No	
	Royal Australasian College of Physicians	Fellow	Continuing Medical Education	No	
	Neurodevelopmental and Behavioural Society of Australia and New Zealand	Member	Professional network	No	
	NZ Institute of Directors	Member	Professional network	No	

28/02/2017

MINUTES OF MEETING FOR THE HAWKE'S BAY CLINICAL COUNCIL HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE ON WEDNESDAY, 8 FEBRUARY 2017 AT 3.00 PM

PUBLIC

Present:
Dr Mark Peterson (Chair)
Chris McKenna (Co-Chair)
Dr Kiri Bird
Dr John Gommans
Dr Russell Wills
Dr Robin Whyman
Dr David Rodgers
Andy Phillips
Debs Higgins
William Allan
David Warrington

In Attendance:
Kate Coley, Director Quality Improvement & Patient Safety (DQIPS)
Ken Foote, Company Secretary
Graeme Norton, Chair HB Health Consumer Council
Lee-Ora Lusis, Clinical Council member from March 2017
Tracy Fricker, Clinical Council Administrator and EA to DQIPS

Apologies:
Jules Arthur

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Dr Mark Petersen (Chair) welcomed everyone to the first meeting of 2017 and hoped that everyone had enjoyed their Christmas/New Year break.

Chris McKenna (Co-Chair) introduced Lee-Ora Lusis the new primary care nurse representative to Clinical Council. Lee-Ora advised that she is originally from Whanganui and has been working as Clinical Nurse Manager at Totara Health since April last year. Her background has been primary health the last 9 years and prior to that as a midwife for 14 years. She has also nearly completed her Nurse Practitioner pathway and is very excited for the opportunity to be a member of the Clinical Council.

Apologies were noted as above.

2. INTERESTS REGISTER

No new interests advised. The Chair advised that if anyone has any new interests or changes they require to the register that they be sent to Tracy Fricker (Clinical Council Administrator).

Dr David Rodgers noted an interest in 13-17 Year Old Primary Care Zero Fees Subsidy Project (Tamatea Medical Centre) and Kiri Bird for the Orthopaedic Review phase 2 paper (Te Timatanga Ararau Trust, Iron Maori).

3. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the meeting held on 7 December 2016, were confirmed as a correct record of the meeting.

Moved and carried.

4. MATTERS ARISING, ACTIONS AND PROGRESS

Item 1: **Clinical Council Annual Work plan 2016/17**
To be discussed next month. A decision is to be made on whether the March meeting will be a quarterly meeting, with a lunch at 12.30 pm and the meeting starting from 1.00 pm. This will be confirmed in due course.

Item 2: **Resignation of Clinical Council Member**
Lee-Ora Lusis has been recommended as the Primary Care Senior Nurse Representative on Clinical Council. This is to be signed off at the February Board Meeting. *Item can be closed.*

Item 3: ***Clinical Governance and Committee Structures***
To be discussed at the March meeting.

Item 4: ***Laboratory Services Committee***
The terms of reference will be reviewed as part of the clinical governance and committee structures review. They will then go back to the Laboratory Committee for sign off. *Item can be closed.*

Item 5: ***Palliative Care and Advanced Care Workshop***
To be discussed at the March meeting.

Item 6: **Resignation of Clinical Council Member**
Letter of thanks has been sent to Dr Caroline McElnay. *Item can be closed.*

It was noted that the vacancy on the Clinical Council is an appointment and will be filled once the role of Clinical Director of Population Health has been made. There will be an interim arrangement until someone is appointed to that role.

Item 7: **Interest Register Changes**
Changes to register will be actioned when received.

5. CLINICAL COUNCIL WORK PLAN

The work plan was included in the meeting papers. The Chair commented that other items members wish to raise can be sent to the Co-Chairs for inclusion on the meeting agendas.

Kate Coley, Director QIPS noted that the Clinical Committees Review needs to be added to the March work plan.

6. PROGRESS ON ANNUAL PLAN 2016/17 OBJECTIVES

To be discussed at the March meeting.

SECTION 2: FOR DISCUSSION AND INFORMATION

7. ICU LEARNINGS – PROGRESS REPORT

Kate Coley, DQIPS provided an update on the progress to date on the recommendations as outlined in the action plan. The ICU SMO job sizing and rostering practices are outstanding but progress is being made.

David Warrington advised that the nursing resources are still being looked to meet the college standards (ratio staff to beds ICU 5.2 fte and HDU 2.6 fte) also having a supernumery senior nurse on each shift and having ability to flex up and down depending on capacity. A paper will go to the Health Services Leadership Team regarding this in due course.

There are a number of actions regarding external reviews and making sure we have a robust process around undertaking reviews, which is being completed. Within Health Services there was a recent reconfiguration and a large part of implementing that is the devolution of the current DRS Unit. All the current processes are being reviewed on what is done for SMOs and RMOs, mapping them out with the intent of SMO management transferring to the directorate teams and RMO management sitting in the resourcing unit. There are elements in the action plan which fall under the DRS Unit transition work.

This report will come back to the Clinical Council each quarter until all recommendations have been completed. The intention is that all of the actions are implemented and that the Clinical Council is aware what is being done around the ICU learnings. It is important that all the loops are closed.

Concern raised at how the Clinical Council was blindsided by the ICU issues and that we do not want to get to that point again. The DQIPS advised that with services writing their service plans and identifying risks, the monthly health services meeting with all directorate teams about risks, identifying where there are risks and what needs to be escalated to the Clinical Council and development of the clinical services plan is a piece of work identifying priorities and risks going forward. There is now much closer monitoring of risks.

Query regarding culture and atmosphere in the ICU at the moment? Dr John Gommans, Chief Medical Officer commented that having the seventh SMO appointed and stability amongst the others has made a significant difference.

8. COLLABORATIVE PATHWAYS PROOF OF CONCEPT PROPOSAL

The Chair advised that the recommendation is to note the contents of the report and support the proof of concept implementation, the budget for which was approved in the 2016/17 budget round. Clinical pathways on paper or via Map of Medicine (MoM) have been under used by clinicians and we are looking at ways to make the pathways more approachable, easier to use and to provide other benefits for clinicians. It is about streamlining the process and making it user friendly. NexxT does not create the pathway, they provide the electronic tool. In the proposal NexxT will take two of the pathways hips and knees and cellulitis to use in the proof of concept to show what they can do to take them from static pathways to dynamic.

Following discussion the Clinical Council supported the proof of concept implementation at a cost of $35,000 with the same conditions as outlined below by the Executive Management Team at their meeting on 24 January 2017:

(a) The success factors of this tool were identified
(b) Clarification be obtained from the provider NexxT for any ongoing costs if they were the successful vendor after the proof of concept trial period concluded
(c) Note that the Map of Medicine contract be reviewed in June 2017

(d) A comprehensive paper come back to EMT and Clinical Council outlining the value of collaborative pathways and what the appropriate tool would be for this.

9. 13-17 YEAR OLD PRIMARY CARE ZERO RATED SUBSIDY FRAMEWORK

The Chair commented that the 13-17 year old subsidy topic has been well canvased by the Clinical Council. This paper talks about the evaluation framework. Part of this project is to identify if there are some positive outcomes from this initiative. The paper includes what those evaluation measures should look like.

Discussion held regarding approaches for evaluation of the framework. Suggestions included:

- Need to look at the qualitative data on what general practices are youth friendly (attendance and access may support this)
- Consumer Council has links to the Youth Council and they would be keen to be involved with this work
- Talking to skilled primary care practitioners already delivering services e.g. school based health services or the Centre for Youth Health
- Need to strengthen what we are evaluating, with particular reference to the consumer experience
- Would like to see standardisation. It's about quality and youth friendliness

The Chair advised that the DHB will not release the funding until the measures are appropriate. We would like to see some standardisation across the sector for the evaluation.

Action: Russell Wills to contact Jill Garrett and Patrick Le Geyt with suggestions for experts who can assist with the evaluation design.

10. ORTHOPAEDIC REVIEW PHASE 2 (DRAFT)

Dr Andy Phillips advised that there are three aspects and goals to this next phase of the orthopaedic review.

1. Community Care – addressing health inequalities using Whanau Ora approach delivered through the Mobility Action Programme

2. Primary Care – ensuring GPs and patients have appropriate expectations delivered by dynamic hip and knee pathways

3. Secondary care – improving patient outcomes and experience of elective surgery by implementing principles of enhanced recovery after surgery

The important thing about the Mobility Action Programme (MAP) are the learnings that will come out of it and measurements like social return on investment. Have we set up a system that is going to lead to elimination of inequities and how do we apply those learnings to some of the complexities working with different providers.

The dynamic hip and knee pathway is taking some time to work through. One of the dynamic aspects of it is GPs having access to scoring tools e.g. Oxford hip and knee or the orthopaedic scoring tool. There are complexities on how to do this in a standardised way and when you use that scoring tool, how it meets the expectations of the GP and the patient.

The most challenging part of the secondary care pathway is putting in enhanced recovery after surgery principles into the orthopaedic pathway. This is about optimising some of the things we are not currently doing rather than starting afresh. The aim of this work is to take someone from

having a condition right through from the community, primary and secondary care pathways and trying to optimise these.

Another challenge of this work is that aspects of it are phased differently.

Questions / Feedback:

- Chronic non-surgical back pain is that part of this pathway? Yes there is an excellent service with the spine practitioners, seeing great results 84% of patients being referred to them not going through to an orthopaedic surgeon and a reduction in pain and disability
- Is there a shared care record? Yes there is a shared care record being used by some of the mental health services in Hawke's Bay, we have access to it for the MAP through the Taiwhenua and Whanau Ora providers. This is one of the complexities to be sorted out
- How will you know we are succeeding, what are the indicators? Three parts MAP has an external evaluation. We want to evaluate using social return on investment approach, the Ministry's success criteria is on evaluation forms returned to them and that is how we get paid. The evaluation forms will include quality of life indicators, patient reported outcome measures and equity measures which will determine the success of the programme. For the dynamic pathways, one of the measures of success would be the Clinical Council supporting dynamic pathways as the way to go in the future, the steering group may have some thoughts on that. Enhanced recovery after surgery will be measuring patient reported outcomes. Other indicators are average length of stay and whether we are meeting the elective joint target.
- If you have a hip/knee pathway you should get plugged into as soon as the osteoarthritis is first diagnosed at early stages of their condition and see them go around the pathway 1-2 times before requiring surgery.
- Are community pharmacists' part of this pathway? There is a major piece of work underway in respect to the community pharmacy contract with an opportunity coming for greater involvement of community pharmacists in patient care.

The Clinical Council noted the second phase of the orthopaedic review and the goals outlined in the report.

SECTION 3: MONITORING

11. TE ARA WHAKAWAIORA / ACCESS (LOCAL INDICATOR)

The Chair advised that he is the Executive Management Team champion for this indicator. At the end of the paper he has included a summary and would like feedback from the Clinical Council. From the data we are doing well with 0-4, with national comparisons and closing the equity gap. What have we done/changed to achieve this? The ASH rates for 45-65 are not good with rates higher than the national average and with large discrepancies between Maori and non-Maori.

Feedback:

- Paediatric respiratory programme has made a difference
- The "Say Ahh" programme preventing children coming into hospital
- We work on what is being measured at the time, dental health is a key marker of poor health in 0-4
- Having the rotavirus vaccine
- Nurses in schools
- Having a Paediatric Assessment Unit and a named doctor that GPs can talk to at all hours, skilled nurses providing early and prompt treatment under standing orders in primary care, vaccinations, improving access for Maori all contribute
- Need to be careful comparing years as there is a lot of movement in the graphs
- Need to look at the big picture, a lot of discussion is focused around the good news. With the older age group it is the reality of how long it takes to make change. The ASH rates show the prevalence of a disease in the community e.g. COPD is about smoking in households and that

is a long term change, it will take decades not year by year. It is about managing the exacerbation of the diseases in the community, for the older age group the long term conditions management strategy. It is about preventative health care, long term disease management. Need better presentation of the data and explanation by us about what this is measuring and what we can do about it in realistic timeframes

- Lessons we can learn is access to highly skilled nurses in primary care, prescribing under standing orders, an acute assessment unit and a named individual GPs can access all helps. With the experience in PAU this makes a huge difference, particularly for Maori
- Removing the improving / not improving
- Should not be comparing ASH rates of 0-4 and adults, these need to be separated into two reports.

The Chair advised that this report will be going to the Board at the end of February and he will amend some of comments at the end of the report to reflect the feedback provided.

12. ANNUAL MAORI HEALTH PLAN - QUARTER 2

The Chair advised that this report is taken as read. No issues discussed.

SECTION 4: REPORTING COMMITTEES

13. IMAGING GUIDELINES IN THE SECONDARY CARE ENVIRONMENT

The Chair welcomed Dr Andrew West (Head of Department – Radiology), Paula Jones (Director – Medical Service) and Angela Fuller (Radiology Manager) to the meeting. The recommendation in the paper is for the Clinical Council is to endorse the imaging guidelines in the secondary care environment and the national criteria for access to community radiology.

Dr West advised the guidelines for primary care have been developed using the best evidenced based information from the New Zealand health care model, what are appropriate examinations to be asking for in a primary health care environment, an indication for assessment and the appropriate imaging test to do. Some of this is based on specialist investigations, what is appropriate to be managed in primary care and what is appropriate for secondary care. They are not meant to supersede local guidelines but to provide a framework and easy reference document for the Radiology Department and primary health on what is an appropriate test.

For secondary care there are no national guidelines or pathways and we have had to develop our own imaging guidelines. The guidelines developed are based around the guidelines produced by Waikato DHB, which reflect international guidelines coming out of Australia and the Choosing Wisely Initiative. It is an easy clinical guideline to look through, based on a clinical problem, you use the appropriate imaging test. Radiology will prioritise referrals according to these guidelines. Variation from the guidelines may require a case by case discussion. This may not cut down our demand but may control future growth of the demand as more stress is put on the system.

The Chair commented that one of the reasons why we what the Clinical Council to endorse these guidelines is to empower the Radiology Department to question requests that are outside of the guideline.

Dr John Gommans (Chief Medical Advisor) supports the guideline. It provides a rationale for why a test is being requested. Imaging is not an alternative to performing an assessment of a patient. It is fundamental that we have some guidance which enables our Radiologists to question what is being ordered. It is not cost cutting, it is about managing waste and reducing the variation on what tests are being ordered. One of the challenges for us is that it is still a paper based system, we really need an electronic ordering system.

Paula Jones commented that electronic ordering will be the next stage and it will enable us to have reporting mechanisms and the ability to do audits and ability to feedback information.

The two guidelines were endorsed by the Clinical Council.

14. RECOMMENDATION TO EXCLUDE THE PUBLIC

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

15. Minutes of Previous Meeting (Public Excluded)
16. Matters Arising – Review of Actions (Public Excluded)
17. Maintaining the Radiology Service to Primary & Secondary Care (draft)
18. Integrating GP Services in Wairoa
19. Urgent Care Update – where to from here?
20. Member Topics of Interest

The meeting closed at 5.05 pm

Confirmed: _____
Chair

Date: _____

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

Action No	Date issue raised	Action to be Taken	By Whom	By When	Status
1	12/10/16	***Clinical Council Annual Work Plan 2016/17*** • Review of the plan to take place between meetings (Mark Peterson, Chris McKenna, Andy Phillips and Russell Wills)	All	Mar	To be discussed at March Meeting
2	9/11/16	***Clinical Governance and Committee Structures*** • Progress and Council representation on five committees and some advisory groups TBC • Timeline for the document in final form TBC	K Coley	Mar	To be discussed at March Meeting
3	9/11/16	Following on from the Workshop on Palliative Care and Advance Care Planning – where to from here?		Mar	To be discussed at March Meeting
4	7/12/16	***Interest Register*** Changes for David Warrington to be actioned when received	Admin	Feb	Actioned – now closed
5	8/2/17	***13-17 Year Old Primary Care Zero Rated Subsidy Framework*** Contact Jill Garrett and Patrick Le Geyt with suggestions for experts who can assist with the evaluation design	R Wills	Feb/Mar	

5

OURHEALTH HAWKE'S BAY Whakawateatia

HB CLINICAL COUNCIL WORKPLAN 2016-2017

Meeting Dates	Papers and Topics	Lead(s)
15 Mar 17 **9.00-3pm**	**Hawke's Bay Health Sector Leadership Forum – Cheval Lounge, Hawke's Bay Racing Centre**	
12 Apr 17	Quality Dashboard Concept Paper – revised for FRAC's viewing in April ***Monitoring*** Laboratory Service Committee Radiology Services Committee Health & Social Care Localities (from March) Collaborative Clinical Pathways HB Nursing Midwifery Leadership Council Update & Dashboard 6mthly Te Ara Whakawaiora / Cardiology (national indicator) Clinical Advisory & Governance Committee	Kate Coley / Russell Wills Kiri Bird Mark Peterson Tracee TeHuia Mark / Leigh White Chris McKenna John Gommans Tae Richardson
10 May 17 **1pm start**	ICU Learnings Report – Action Plan update (qtly) Best Start Healthy Eatng Plan *yearly review" for information Final Draft Annual Plan 2017 ***Monitoring*** HB Clinical Research Committee Update (6 monthly) Infection Control Committee (6 monthly) Clinical Advisory & Governance Committee	Kate Coley Dir Pop Health / Shari Carina Burgess John Gommans Chris McKenna Tae Richardson
14 Jun 17	Youth Health Strategy Update for information Adult Inpatient Experience Results (March, **June**, Sept, Dec) ***Monitoring*** Te Ara Whakawaiora / Oral Health (national indicator) Clinical Advisory & Governance Committee	Nicky Skerman Kate Coley Robin Whyman Tae Richardson
12 July 17	Laboratory Service Committee Radiology Services Committee Clinical Advisory & Governance Committee	Kiri BIrd Mark Peterson Tae Richardson
9 Aug 17 **1pm start**	Annual Meeting ICU Learnings Report – Action Plan update (qtly) Collaborative Clinical Pathways Clinical Advisory & Governance Committee	 Kate Coley Mark / Leigh White Tae Richardson

Meeting Dates	Papers and Topics	Lead(s)
6 Sept 17	**HB Health Sector Leadership Forum – venue TBC**	
13 Sep 17	Orthopaedic Review – phase 3 draft Health & Social Care Localities ***Monitoring*** Te Ara Whakawaiora / Healthy Weight Strategy TBC Falls minimisation Committee Maternity Clinical Governance Group Clinical Advisory & Governance Committee	Andy Phillips Tracee TeHuia Patrick LeGeyt / Shari Chris McKenna Chris McKenna Tae Richardson
11 Oct 17	***Monitoring*** Laboratory Service Committee Radiology Services Committee HB Nursing Midwifery Leadership Council Update & Dashboard 6mthly Clinical Advisory & Governance Committee	 Kiri Bird Mark Peterson Chris McKenna Tae Richardson
8 Nov 17	ICU Learnings Report – Action Plan update (qtly) ***Monitoring*** HB Clinical Research Committee Update Te Ara Whakawaiora / Smoking TBC	Kate Coley John Gommans Patrick LeGeyt / Penny
6 Dec 17	Clinical Pathways Committee ***Monitoring*** Clinical Advisory & Governance Committee	Mark Peterson / Leigh Tae Richardson

HAWKE'S BAY CLINICAL COUNCIL - ANNUAL PLAN 2016/17 - 4 October 2016

FUNCTIONS	Provide Clinical advice and assurance to the Hawke's Bay health system senior management and governance structures	Work in partnership with the Hawke's Bay Health Consmer Council to ensure that Hawke's Bay health services are organised around the needs of people.	Provide oversight of clinical quality and patient safety	Provide clinical leadership to Hawke's Bay health system workforce
ROLES	Provide advice and/or assurance on: • Clinical implications of proposed services changes. • Prioritisation of health resources. • Measures that will address health inequities. • Integration of health care provision across the sector. • The effective and efficient clinical use of resources.	• Develop and promote a "Person and Whanau Centred Care" approach to health care delivery. • Facilitate service integrations across / within the sector. • Ensure systems support the effective transition of consumers between/within services. • Promote and facilitate effective consumer engagement and patient feedback at all levels. • Ensure consumers are readily able to access and navigate through the health system.	• Focus strongly on reducing preventable errors or harm. • Monitor effectiveness of current practice. • Ensure effective clinical risk management processes are in place and systems are developed that minimise risk • Provide information, analysis and advice to clinical, management and consumer groups as appropriate. • Ensure everyone in the HB health sector are aware of their responsibility for quality improvement and patient safety.	• Communicate and engage with clinicians and other stakeholders within HB Health Sector, providing clinical leadership when/where appropriate. • Oversee clinical education, training and research. • Ensure clinical accountability is in place at all levels.

STRATEGIES	• Review and comment on all reports, papers, initiatives prior to completion and submission to the Board.
	• Proactively develop, promote and recommend changes to improve health outcomes, patient experience and value from health resources.
	• Develop, promote and advise on strategies and actions that could assist with the reduction in health inequities.
	• Develop and promote initiatives and communications that will enhance clinical integration of services.
	• Provide input through representation on EMT, Alliance Leadership Team and through attendance at HB Health Sector Leadership Forum.
		• Work collaboratively with the Consumer Council to design and implement a Person and Whanau Centred Care approach.
		• Understand what consumers need.
		• Understand what constitutes effective consumer engagement.
		• Promote clinical workforce education and training and role model desired culture.
		• Promote and implement effective health literacy practice.
		• Promote the development and implementation of appropriate systems and shared clinical records to facilitate a 'smooth patient experience' through the health system.
			• Develop and maintain relevant and effective Clinical Indicator reporting and performance management processes.
			• Establish and maintain effective clinical governance structures and reporting processes.
			• Ensure safety and quality risks are proactively identified and managed through effective systems, delegation of accountabilities and properly trained and credentialed staff.
			• Ensure the "quality and safety" message and culture is spread and applied in all areas of HB health sector.
			• Promote "value-based decision-making" at all levels. This involves improving the processes by which decisions are made, so they take into consideration all three Triple Aim objectives:
			  ○ Enhanced patient experience
			  ○ Improved health outcomes
			  ○ Better value for money
			• Ensure attendance at appropriate meetings/forums to provide appropriate assurance and confidence.
				• Ensure all HB clinicians and other stakeholders are aware of the role, membership and activities of the Clinical Council.
				• Oversee the development, maintenance and implementation of a HB Clinical Workforce Sustainability Plan.
				• Promote clinical governance at all levels within the HB heatlh system.
				• Ensure appropriate attendance/input into National/Regional/ Local meetings/events to reflect HB clinical perspective.
				• Promote ongoing clinical professional development including leadership and "business" training for clinical leaders.
				• Facilitate co-ordination of clinical education, training and research.
				• Role model and promote clinical accountability at all levels.

OBJECTIVES 2016/17	• Prioritise meeting time to focus on papers with significant clinical issues. • Encourage proactive presentations / discussions on innovative issues / ideas. • Ensure risk management processes provide for early Clinical Council visibility (and input) of all significant clinical issues. • Align portfolio areas of responsibility to clinical governance structure memberships (once confirmed).	• Work in partnership with Consumer Council to develop an appropriate "Person & Whanau Centred Care" approach and culture. • Monitor "Quality Dashboard" and support performance improvement initiatives as appropriate. • Promote and support ongoing enhancements to information systems relating to clinical process and consumer records. • Support a review of the "Primary Heatlh Care" model of care. • Support and champion the development of a health literacy framework, policies, procedures, practices and action plan.	• Implement and progressively develop the proposed new Clinical Governance Committee / Advisory Group structures. • Monitor and report on the implementation of the action plan for "Governing for Quality. • Oversee and monitor the achievement of objectives within the QIPS Annual Plan.	• Enhance the profile and perceived value of Clinical Council within the sector, through improved effective two way communications. • Facilitate the development of a HB Clinical Workforce Sustainability Plan • Promote Strategies to enable the HB Clinical Workforce to adapt to meet the challenges of the future. • Support and promote the ongoing implementation of clinical leadership training and developments.

@BCL@5804CE70

HAWKE'S BAY District Health Board Whakawāteatia	**Palliative Care in Hawke's Bay**
	For the attention of: **Māori Relationship Board, HB Clinical Council and HB Health Consumer Council**
Document Owner: Document Author:	Chris McKenna Director of Nursing Mary Wills Head of Strategic Services
Reviewed by:	Executive Management Team
Month:	March, 2017
Consideration:	For approval

RECOMMENDATION

That the Maori Relationship Board, Clinical and Consumer Councils:

1. Note amendments to the plan following workshops with primary care, palliative care stakeholders, consumers and in rural areas
2. Approve the plan.

OVERVIEW

A draft plan was circulated in December 2016. Overall feedback has been positive and stakeholders believed that the plan covers high priorities for the next 10 years.

The document has been amended to reflect the following comments:

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

Stakeholders would like timelines for implementation and more detail about how actions will be implemented and funded. The timeframes will be determined by the national palliative care strategy, the Healthy Ageing Strategy and budget announcements in May.

Live Well
Stay Well
Die Well

Palliative Care in Hawke's Bay

Our vision and priorities for the future 2016 – 2026

Executive Summary

"You matter because you are you, and you matter to the last moment of your life.
We will do all we can, not only to help you die peacefully, but also to live until you die"
Dame Cicely Saunders

Dying is a normal part of the human experience and affects people regardless of age. Whenever a person dies in Hawke's Bay, there are impacts for their family/whānau, friends, work colleagues and the community in which they live. Many people would prefer to die in their own home, cared for and surrounded by their loved ones.[1] Others will die in hospice, hospital or aged residential care, by choice or by necessity.

The experience of dying, and of caring for loved ones at the end of life, can have a deep and lasting impact on those involved. Poorly supported dying, with inadequate symptom control and failure to meet the needs of those who are dying as well as those who care for them, may lead to a complicated bereavement process for those left behind. In contrast, high quality and well-co-ordinated care at the end of life provides a setting for a healthy experience of death for both family/whānau and surrounding community.

The quality of care provided in the Hawke's Bay region to those at the end of life is everyone's responsibility. Death is not a subject that should be avoided or concealed. It is one of the great certainties of life, and involvement in caring for those people who are dying can, not only strengthen family relationships, encourage compassion and resilience, and promote positive connections in the community, enhance respect for health and life, and reduce community fears about death and dying.

We will extend the ways we receive patient feedback and hear what is important to patients and family/whānau. Patients and whānau have told us they are not always told when a person is dying. Having "conversations that count" earlier can support everyone to understand what is happening.

As the numbers of people needing palliative care grows rapidly over the next 10 years, we will need to be culturally responsive in our practice. Services will need to respond to Māori and Pacifika needs. This will be supported by shared leadership, working as one team and with agreed priorities for the next 10 years.

We will recruit and train staff in palliative care. This includes sustainable medical staff and replacement of our retiring nursing workforce. Allied health and family support team members will work with primary care to provide a multidisciplinary response for patients with dementia and who are frail. Our focus on education and training will develop the next generation of palliative care practitioners in primary and specialist palliative care.

We will agree how services provide access 24 hours a day 7 days a week. As the national strategies for Healthy Ageing and Palliative Care are implemented in Hawke's Bay, we will invest in sustainable specialist palliative care services and education and training. This will be supported by technology, shared information across services and using information to inform service improvement.

Our six priorities for the future will improve care for people and their family/whānau. To achieve this requires us to work together as one team to strengthen the foundations on which our vision is built.

[1] Gomes, Calanzan, Gysels, Hall, Higginson *Heterogeneity and changes in preferences for dying at home: a systemic review* 12:7 BMC Palliative Care 2013 12:7

Live Well Stay Well Die Well

Our six priorities:

1. **Each person and their family/whānau will have their individual needs as the centre of care**
2. **Each person gets access to high quality individualised care and we improve equity**
3. **Comfort and wellbeing maximised**
4. **Care is coordinated**
5. **The community is involved**
6. **People are prepared to care**

Introduction

In today's society, people are increasingly expressing the importance of choice and independence as major components of dignity in advancing illness and old age. Most of us expect to make decisions, not only on how we live our last years, months, weeks and days of life but also on how and where we die. With advances in chronic disease management, single disease approaches for planning end of life will make less sense as functional decline towards end of life could be very hard to predict. This will have wide reaching implications for the co-ordination of care, health and social needs, predictions of future outcomes, referrals and patient, family/whānau experience and choice.

Increasing numbers of people with neurodegenerative conditions like dementia suggests an increasing need for early participation in planning for, and conversations about dying if we are going to be able to provide quality care to those at end of life.

Palliative care is recognised as a speciality that focuses on patient centred care, but as future demands for services increase, more than ever we will need to ensure we continue to place the patient and their family/whānau needs and goals at the centre. Our response to needs will have to be tailored so that we are providing just the right amount of support to empower and enable individuals to achieve their goals and to live their lives until they die. Services will need to ensure that they are providing a culture of enablement alongside our care. This will enable people greater choice, independence and dignity in advancing illness and/or old age.

For Hawke's Bay the level of need for palliative care is hard to predict. There is literature stating that for most people their palliative care needs can be met through good primary palliative care provided by general practitioners, hospitals, aged residential care, district nurses and Māori health providers without the need for direct care provision of specialist palliative care.[2] [3] Providing palliative care needs to be a core part of everyone's practice.

[2] Temel, J.S, Greer, J.A, Muzikansky, M.A, Gallagher, E.R, Admane, M.B, et al (2010). *Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer*. N Engl J Med 2010; 363:733-42

[3] Quill, T.E., & Abernethy, A.P. (2013). *Generalist plus Specialist Palliative Care — Creating a More Sustainable Model.* N Engl J Med; 368:1173-1175March 28, 2013DOI: 10.1056/NEJMp1215620

What is palliative care?

Palliative care is the care of people who are dying from active, progressive diseases or other conditions that are not responsive to curative treatment. Palliative care embraces the physical, social, emotional and spiritual elements of wellbeing–tinana, whānau, hinengaro and wairua – and enhances a person's quality of life while they are dying. Palliative care also supports the bereaved family/whānau.[4]

The principles of palliative care are that it:

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten or postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patient's illness and in their own bereavement
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- will enhance quality of life, and may also positively influence the course of illness
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Palliative care is provided according to an individual's need, and may be suitable whether death is days, weeks, months or occasionally even years away. It may also be suitable sometimes when treatments are being given aimed at extending quality of life.

It should be available wherever the person may be located. It should be provided by all health care professionals, supported where necessary, by specialist palliative care services.

Palliative care should be provided in such a way as to meet the unique needs of people from particular communities or groups. This includes but is not limited to: Māori, children and young people, immigrants, those with intellectual disability, refugees, prisoners, the homeless, those in isolated communities and lesbian, gay, transgender and intersex people.[5]

[4] Ministry of Health. (2001). *New Zealand Palliative Care Strategy*. Wellington. MoH

[5] Palliative Care Subcommittee, NZ Cancer Treatment Working Party (2007) *New Zealand Palliative Care: A Working Definition.* [Online]. Available from: http://www.moh.govt.nz/moh.nsf/pagesmh/2951/$File/nz-palliative-care-definitionoct07.pdf.

Palliative care will be delivered by both primary palliative care and specialist palliative care providers working together as one team. [6]

Primary palliative care (PPC) refers to care provided by general practices, Māori health providers, allied health teams, district nurses, aged residential care staff, general hospital ward staff as well as disease specific teams e.g. oncology, respiratory, renal and cardiac teams. The care provided is an integral part of usual clinical practice. Primary palliative care providers assess and refer people to specialist palliative care services when the needs of the person exceed the capability of the primary palliative care provider.[7]

Specialist palliative care (SPC) is palliative care provided by those who have undergone specific training or accreditation in palliative care/medicine, working in the context of a multidisciplinary team of palliative care health professionals.

Specialist palliative care may be provided by hospice or hospital based palliative care services where people have access to at least medical and nursing palliative care specialists.

Specialist palliative care is delivered in two key ways:

- Directly – direct management and support of the person and family/ whānau where more complex palliative care needs exceed the physical, spiritual or social resources of the primary provider. SPC involvement with any person and the family/ whānau can be continuous or episodic depending on the changing need.
- Indirectly – to provide advice, support, education and training for other health professionals and volunteers to support the primary provision of palliative care.

Future need

Like all of New Zealand, and the World, the increasing numbers of people dying and the changing patterns of illness means the number of people who could benefit from a palliative approach to care is increasing. We will need to manage resources and ensure that we have the right people equipped to care and support the needs of those with a life limiting condition.

Evidence is showing us that in the next 20 years we will have more people dying. They will be living with and dying from not only malignant conditions such as cancer, but chronic conditions and multiple comorbidities, including dementia. Their longevity will be frequently compromised by fragility and disability.[8]

[6] Palliative Care Council of New Zealand. (2012). New Zealand Palliative Care Glossary. Wellington: Ministry of Health

[7] Hospice New Zealand. (2011). *Hospice New Zealand standards for the care of people approaching the end of life.* Wellington: MoH

[8] Ministry of Health (2016). *Review of Adult Palliative Care Services*, DRAFT June 2016

For New Zealand the estimates are:

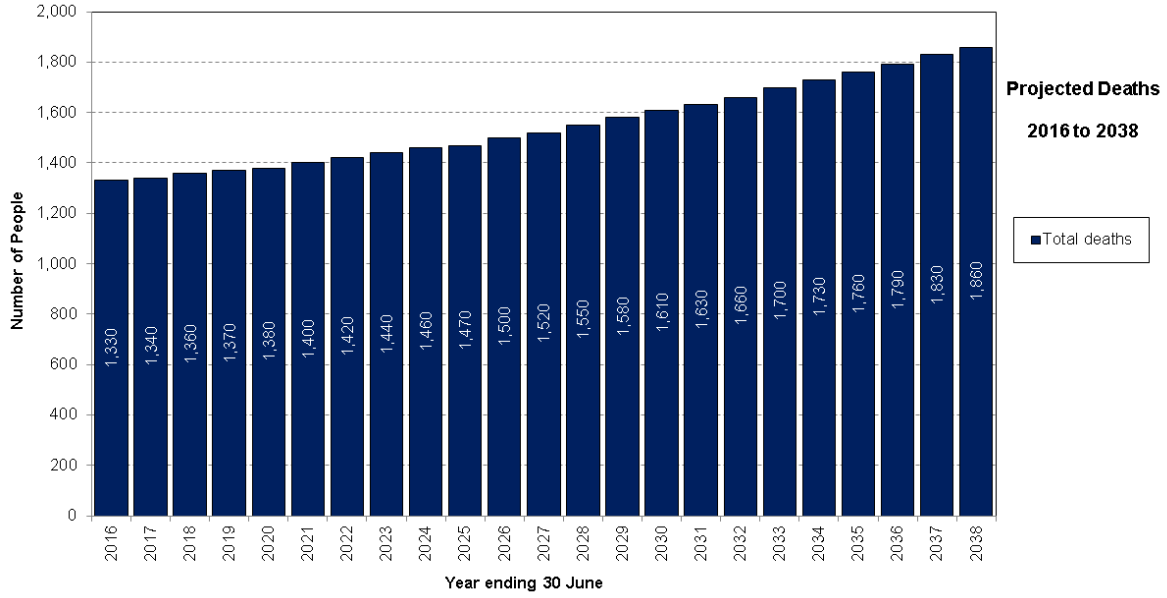
- Projected deaths will increase by almost 50 percent (from 30,000 to 45,000 per annum in 2038).
- Deaths will reach 55,500 per annum by 2068. This is the result of people living longer than before, coupled with an absolute increase in numbers due to the “baby boom” generation (born between 1946 – 1965) entering their older years.
- There will be rapid ageing of those deaths. In 20 years over half of the deaths will be in the age group 85 years and older. Deaths at the oldest ages will be predominantly women.
- Over the last decade deaths from circulatory system conditions have been declining and deaths from other conditions, including respiratory conditions, dementia and frailty, have been proportionally increasing.

For Hawke’s Bay our data is showing us:

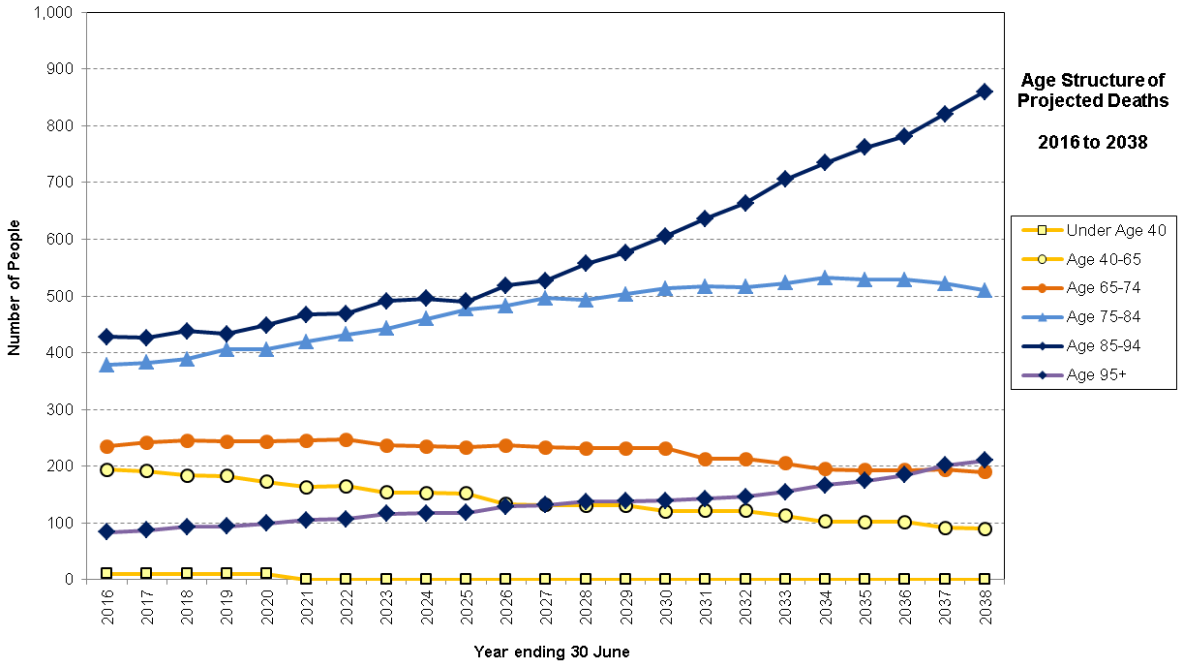
- The number of deaths per year will increase by over 500 people. From 1,330 predicted for 2016 to 1,860 by 2038. See graph 1.
- People in the 84-94 age group will more than double from 420 in 2016 to 870 by 2038. See graph 2.
- We will also see an increase in the 95 years and over age group with increases from 100 in 2016 to 200 by 2038.
- The number of Māori and Pasifika people dying will increase and whilst the numbers are relatively small per annum, the increased incidence of poverty plus barriers to access caused by cultural differences and lack of resources means that they are likely to require more support to achieve equitable outcomes.
- The estimated number of people dying who are likely to benefit from palliative care services is 822 in 2015 rising to 927 in 2025.
- The Hospice NZ Palliative Care Demand Model suggests that Cranford Hospice could possibly have been involved with 822 deaths in 2015 based on population data. They were actually involved in 663 deaths. There may be an unmet need of approximately 160 patients currently per annum.

Uptake of specialist and primary palliative care services by Māori (15.8%) and Pasifika (1.1%) was in line with their younger population profiles in 2014. However, it is not known whether the experiences of those groups is equitable, or whether they receive similar number of contacts per person as other non-Maori, non-Pasifika people.

Graph 1 : Number of projected deaths in Hawke's Bay 2016 to 2038



Graph 2 : Estimated change in age of death in Hawke's Bay from 2016 to 2038

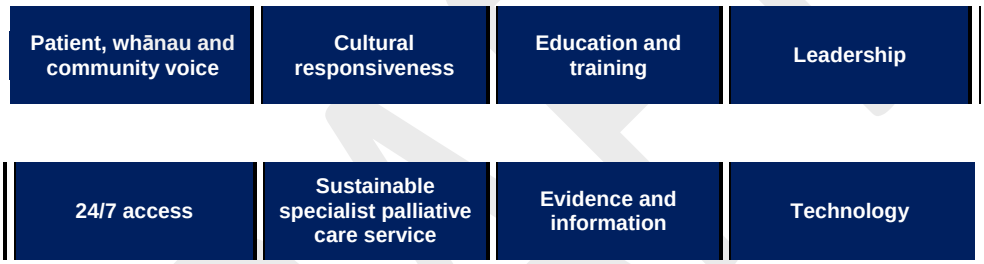


Acknowledgement: This document was developed using the National Palliative and End of Life Care Partnership. Ambitions for Palliative and End of Life Care; A national framework for local action 2015-2020. www.endoflifeambitions.org.uk.

Foundations on which our vision is built

"All people who are dying and their family/whanau who could benefit from palliative care have timely access to quality palliative care services that are culturally appropriate and are provided in a coordinated way"[4]

To realise our vision we have identified eight foundations that need to be in place to meet our commitments to palliative care in Hawke's Bay. They are necessary for each and underpin the whole. These foundations are prerequisites for success in providing quality palliative care to our community now and into the future.



1. Patient, Whānau and Community Voice

Systems for palliative care are best designed in collaboration with people who have had personal experience of death, dying and bereavement. We need to ensure that we are listening to the voices of patients, family/whānau, carers and communities in all that we do.[9] We need to engage communities in their own care design and how health services are delivered. Patients and whānau have told us they need better information so they are aware of support and can access it when they need it.[9] [10]

2. Equity and Cultural Responsiveness

We will provide culturally responsive care that is mindful of the beliefs and values of patients, family/whanau. This will include considering how to provide palliative care for the growing numbers of Māori and Pasifika who will need these services. When providing palliative care for Māori it is essential to see things through the patient's eyes. This includes understanding cultural influences on the pathway of death, acknowledging the strengths and resources of whānau and taking the time to understand what is important to the person. Whānaungatanga, kanohi ki te kanohi, wairuatanga, and the availability of Māori kaitakawaenga are all important for effective communication with Māori patients and their family/whānau.[11] [12]

[9] Boon, A. (2012). *Excellence through Patient and Family Centred Care; Literature Review.* Wellington: Health Quality and Safety Commission

[10] Layden, Connelly, Sandeman, Hekerem, Alexander, McLoughlin & Tyrrell. (2014). *Understanding palliative and end of life care through stakeholder and community engagement.* BMJ Support Palliat Care 2014;4:117-118 doi:10.1136/bmjspcare-2014-000653.39

[11] Ministry of Health. (2014). *Palliative Care and Māori from a Health Literacy Perspective.* Wellington: Ministry of Health.

[12] BPAC. (2016). *Providing palliative care to Maori.* http://www.bpac.org.nz/resources/campaign/palliative/palliative_maori.asp

3. Education and Training

To have palliative care as everybody's business there is a large education programme that needs to be implemented. We will need to educate patients, family/whānau, carers and primary palliative care providers in palliative care. With increasing demands on time we will need to look at a range of methods to teach appropriate knowledge and skills in end of life care. They include face-to-face, e-learning, simulation, reflective learning, health promotion, telemedicine, case studies, death reviews, mentoring and supervised clinical practice. We also need to look at ways to educate and train our informal workforce, unpaid volunteers and carers so they too are well equipped to provide hands on care and support. We will need to understand death and dying and advance care planning.

For PPC providers core elements will include:

- Identifying patients who need palliative care
- Breaking bad news
- Conversations with patients and their family/ whānau around advance care planning
- Providing care according to patient and family/whanau needs
- Basic symptom management
- Psychosocial support
- Knowledge of when to refer to specialist palliative care

These should be routine aspects of care delivered by any PPC health practitioner.

With a greater focus on primary palliative care, we will need a sustainable and sufficient specialist workforce to provide advice, support and education to PPC providers. They will also be educated, trained and equipped to manage and care for those who will need complex palliative care management including those with dementia and frailty.

There needs to be a focus on increasing opportunities for introducing and training students in all disciplines in palliative care.

In 2016 Cranford Hospice was successful in its submission for Ministry of Health innovation funding. The following roles have been established, based on feedback from General Practice and Aged Residential Care.

The existing Aged Residential Care Palliative Care Resource Nurse position increased from 0.6 to 1.2 full time equivalent. The Aged Residential Care liaison nurse will support and teach skills in palliative care.

A new 0.9FTE Palliative Care Nurse Practitioner supports primary care and rural services. This role works within General Practice with an emphasis in the first instance on rural populations in Central Hawke's Bay and Wairoa. The focus of this role will be to develop the skills, capacity and systems/processes required in primary care to deliver high quality primary palliative care. The Nurse Practitioner will support a primary care training programme and establish a process for regular case review with practices.

A new Caregiver Support Coordinator provides support to family/whanau caring for palliative patients by mobilising existing support services and volunteer networks.

4. Leadership Specialist and Primary

Shared leadership with clear responsibilities will deliver our vision and priorities. A business case will describe the priorities for investment so that services are planned to meet Hawke's Bay population needs.

Clinical leadership must be at the heart of this strategic vision to ensure that each person and their family/whānau receives the care they need, at the right time, by the right people. They must be committed to the priorities and are key in ensuring outcomes are met. As the Ministry of Health finalises the Palliative Care Strategy and Healthy Ageing Strategy, we will link new national priorities to our agreed local priorities.

5. Access 24 hours, 7 days a week

Every person at the end of life should have access to services 24 hours, 7 days per week (24/7). In times of distress, uncontrolled pain and other symptoms cannot wait for office hours. People need to know who to contact, no matter what the time. PPC providers, especially GPs, are providing the majority of care. They need to be resourced to meet the demands, with access to 24/7 advice and support from SPC. Pre-emptive charting and protocols for district nurses, ambulance, aged residential care and other community services need to be in place. For those who experience complex symptoms, the SPC nursing and medical team needs to be able to provide advice, care and support to those in need.

In Hawke's Bay we have a PPC programme that is intended to support patients who have a life limiting condition. The funding allocated to this programme is focussed on providing patients with dedicated care led by their primary health care team that works to moderate symptoms, pain, physical stress and the mental stressors associated with serious illness. The goal of this programme is to support planned care to improve the quality of life for both patients and their families.

A patient is offered access to this programme when they meet criteria and when there is a sense of need to provide palliative care therapies when no cure can be expected and when there is an expected length of life of six months or less. We will plan for sustainable funding past 30 June 2017.

6. Sustainable Specialist Palliative Care Service

Specialist palliative care is a vital foundation if we are to realise our vision and our priorities. Our specialist service needs to be equipped and resourced to meet the needs of complex patients, family/whānau, increased education needs, support of primary palliative care providers, advice and support 24/7.

There is a national shortage of palliative medicine specialists, an ageing nursing workforce and the low use of allied health teams.[1 13] Allied health professionals are commonly part of the palliative care multidisciplinary team in other countries (e.g. United Kingdom) but are not always in New Zealand.

SPC has been working hard since 2011 to build its workforce for the future needs with the introduction of advanced trainee positions, the introduction and expansion of clinical nurse specialists in hospice and hospital and the development of a nurse practitioner role. There is still work to do to ensure that we have a sustainable workforce that is well educated and equipped to meet needs.

Alongside new innovation and new roles the core clinical team positions need development to meet current and future demands. Our specialist medical workforce is an urgent priority. We do not have a sustainable medical workforce to meet required needs. With increasing complexity of patient and family/whānau needs and population growth we need to plan to increase resources.

This is not unique to Hawke's Bay. In 2014 the national Palliative Medicine and Training Coordination Committee surveyed District Health Boards and reviewed work force projections for Senior Medical Officer positions. They found 12 Senior Medical Officer positions were vacant and over the next five years to 2019, vacancies due to retirement would increase this to 30.[8]

The current medical, nursing, allied health, family support workforce is summarised in Appendix 1. Proposed roles and FTEs are described for 2026, to be able to cope with an increased demand for clinical care provision, advice, mentorship, supervision, rural support and education.

Over 50% of our SPC nursing workforce are eligible for retirement in the next 2 to 5 years. In the last few years we have been successful in recruiting for positions, as more nurses are considering palliative care as a speciality. These nurses will need time (2 to 3 years) to specialise and train. As half of our experienced workforce retires in the next 5 years providing support, mentorship and training will be challenging.

We have proposed increases in the nursing workforce to meet the increased need for complex care provision, an increase in inpatient beds at Hospice from 8 up to10, increased education and mentorship of primary care providers and training new specialist nursing staff. Staff, services and facilities will respond to the growing numbers of people with dementia and frailty.

To provide a holistic approach to care, SPC has also been growing its family support team and allied health team. This team will almost double to be able to meet demands in the community, especially with increased frailty, the need for a rehabilitative approach and patients living for longer with multiple comorbidities. As interdisciplinary teams develop further with primary care we will improve our communication and systems so we coordinate with new services such as engAGE services for frail older people.

[13] Palliative Care Council. (2013). *Needs Assessment for Palliative Care: Summary Phase 2 Report: Palliative Care Capacity and Capability in New Zealand* June 2013

To respond to the needs of the Hawke's Bay population, we will integrate Cranford Hospice and the Hospital Specialist Palliative Care team (HPCT) to form one specialist palliative care service for Hawke's Bay. This integrated service will provide quality clinical care at Cranford Hospice, within the community, and an in-reach consultation liaison service to the Hawke's Bay Fallen Soldiers Memorial Hospital. The service will use the same management support, human resources and clinical guidelines across all care settings. There will be one single point of entry to SPC, and care will be more seamless no matter what bed you are in or which setting that bed is placed in. SPC will be delivered equitably, with greater care coordination and with opportunities for workforce development. There will be rotation of staff across hospice, community and hospital areas.[14]

7. Technology

Care planning conversations need to be effectively recorded and appropriately shared through electronic systems. Electronic systems will need to support wider access to information, extended information context and new functions, such as write access by multiple sources. Access to Advanced Care Plans, pre-emptive charting and crisis plans must be maximised.[13] [15]

8. Evidence and Information

We need to ensure that data and evidence, including people's accounts of their experience of care are used effectively to inform learning, improvement. We will improve the collection, analysis, interpretation and dissemination of data related to palliative and end of life care. This will include evidence relating to needs, provision, activity, indicators and outcomes.[15]

[14] Canadian Hospice Palliative care Association. (2013). *Innovative Models of Integrated Hospice Palliative Care, the Way Forward Initiative: An Integrated Palliative Approach to Care.*

[15] The Scottish Government. (2015). *Strategic Framework for Action on Palliative and End of Life Care 2016-2021.* Edinburgh: The Scottish Government.

1 Each person and their family/whānau will have their individual needs as the centre of care

"On one occasion the hospice nurse arrived after he was discharged from hospital and worked through the discharge summary to make sure we understood the plan"
Wife of patient

What we already know

- People are unique, they want to be listened to, respected and involved in their care.
- People and their family/whānau require care. The needs of all individual members need to be identified and addressed.
- Leaders and care professionals need to be innovative in how they ask, record and work to support choices, particularly with limited resources.
- People, family/ whānau want to be involved in their care. They should be given all the information, advice and support they need to make decisions about it.
- Advance care planning gives everyone a chance to say what is important to them, ahead of time. It helps people understand what the future might hold and to say what treatment they would and would not want. It helps people, their families and healthcare teams plan for the future and end of life care.[16]
- Having conversations about death, dying and end of life requires compassion, knowledge, experience, sensitivity and skill on the part of the health professional involved. A series of conversations may be needed to determine the goals, values and wishes of the person and their family/ whānau in order to reach decisions about the appropriate plan of care.

[16] Northern Regional Alliance. (2016). *Advance Care Planning asks "What matters to you?"* http://www.advancecareplanning.org.nz/

Live Well Stay Well Die Well

The building blocks we need in place

Enablers for person centred care

Care must be delivered by systems that are carefully and consciously designed to ensure people retain control and are active participants in their care. Whenever possible care must be respectful of the person's values and preferences[5]

Access to social support

There is a mix of health, personal and social need at the end of life and afterwards which requires skilled assessment and available resources, delivered in an appropriate environment.

Meaningful conversations

People should have the opportunity to say what's important to them and be well informed about dying, death and bereavement by the right people in the right way at the right time[16]

Clear expectations

People and their family/whānau should know what they are entitled to expect as they reach the end of their lives[17]

Integrating the philosophy

The philosophy of person centred care is promoted and integrated into models of care across the health and social sectors

Good end of life care includes bereavement

Caring for the individual includes understanding the need to support the unique set of relationships between family, friends, carers, other loved ones and their community, and includes preparations for loss, grief and bereavement[18]

[17] National Palliative and End of Life Care Partnership. *Ambitions for Palliative and End of Life Care; A national framework for local action 2015-2020.* www.endoflifeambitions.org.uk.

[18] Heatley, R. (2006). *Carers' services guide*. London: Help the Hospices

2 Each person gets access to high quality individualised care and we improve equity

"The hospital palliative care team explained what 'hospice' meant, communication was great. Once this had been explained they were happy to accept a referral"
Consumer feedback

What we already know

- The number of Māori and Pasifika people dying will increase and whilst the numbers are relatively small per annum, the increased incidence of poverty in this population and the barriers to access caused by cultural difference and lack of resources means that they are likely to require more support to achieve equitable outcomes.[11]

- We cannot identify and predict when every person will die. The population is ageing and chronic conditions and co-morbidities will increase, making this even more difficult.

- Adults living in Wairoa and Central Hawke's Bay had fewer face to face contacts with SPC than in urban areas. They did not receive a corresponding increase in GP contacts, suggesting an inequity between urban and rural service delivery.[19]

- There is substantial data available regarding the palliative population. This needs to be standardised and used appropriately to identify the needs of the Hawke's Bay population and inform decision making.[20]

- Access to good and early palliative care can improve outcomes, not only with regards to quality of life, but also life expectancy.[2] [17]

- The way messages relating to the likely outcomes of medical conditions are communicated to people, affect their transition from curative to palliative care and willingness to accept referral to specialist palliative care.

- A public health approach recognises and plans to accommodate those disadvantaged by the economy, including rural and remote populations, tangata whenua, the homeless, lesbian, gay, bisexual, transgender and intersex communities.

- "Until recently, almost all assessments of the quality of palliative care focused on care structures and processes rather than on outcomes. Outcome measures are widely used in palliative care research to describe patient populations or to assess the effectiveness of interventions, but they are not, as yet, always incorporated into routine clinical practice".[21]

[19] *HBDHB palliative care data 2016*

[20] McLeod, H. (2016*). Hospice New Zealand Data Project Plan*

[21] Bausewein et al. (2016). EAPC *White Paper on outcome measurement in palliative care: Improving practice, attaining outcomes and delivering quality services.* Palliat Med. 2016 Jan;30(1):6-22. doi: 10.1177/0269216315589898. Epub 2015 Jun 11.

The building blocks we need in place

Person centred outcome measurement

With a consistent data set, improvement can be tracked and action taken to ensure all providers are accountable for enabling fair access to quality care.

Using data

"Well-organised data collection can help us to target different population groups and track their progress towards better outcomes, access and wider goals shared with other agencies. Information we collect can improve our understanding of the cause and effect relationships between health and other social services, the effectiveness of different ways of working, and the value for money offered by different interventions".[4]

Unwavering commitment

To achieve equity and access, provision and responsiveness requires unwavering commitment to local contracts and sustainable funding.

Referral criteria

A clear referral process is designed to ensure limited resources are appropriately allocated to serve those most in need. Other barriers to access are proactively evaluated and reduced to ensure an equitable service.

Community partnerships

Local plans should include partnerships between different faith groups and cultural communities, as well as the diverse organisations that support children and young adults, people living with different life shortening illness, and those managing the difficulties of older age.

Population based needs

Palliative care needs for the Hawke's Bay population should inform service design and resource allocation.

3 Comfort and wellbeing maximised

"The hospice doctor was the first to look at my whole picture, she asked "what sort of person are you? Do you want to know anything? She was the first to work with my interest in other therapies"
Patient feedback

What we already know

- What matters most to people at the end of life is good control of pain and other symptoms and being accompanied by but not a burden to their family/whānau.[8]
- People want to be considered as a whole. We need to care for physical, spiritual, family and mental health needs.
- Many people approaching death are fearful of being in pain or distress. Dying and death can be a powerful source of emotional turmoil, social isolation and spiritual or existential distress.[17]
- The experience of dying, and of caring for loved ones at the end of life, can have a deep and lasting impact on those involved. Poor support and inadequate symptom control may mean we fail to meet the needs of those who are dying, as well as those who care for them. This may lead to a complicated bereavement process for those left behind.
- A rehabilitation approach to palliative care is central to the person-centred ethos of hospice care, and promotes a culture that helps patients to thrive, not just survive, when faced with uncertainty and serious illness.[22]
- "The benefits of this rehabilitative approach are huge, not only for patients and their families but for hospices too, as they seek to respond to the challenges of supporting more people living longer with chronic conditions".[22]
- Members of the interdisciplinary team offer a diverse range of skills in the provision of emotional, social, psychosocial, cultural, religious and spiritual support, and it is recognised that all team members play a vital role.

[22] Hospice UK. (2015). *Rehabilitative palliative care: enabling people to live fully until they die – A challenge for the 21st century*.

The building blocks we need in place

Recognising distress whatever the cause

"Promptly recognising, acknowledging and working with the person to assess the extent and cause of the distress, and considering together what might be done to address this is important. This must be available in every setting."[17]

Skilled assessment and symptom management

Attending to physical comfort and pain and symptom management is the primary obligation of health professionals at this time of a person's life. Their skills to do so must be assured and kept up to date.[17]

Addressing all forms of distress

The experience of suffering associated with physical symptoms may be caused or made worse by emotional or psychological anguish or social or spiritual distress. Addressing this requires professionals to recognise, understand and work to alleviate the causes.

Priorities for care of the dying person

The delivery of care is respectful, individualised and tailored to the person who is in their last days of life. This includes acknowledgement of physical, spiritual, social, mental and cultural factors important to each individual and their family/whanau. Mechanisms to incorporate these factors into the delivery of care are prioritised as decided by the person, wherever they may be dying.

Specialist palliative care

Specialist palliative care is available to those people whose assessed needs exceed the capability of the primary palliative care provider. Specialist palliative care is responsible for supporting primary palliative care to achieve improved outcomes for patients and their family/whānau.

Rehabilitative palliative care

Rehabilitation aims to improve quality of life by enabling people to be as active and productive as possible, with minimum dependence on others, regardless of life expectancy.[22]

Fit for purpose facility

A suitable, well located facility will ensure that everyone has access to expertise and care. It also provides a hub for community engagement.

4 Care is coordinated

"It feels like the nurses are all up with the play, we don't have to repeat the story each time, it quickly felt like they really know us"

Patient feedback

What we already know

- People report not having a clear understanding of the role of the multiple health services involved in their care.
- Feedback indicates that lack of coordinated care and services increases the stress experienced by the patient, their carer/s, family and whānau. The alleviation of this would add significantly to their quality of life.
- People feel supported and safe with 24 hour advice available. The quality of the advice directly influences the level of trust people have with a service as a whole.
- Poor communication and failure to share information about the person who is dying is a recurrent theme when care is not good enough.[17]
- Primary palliative care professionals, including aged residential care staff report the increased confidence and increased ability to provide quality of care when access to specialist advice is available.
- High quality and well-co-ordinated care at the end of life provides a setting for a healthy experience of death for both family/whānau and the surrounding community.[15]
- People at the end of life with high levels of health, support and palliative needs require flexible packages of quality home nursing and support services to enable them to die at home, and to support their family and whanau at this time.

The building blocks we need in place

Systems for shared records

Health records for all people living with a life-limiting condition must include documentation of their assessed needs, as well as their preferences for end of life care. The person must have given their informed consent and the records should be shared electronically with all those involved in their care.

Clear roles and responsibilities

People living with life limiting conditions may have different services involved in their care. It is essential that people and their families know who and where to turn to for advice in times of change or crisis.

A system-wide response

Coordinated services need to be responsive to need in the community. These systems must include enabling dying people and their family/whānau access to 24/7 advice and support.

Continuity in partnership

Communication between service providers and consistent knowledge across settings, facilitates the smooth and timely delivery of quality care.

5 The community is involved

What we already know

- Talking about death, dying and bereavement is avoided in most community groups.
- Many members of the community do not understand what palliative care is.
- People who are dying and bereaved people often feel disconnected or isolated from their communities and networks of support.[17]
- Globally there is much known about helping to nourish compassionate and resilient communities, and how to build capacity to provide practical support.[17]
- Death, dying and loss affect everybody.
- The majority of people living and eventually dying from life-limiting conditions spend the greater part of their time at home being cared for and supported by family members, friends and neighbours.
- Many people feel unprepared when faced with the experiences of life-limiting conditions, death and bereavement and are uncertain about how to offer support and assistance.
- The experience of death, dying and bereavement can bring additional personal, health and social costs to those left behind. Much of this is preventable and/or relievable if the right supports are available in the right place at the right time.[23]
- The use of volunteers maximises community engagement and promotes partnerships between agencies and the community. Volunteers add value to the patient and family experience and complement the work of paid staff.

[23] Kellehear, A. (1999). *Health Promoting Palliative Care.* Melbourne: OUP

The building blocks we need in place

Compassionate and resilient communities

In a compassionate community, people are motivated by compassion to take responsibility for and care for each other with collective benefit.
http://www.charterforcompassion.org/index.php/shareable-community-ideas/what-is-a-compassionate-community

Public awareness

A community will be in the best position to care when they are comfortable with death and dying, can understand the difficulties people face, and know what help is available.

Practical support

Practical support, information and training are needed to enable families, neighbours and community organisations to help.

Volunteers

To meet our commitment, more should be done locally to recruit, train, value and connect volunteers into a more integrated effort to help support people, their family/whanau and communities.[17]

6 People prepared to care

"People didn't focus on physical symptoms – hospice staff were able to see the whole picture" Consumer feedback

What we already know

- The recruitment and retention of palliative care medicine specialists in urban and provincial areas is a major issue.[24] This is also an issue for Hawke's Bay.
- We have an ageing specialist palliative care nursing workforce.
- The demand for palliative care services, and thus workforce, will increase slowly over the next ten years but thereafter will increase more rapidly in line with the ageing population.[24]
- There is a growing need for a workforce that is culturally competent to accommodate diverse personal, cultural and spiritual customs and values.[8]
- Feedback suggests that the relationship people have with their GP and practice nurse is extremely important.
- The ageing population and emphasis on integrated care means that home and personal caregiver roles are becoming an increasingly critical part of the palliative care multidisciplinary team.
- Much of palliative care is provided by family members as informal carers. Reliance on informal carers and the volunteer workforce will only increase and we will need to support them to undertake potentially more complex roles.[8]
- A primary palliative care workforce works best when it is well-informed, educated and supported by specialist palliative care in caring for those with life-limiting conditions.
- Specialist palliative care services will need the capability and capacity to be able to provide care, support and educate others to meet projected demands and complexities of care.
- In order to meet identified needs of patients and their family/whanau we need a diverse range of skill and expertise within the interdisciplinary team.
- Staff can only compassionately care when they are cared for themselves. They must be supported to sustain their compassion so that they can remain resilient. This allows them to use their empathy and apply their professional values every time.[19]

[24] Ministry of Health. (2011). *Palliative Care Workforce Service Review; Health Workforce New Zealand.* Wellington: Ministry of Health

The building blocks we need in place

Knowledge base

Only well-trained competent and confident staff can bring professionalism, compassion and skill to the most difficult, and intensely delicate, physical and psychological caring.[17]

Support and resilience

Dealing with death and dying can be challenging. The potential impact of providing end of life care should not be minimised by clinicians, the team or the health service.[25]

Sustainable workforce

A sufficient formal and informal workforce is needed to provide the necessary hands-on support, advice and education, now and into the future.

Using technology

Professionals have to adapt to new ways of learning and interacting with the people that they are supporting and they need help and guidance to do so. Technology can also play a significant role in enhancing professional's self-directed learning and development.[17]

Clinical governance

Specialist and primary palliative care services will lead and co-ordinate a single system of care.

[25] Australian Commission on Safety and Quality in Health Care. (2015). *National Consensus Statement: essential elements for safe and high-quality end-of-life care.* Sydney: ACSQHC

HOW WE PLAN TO STRENGTHEN OUR FOUNDATIONS AND MEET OUR PRIORITIES

OUR PRIORITIES

Each person and their family/whānau will have their individual needs as the centre of care

- Enablers for person centred care
- Access to social support
- Meaningful conversations
- Clear expectations
- Integrating the philosophy
- Bereavement Support

Each person gets access to high quality individualised care and we improve equity

- Using data
- Unwavering commitment
- Person centred outcome measurement
- Population based needs
- Referral criteria
- Community partnerships

Comfort and wellbeing is maximised

- Recognising distress
- Skilled assessment & symptom management
- Priorities for care of the dying person
- Addressing all forms of distress
- Specialist palliative care
- Rehabilitative palliative care
- Fit for Purpose Facility

Care is coordinated

- Systems for shared records
- Clear roles and responsibilities
- System-wide response
- Continuity in partnership

The community is involved

- Compassionate communities
- Public awareness
- Practical support
- Volunteers

All staff are prepared to care

- Knowledge base
- Support and resilience
- Using technology
- Sustainable workforce
- Clinical governance

ACTIONS REQUIRED

- Services are co-designed with patients and whānau.
- Implementation of a rehabilitative approach to palliative care.
- Patients and family members know where to go for palliative care and are connected to services
- Information, education and visibility in the community on innovative ways to increase awareness and community culture around death and dying.
- Health and support workforce is skilled and informed to be able to support conversations around death and dying.
- Training and supervision systems in place to support the development of SPC workforce.
- Specialist palliative care provide education and support the efforts of primary palliative care providers in delivering patient care.
- Last Days of Life (Te Ara Whakapiri) Pathway is developed and implemented across the region.
- Integration of Cranford Hospice and Hospital Palliative Care Team to form one specialist palliative care service.
- Confirm sustainable and responsive after hours primary palliative care arrangements
- Specialist medical workforce developed to meet minimum recommended requirements.
- Develop and expand nurse-led initiatives and expert roles such as the Nurse Practitioner.
- Increase the role and size of the allied health and family support services.
- New purpose built facility for specialist palliative care. Increase from 8 up to 10 inpatient beds as per recommendations.[13]
- Look for opportunities to expand volunteer and informal support services in the community.
- Information technology systems accessible across primary and specialist settings. Palcare or other system.
- Continued involvement in national data work – to develop measurable patient outcomes.
- Research and evaluation outcomes are used to inform best practice.

OUTCOME MEASUREMENTS

- Maintain feedback from family members surveyed after death using a standard questionnaire relating to comfort and wellbeing. Satisfaction for SPC in 2016 is 99%.
- People with palliative care needs living in aged residential care facilities have care plans reflecting individual needs and best practice via documentation peer review.
- 95% of referrals to specialist palliative are accepted, reflecting appropriateness.
- Monitor access to SPC compared to our population profile & then adapt services to respond:
  - - Death by ethnicity in HB.
  - - Access by area reflects deaths in each area.
  - - Access by condition reflects deaths by condition.
- The proportion of people dying where they live will increase.
  - The proportion of people dying in hospital with SPC needs will decrease by one third from 34% to 21% by 31 December 2018
- 100% of aged residential care facilities and hospital wards have implemented the Last Days of Life Care (Te Ara Whakapiri) Plan supported by Specialist Palliative Care services.
- New SPC facility built using co-design principles by 31 December 2019.
- 20% nursing staff under the age of 50 by 2021.
- Increase the proportion of Maori workforce in SPC from 5.7% to 11.4% by 2026.
- SPC FTE medical staff increased from 3.2 to 6.8 by 31 December 2018
- 70% of GP practice have access to the electronic patient management system Palcare (or another) by 1 July 2018 and 70% of hospital by 1 July 2021.
- National palliative care outcome measures are implemented and used for data collection and evaluation by 31 December 2017.

FOUNDATIONS

- Patient, whānau and community voice
- Equity and cultural responsiveness
- Education and training
- Leadership
- 24/7 access
- Sustainable specialist palliative care service
- Evidence and information
- Technology

Appendix 1

Table 1: Current & Proposed Specialist Workforce

Role 2016	Full Time Equivalent (FTE)	Proposed Roles 2026	Full Time Equivalent (FTE)
Palliative medicine specialist (Hospital 0.5; Hospice 0.5)	1.0	Palliative medicine specialist	2.4
Medical officer special scale Advanced trainee (currently in Hospital)	1.8 0.4	Medical officer special scale or GP with special interest, or advanced trainee or registrar physician training. (Covering community, hospice inpatient unit and hospital services)	3.0
		House officer trainee Hospital & Hospice	1.0
Medical Director	0.4	Medical Director	0.4
TOTAL	**3.6**		**6.8**

Table 2: Current & Proposed Nursing Workforce

Roles 2016	Full Time Equivalent (FTE)	Proposed Roles 2026	Full Time Equivalent (FTE)
Nurse Practitioner Candidate	0.9	Nurse Practitioner	0.9
Clinical Nurse Specialists Hospital 2.0; Hospice 2.8	4.8	Clinical Nurse Specialists Hospital 2.0; Hospice 3.0	5.0
Aged Care Liaison Nurses	1.2	Aged Care Clinical Nurse Specialist	2.0
Registered Nurses inpatient unit and community nurses	18.2	Registered Nurses inpatient unit and community nurses, new graduate position	21.8
Education	0.5	Education	2.0
	0.8	Enrolled Nurse	0.8
		Health care assistants	3.0
TOTAL	**26.4**		**35.5**

Table 3: Current & Proposed Allied Health & Family Support Workforce

Roles 2016	Full Time Equivalent (FTE)	Proposed Roles 2026	Full Time Equivalent (FTE)
Counsellor	1.0	Counsellor	2.0
Social Worker	1.0	Social Worker	2.0
Pastoral Care	0.8	Pastoral Care	1.0
Carer Support Coordinator	1.0	Carer Support Coordinator	1.6
Music Therapist	0.4	Music Therapist	0.6
Kaitakawaenga	0.8	Kaitakawaenga	1.0
Cultural Advisor	0.2	Cultural Advisor	0.2
Pharmacist	0.5	Pharmacist	0.8
Occupational Therapist	0.6	Occupational Therapist	1.0
		Physiotherapist	1.0
TOTAL	**6.3**		**11.2**

Consumer feedback 2015 – 2016

This information is from written and verbal feedback. Quotes are adapted to maintain confidentiality

PRIMARY PALLIATIVE CARE

Almost all mentioned their GP – always expressed strongly, whether good or bad This is a very important relationship. Majority spoke positively about their GP, the sense of support, advocacy and availability. Practice nurses mentioned occasionally, positive addition to sense of support.
Criticisms related to communication:
- of prognosis and introduction of the idea of referral to Hospice
- availability, the need to be able to access as needed and not to have to see other GPs who don't know them
- concentration on physical / medical needs of the patient

SECONDARY PALLIATIVE CARE

Some people reported satisfaction with the service they were provided if/when admitted. Of those that met with the HPCT, all but one was positive and the communication provided relief and more confidence and understanding of hospice.
Several negative experiences expressed of communication from specialists / doctors regarding diagnosis and prognosis. These were all expressed with quite a bit of emotion. Mostly related to 'abruptness' or suddenness of the message. Some felt that this was even "rude" and left them with negative feelings including an inability to ask questions. Many left not knowing what 'palliative care' was and afraid to accept the referral.
Many felt the doctors at the hospital were only interested in one aspect of them and this was a barrier to quality care.

I can tell my GP anything, she is a great advocate

The Hospital Palliative Care Team explained what 'hospice' meant, communication was great. Once this had been explained they were happy to accept referral

It is hard to get the same GP so we have to "start again" each time - this stopped us talking about Long Term Care like we wanted to. GP is there for/focuses on "medical matters"

When they decide they can't do anything medically for you, you are off on your own, they don't want to know you….

SPECIALIST PALLIATIVE CARE

The majority of those visited described having strong beliefs about Hospice as a 'place to die' and were unhappy about the referral, some saying that this meant they refused referral initially and later regretted this once they learned what it is really about.
All felt that Cranford Hospice staff were great and there were no complaints or criticism about this. Often people felt supported and safe with the 24 hour advice available.
People didn't focus on physical symptoms – most were more interested in talking about the general feeling of psychosocial support and several mentioned that the Hospice staff were able to see the 'whole picture'.
Actually coming into the Hospice building for an appointment was universally a positive experience and reduced fears / barriers to accepting admission if needed.
People talked about the need to keep 'living' and things like vague appointment times were interruptions to that.

My out-patient appointment made all the difference, they linked everything together

Cranford people are non-intrusive; responsive and great for advice

When we ask for a visit – the response is always "yip, no problem"

The doctor was the first to look at the "whole picture"

Rural feedback 2016 – 2017

Having the conversations about what to expect, who is in charge, what the person and whānau want is really important

Carers with recent experience of deaths in the family were prepared to discuss death & dying. They would be comfortable doing an advance care plan with their family

Explain what to expect next in the journey so that whanau can anticipate what they need and why

A rural approach is needed as accessing services in remote areas can be difficult

Making sure the medical people involved are all aware of all of that so plans can be put in place so it happens as the family expect and want it to

Provide really solid carer support that continues after the person has passed

Link people to networks within the community

Having access to local staff who know you and your family is really important. Health navigator/supporter who can direct you to what you need just ahead of when you need it and explain how to use the service

Health professionals need to have more of a palliative care approach.

Good at interventions & surgeries - quality of life

Don't leave it too late. Timing is crucial. Still not easy but a relief to have support

Who should I be listening to? Chemist, GP, nurse

Need more of a group approach – GP, specialists, district nurse

Hospital visits are rushed

No social work input

How it could have been different plays on my mind

Reassurance helps

One nurse made all the difference in our lives. She asked you know you are going to die -have you planned anything? I couldn't say it & neither could he. The last three months with him were wonderful. The doctor who knows us well said he didn't like to tell me. I felt in limbo.

Needed a syringe driver much earlier for pain relief

When is it palliative care?

HAWKE'S BAY District Health Board Whakawāteatia	**Implementation of the Hawkes Bay Clinical Governance Committee Structures**
	For the attention of: **Clinical Council**
Document Owner: Document Author(s):	Kate Coley Kate Coley
Reviewed by:	Chris McKenna, Ken Foote and Andrew Phillips
Month:	March 2017
Consideration:	For Discussion and Endorsement

RECOMMENDATION

That Clinical Council:

- **Endorse** the proposed Terms of Reference for the five Clinical Committees (Appendix 2)
- **Endorse** the proposed Chairs of those committees (page 4)
- **Note** the key responsibilities of members for both the clinical committees and advisory groups (page 5 and Appendix 3)
- **Note** the next steps

Purpose

Purpose of this paper is to confirm the Terms of Reference for the five Clinical Committees, the chairs of those committees and outline the next steps for the full implementation of the clinical governance structure by end of May 2017.

Clinical Governance – An Executive Summary

Domains of Quality & Safety

Consumer participation, clinical effectiveness, an effective workforce and risk management are consistently described as the four domains of quality and safety that provide a conceptual framework for strategies to enhance the delivery of care.

Within each domain there are a number of quality and safety management functions that require direction and oversight by governing bodies. Under these domains all of the required principles of clinical governance should be addressed.

- *Consumer Participation* – this should occur at all levels of the organisation, for planning, policy development etc. The organisation should use consumer complaints, feedback, and survey to inform improvements.

- *Clinical Effectiveness* – is ensuring the right care is provided to the right patient who is informed and involved in their care at the right time by the right clinicians with the right skills in the right way.

- *Workforce* – all staff employed must have the appropriate skills and knowledge required to fulfil their role. Focussed on continuous learning, processes should be in place to recruit staff, including credentialing clinical staff, maintenance of professional standards and control of safe introduction of new therapies or procedures.

- *Risk Management* – minimising clinical risk and improving safety of care requires a system approach, one that is 'just' focussing on learning and improvement rather than blame Clinical risk management and improvement strategies are integrated within improvement and performance monitoring functions.

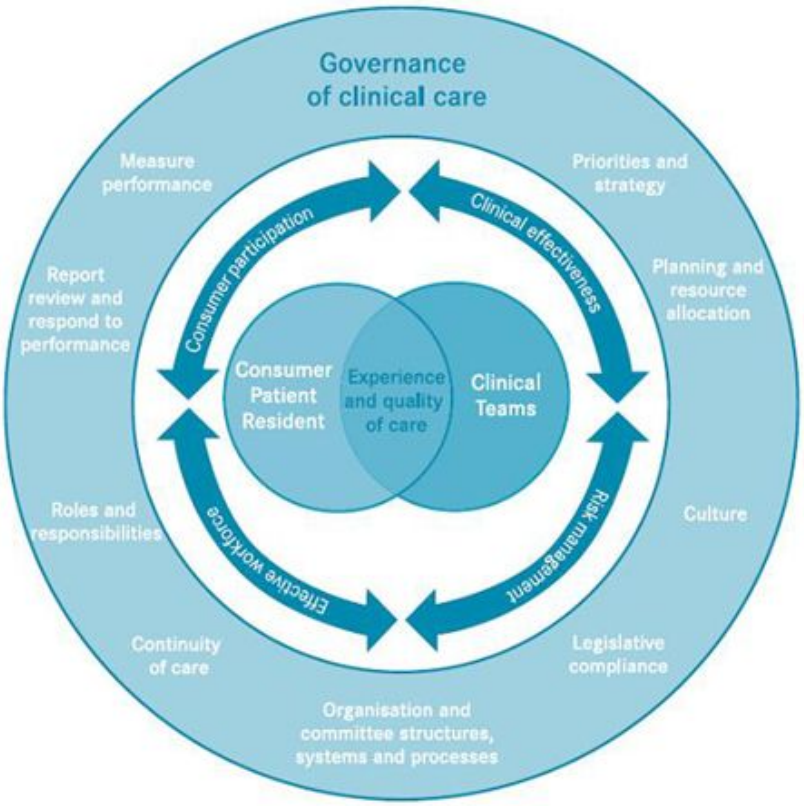
Clinical Governance

Clinical Governance is defined as

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

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

The below framework aligns to both the domains of quality and safety and provides the key principles on which good clinical governance is based.



[1]

[1] Victorian Clinical Governance Policy Framework, 2009

Principles:

- Strong clinical leadership & ownership
- Health sector wide
- Multi discipline with consumer participation
- Rigorous measurement of performance and progress, including reporting and review
- Continuous improvement of quality & safety
- Roles & Responsibilities clearly defined and understood by all
- Compliance with legislation
- Culture of committees, systems and processes to support safety and quality improvement initiatives
- Priorities and strategic direction is clear and communicated
- Focus on consumer experience throughout the continuum of care
- Outcomes and learnings widely communicated

The HB Health Sector Clinical Governance Structure

Clinical Council endorsed the new clinical governance structure for the Hawkes Bay health sector. (Appendix 1)

Clinical Council

Clinical Council is the principal clinical governance, leadership and advisory group for the Hawkes Bay health system. Its functions are to:

- Provide clinical advice and assurance to the HB health system management and governance structures
- Work in partnership with the HB Health Consumer Council to ensure the HB health system is organised around the needs of people
- Provide oversight of clinical quality and patient safety
- Provide clinical leadership to the HB health system workforce
- Co-ordinate and manage this clinical governance structure

Clinical Committees

As previously agreed, there will be five clinical committees, who will meet on a quarterly basis and be provided with a full report from each of the advisory groups. On a rolling basis each committee will provide the Clinical Council with a written report summarising issues, activities, learnings and improvements identified and implemented by these groups. The purpose of these reports is to ensure that the clinical council has assurance that all patient safety and clinical quality matters are being managed appropriately and that there is a focus on learning and continuous improvement.

The five clinical committees:

- ***Professional Standards and Performance Committee*** – to provide assurance that all essential requirements relating to credentialing, professional standards, clinical training and research are actively promoted and maintained

- ***Clinical Effectiveness & Audit Committee*** – to provide advice and guidance to ensure that quality clinical practice is delivered by all publicly funded health service, diagnostic, pharmaceutical and therapeutic providers.

- ***Patient Safety & Risk Management*** – to provide assurance that all matters relating to patient safety and clinical risk are effectively monitored and managed

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

- ***Information Management*** – to provide advice and clinical advocacy for the provision of appropriate ICT systems, processes and data, to aid effective clinical decision making and the provision of quality care.

The Terms of Reference for all of these Clinical Committees have been developed and can be found in Appendix 2.

Recommendations for Chairs of Clinical Committees

It is proposed that each of the Clinical Committees will be chaired by a Clinical Council Clinician or Executive member, supported by a deputy chair. The following outlines the proposed chairs:

Clinical Committee	Proposed Chair
Professional Standards and Performance Committee	John Gommans
Clinical Effectiveness & Audit Committee	Andrew Phillips
Patient Safety & Risk Management	Chris McKenna
Patient Experience	Kate Coley
Information Management	David Rodgers

Expectations of Members of Clinical Committees and Advisory Groups

- Act in accordance with good clinical governance principles and practice (Appendix 3)
- Actively promote clinical governance, patient safety and quality clinical care to other clinicians
- Attend all relevant meetings when available
- Apologise for unavoidable non-attendance and/or send an alternate where applicable
- Actively participate and contribute to discussions and decisions
- Be bound by collective decision making
- Maintain confidentiality as required
- Be familiar with the Terms of Reference for the Committee or Advisory Group
- Acknowledge that committees and advisory groups are 'governance' groups and not 'management' teams.

Next Steps

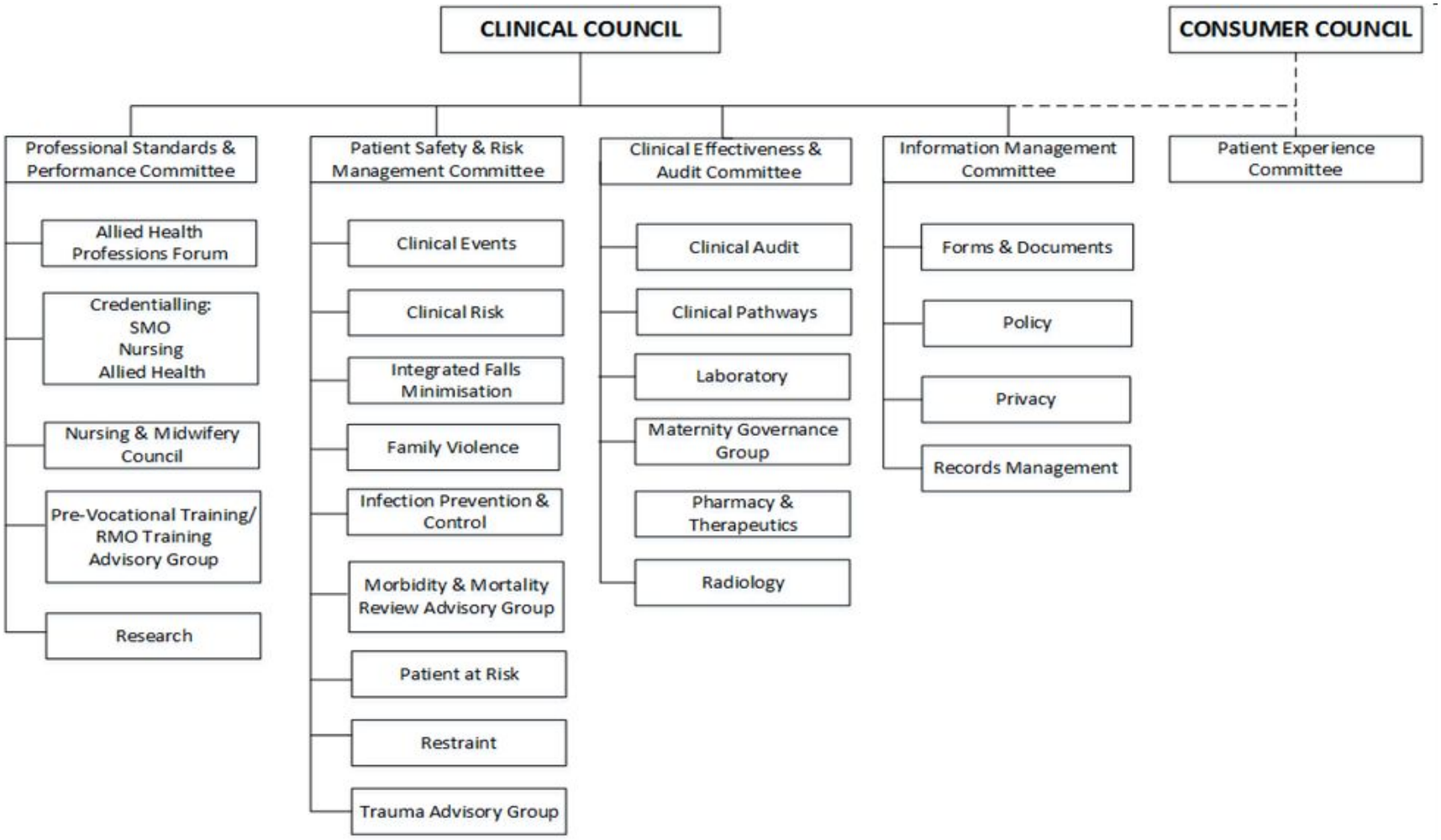
Once Clinical Council has met in March and endorsed the recommendations, a significant amount of activity will be undertaken to ensure the effective implementation of the governance structures by end of May 2017.

A number of considerations and issues will need to be addressed which are identified in Appendix 4.

The below provides a high level plan for next steps.

Activity	Responsibility	Timeframe
Endorse Chairs of Clinical Committees	Clinical Council	March meeting
Endorse Terms of Reference for Clinical Committees	Clinical Council	March meeting
Chairs review and consider the Advisory Group structure beneath their Clinical Council Committee	Chairs (Clinical Committees)	
Quality dashboard developed to align to governance structure	Executive Director of People & Quality (EDPQ)	March
Chairs (Clinical Committees) present finalised advisory structure for endorsement and proposed representation from Clinical Council members	Chairs (Clinical Committees)	April Meeting
Quality dashboard endorsed by Clinical Council	EDPQ	April meeting
Resolve current implementation issues and considerations and work with Clinical Council chairs and Chairs of Clinical Committees	EDPQ, Company Secretary	March - May
All Committee and Advisory Groups established, Terms of Reference in place, meeting schedule and reporting timeframes established.	Chairs, EDPQ & Company Secretary	End May

APPENDIX 1 – CLINICAL GOVERNANCE COMMITTEE STRUCTURE



6

APPENDIX 2 - SUMMARY TERMS OF REFERENCE FROM JULY 2017

See separate A3 Sheet.

APPENDIX 3 - CLINICAL LEADERSHIP REQUIREMENTS & PRINCIPLES

1. Self-Belief – The inner confidence to succeed and overcome obstacles to achieve the best outcomes for patients and whanau
2. Self-Awareness – Knowing their strengths and limitations and understanding their own emotions and the impact of behaviour on others in diverse situations
3. Self-Management – Being able to manage emotions and be resilient in a range of complex and demanding situations
4. Drive for Improvement – A deep motivation to improve performance in the Hawkes Bay health sector and thereby to make a real difference to others' health and quality of life.
5. Personal Integrity – A strongly held sense of commitment to openness, honesty, inclusiveness and high standards in undertaking the leadership role.
6. Seizing the Future – Being prepared to take action now and implement a vision for the future development of services
7. Intellectual Flexibility – The facility to embrace and cut through ambiguity and complexity and to be open to creativity in leading and developing services
8. Broad Scanning – Taking the time to gather information from a wide range of sources
9. Political Astuteness – Showing commitment and ability to understand diverse groups and power bases within organisations and the wider community, and the dynamic between them, so as to lead health services more effectively
10. Drive for Results – A strong commitment to making service performance improvements and a determination to achieve positive service outcomes for users.
11. Delivering the Service
12. Leading Change Through People – Communicating the vision and rationale for change and modernisation, and engaging and facilitating others to work collaboratively to achieve real change
13. Holding to Account – The strength of resolve to hold others to account for agreed targets and to be held accountable for delivering a high level of service
14. Empowering Others – Striving to facilitate others' contribution and to share leadership nurturing capability and long-term development of others
15. Effective and Strategic Influencing – Being able and prepared to adopt a number of ways to gain support and influence diverse parties with the aim of securing health improvements
16. Collaborative Working – Being committed to working and engaging constructively with internal and external stakeholders

APPENDIX 4 - IMPLEMENTATION CONSIDERATIONS & ISSUES TO BE RESOLVED

Terms of Reference/Appointments

- Appointment of initial members – Process, EoI, who, when, coordination
- Rotation/reappointment/replacement processes
- 'Missing' Advisory Groups?
  - Product Evaluation
  - Education and Development (recommended by Clinical Council August 2016)
- PHO Clinical Advisory & Governance Committee - status
- Rural Clinical Governance structures – linkage

Leadership/Chairs

- Ensure Chairs capable of running effective & efficient meeting
- Provide training as appropriate
- Consider Clinical Council preferences for initial chairs / membership where appropriate

Clinical Governance - Roles & Responsibilities

- Short document to be developed for all Committee & Advisory group Members
- Provides context and sets expectations

Management & Administration

Payments

- Policy Attached
  - Medical practitioners - $187.50 per meeting
  - Other Clinicians - $125.00 per meeting
  - Consumer reps – NIL
  - Others
- Cost centres/Budgets

Management Responsibility/Resources (Whole structure)

- Terms of reference to be maintained, updated and amended as necessary
- New appointments/reappointments to be appropriately approved and membership schedules maintained
- Chairs appointed/briefed and 'trained' as necessary
- Details of any payments to members and approval processes to be agreed, documented and actioned.
- Management of budget and cost centre
- Work plans to be coordinated and maintained.
- Ensure appropriate reports are prepared, submitted, distributed and filed as appropriate
- Committee/Advisory group secretaries to be appointed, coordinated and 'trained' as necessary.
- Standard templates developed for minutes/actions plans/reports etc
- Overall coordination/management of structure.

Administration Responsibility/Resources (Individual advisory groups/committees)

- Meetings to be set up/rooms booked etc
- Agendas prepared and distributed
- Attendance registers completed
- Any payments to members to be actioned
- Minutes to be taken, approved and distributed
- Action plans to be recorded, followed up and completed actions noted
- Liaison with Advisory group/Committee Chair maintained
- Reports to be written/presented as required.

Minutes

- 'Action Minutes' templates to be developed/distributed
- Training for minute taking to achieve standardisation, efficiency and effectiveness

Communication Plans

- How to advise health sector that this is happening
- Encourage nominations/participation/ownership/confidence
- Ensure effective flow of information and sharing of learnings

APPENDIX 2

CLINICAL GOVERNANCE STRUCTURES
SUMMARY TERMS OF REFERENCE FROM JULY 2017

Body	Purpose	Functions	Authority	Membership	Tenure	Chair	Quorum	Meetings	Reporting	Minutes
Clinical Council	**Principal clinical governance, leadership and advisory group for the Hawkes bay health system**	**Provide clinical advice and assurance to the HB health system management and governance structures Work in partnership with the Consumer Council to ensure HB health services are organised around the needs of people Provide oversight of clinical quality and patient safety Provide clinical leadership to the HB health system workforce Coordinate and manage clinical governance structure**	**Provide advice & recommendations to HBDHB and HHB mgmt and boards Delegated authority to commission reports, investigations and audits and to co-opt resources as necessary for a specific purpose Delegated authority to make decisions within mandate of HB Health Alliance & issue directives on quality clinical practice & patient safety issues**	**CMO Hospital; CMO Primary Care; CNO; CAHPO; Midwifery Director; Chief Pharmacist; Director Public Health; Clinical Lead CAGC; 2xGP; 2xSMO; 3xSenior Nurse; Senior Allied Health Professional**	**Non specific appointment holders - 3 years One third retire by rotation each year May be reappointed for up to 3 terms Must ensure wide range of perspectives & interests viz Maori & rural**	**Chair & deputy or Co-Chairs elected annually**	**Half (if even) or majority (if odd)**	**Monthly Open to Public Consumer Council liaison**	**Through HBDHB and HHB CEOs to Boards Monthly report on HBDHB website**	**Council Administrator Circulated within 1 week of meeting**
COMMITTEES										
Professional Standards & Performance Cttee	Provide assurance that all essential requirements relating to credentialling, professional standards, clinical training and research are actively promoted and maintained	Ensure that all health professionals are approriately credentialled, professional standards are upheld and clinical competence is maintained. Provide oversight and forums for discussion on clinical innovation, best practice, professional training and workforce development To govern and promote a research culture, clinical research activities and implementation of appropriate research findings Oversee and monitor activities and delegated responsibilities of relevant AGs	Provide advice and recommendations to Clinical Council on strategy, processes and policy Delegated authority from Clinical Council to run forums/workshops and make decisions on individual cases relating to professional standards or research	Chairs of Credentialling AGs - Medical, Nursing, Allied Health; Chair RMO Training AG; Chair Research AG; Exec Dir People & Quality; Medical Director QIPS; Consumer Council Rep; Health Services Directors - Service, Nursing Medical/Surgical	Non specific appointment holders - 3 years One third retire by rotation each year May be reappointed for up to 3 terms	Appointed by CC CC Member or Executive Clinical Leader	7	Quarterly (or as required by the Chair)	Following each meeting Formal Annual report	HR Administrator Circulated within 1 week of meeting
Patient Safety & Risk Management Cttee	Provide assurance that all matters relating to patient safety and clinical risk are effectively monitored and managed	Lead and promote a culture of continuous quality improvement and patient safety Ensure effective systems are in place and used to appropriately capture, analyse, manage and report issues associated with patient safety and clinical risk Recommend approriate strategies, policies and actions that will enhance patient safety and reduce/remove areas of clinical risk Initiate improvement projects and/or training programmes as appropriate Oversee and monitor activities and delegated responsibilities of relevant AGs	Provide advice and recommendations to Clinical Council on strategy, systems, processes and policy Delegated authority from Clinical Council to run training/workshops and make decisions on individual events/issues relating to patient safety or clinical risk	Chairs of AGs - Infection Prevention and Control; Falls; Clinical Events; Restraint; Clinical Risk; Patient at Risk; Family Violence; Trauma; Morbidity & Mortality Review Exec Dir People & Quality; Medical Director QIPS; Consumer Council Rep; Health Services Directors - Service, Nursing Medical/Surgical	Non specific appointment holders - 3 years One third retire by rotation each year May be reappointed for up to 3 terms	Appointed by CC CC Member or Executive Clinical Leader	Two thirds of the appointed members	Quarterly (or as required by the Chair)	Following each meeting Formal Annual report	QIPS Patient Safety Administrator Circulated within 1 week of meeting

Clinical Effectiveness & Audit Cttee	Provide advice and guidance to ensure that quality clinical practice is delivered by all publicly funded health service, diagnostic, pharmaceutical and therapeutic providers.	Ensure an appropriate clinical audit programme is developed, implemented, monitored and managed, with associated learnings and quality improvements shared and implemented as appropriate Provide advice and guidance of what constitutes 'best practice' within HB health system Oversee clinical practice integration initiatives, including clinical pathways Endorse and/or recommend guidelines and directives relating to referrals and delivery of diagnostic services, and presribing and delivery of pharmaceutical and therapeutic services. Oversee and monitor activities and delegated responsibilities of relevant AGs	Provide advice and recommendations to Clinical Council on strategy, systems, processes, policy and major changes to clinical practice Delegated authority from Clinical Council to require minor quality improvement changes to clinical practice	Chairs of AGs - Audit; Clinical Pathways; Laboratory; Radiology; Pharmacy & Therapeuditics; Trauma Exec Dir People & Quality; Medical Director QIPS; Consumer Council Rep; Health Services Directors - Service, Nursing Medical/Surgical	Non specific appointment holders - 3 years One third retire by rotation each year May be reappointed for up to 3 terms	Appointed by CC CC Member or Executive Clinical Leader	Two thirds of the appointed members	Quarterly (or as required by the Chair)	Following each meeting Formal Annual report	QIPS Patient Safety Administrator Circulated within 1 week of meeting
Information Management Cttee	Provide advice and clinical advocacy for the provision of appropriate ICT systems, processes and data, to aid effective clinical decision making and the provision of quality care	Identify & document the clinical and patient care benefits of appropriate ICT systems, processes and data. Liaise as necessary and advocate for the provision of such identified systems, processes and data Ensure all data used for clinical decision making and the provision of care is current and accurate, with one single 'source of the truth'.	Provide advice and recommendations to Clinical Council on strategy, systems, processes and policy Delegated authority from Clinical Council to liaise internally as required and advocate for the provision of appropriate systems, processes and data.	Chairs of AGs - Forms & Documents; Policy; Privacy; Clinical Records Management; CIO; Consumer Council Rep; Health Services Directors - Service, Nursing Medical/Surgical	Non specific appointment holders - 3 years One third retire by rotation each year May be reappointed for up to 3 terms	Appointed by CC CC Member or Executive Clinical Leader	Two thirds of the appointed members	Quarterly (or as required by the Chair)	Following each meeting Formal Annual report	QIPS Patient Safety Administrator Circulated within 1 week of meeting
Patient Experience Cttee	Jointly develop and recommend strategies, systems, policies, processes and actions that will contibute to the continuous improvement of patient's experience within the HB health system.	Develop/enhance/confirm appropriate systems and surveys to be used to gather indicators of patient experience Agree targets, monitor and analyse performance Report on performance and recommend performance improvement initiatives and actions	Provide advice and recommendations to Clinical and Consumer Councils on strategy, systems, processes, policy, clinical practice and customer service	Four members from each of Clinical Council and Consumer Council Executive Director of People and Quality; Health Services Directors - Service, Nursing Medical/Surgical	Non specific appointment holders - 3 years One third retire by rotation each year May be reappointed for up to 3 terms	Jointly agreed between Clinical and Consumer Councils	Minimum of two members from each Council	Quarterly (or as required by the Chair)	Following each meeting Formal Annual report	Consumer Engagement Administrator Circulated within 1 week of meeting

PROFESSIONAL STANDARDS & PERFORMANCE
SUMMARY TERMS OF REFERENCE FROM JULY 2017

Body	Purpose	Functions	Authority	Membership	Tenure	Chair	Quorum	Meetings	Reporting	Minutes
Professional Standards & Performance Cttee	**Provide assurance that all essential requirements relating to credentialling, professional standards, clinical training and research are actively promoted and maintained**	**Ensure that all health professionals are approriately credentialled, professional standards are upheld and clinical competence is maintained. Provide oversight and forums for discussion on clinical innovation, best practice, professional training and workforce development To govern and promote a research culture, clinical research activities and implementation of appropriate research findings Oversee and monitor activities and delegated responsibilities of relevant AGs**	**Provide advice and recommendations to Clinical Council on strategy, processes and policy Delegated authority from Clinical Council to run forums/workshops and make decisions on individual cases relating to professional standards or research**	**Chairs of Credentialling AGs - Medical, Nursing, Allied Health; Chair RMO Training AG; Chair Research AG; Exec Dir People & Quality; Medical Director QIPS; Consumer Council Rep; Health Services Directors - Service, Nursing Medical/Surgical**		**Appointed by CC CC Member or Executive Clinical Leader**	**7**	**Quarterly (or as required by the Chair)**	**Following each meeting Formal Annual report**	**HR Administrator Circulated within 1 week of meeting**
ADVISORY GROUPS										
Credentialling; SMO, Nursing, Allied Health										
Pre-Vocation/RMO Training AG										
Allied Health Profession Forum										
Nursing & Midwifery Council										

Education & Professional Pevelopment AG										
Research AG	Maintain an overview and provide advice to on all health and disability research being undertaken within the pulic health sector within HB	Promote a research culture, clinical research activities and research findings Review clinical research and make recommendations as appropriate, including promotion of research that reduces health inequity Oversee the locality review and authorisation processes as required by the SOP of the national HDEC Ensure that clinical research undertaken is clinically sound maintain records of all such research undertaken	Provide advice and make recommendations to Clinical Council Delegated authority to request reports and presentations from particular groups and/or co-opt people from time to time for a particular purpose	8 - 11 members appointed by CC on an annual basis (members may be reappointed) based on need at the time, from: Clinical Council Consumer Council HB Medical Research Fdn EIT - Health Sciences University of Otago HBDHB Clinical Trials HBDHB Nursing Practice Devpt Educator Medical Practitioner Allied Health Practitioner HBDHB maori Health HBDHB Health Services	Non specific appointment holders - 1 year May be reappointed for up to 5 years	Appointed by CC CC Member or Executive Clinical Leader	More than 50% of the appointed members, at least 2 of whom shall be registered health professionals	Quarterly or more frequently as required by the chair	Formal 6 monthly reports Annual publication summarising clinical research activity.	Secretary to be appointed by HBDHB Minutes circulated within 1 week of meeting

PATIENT SAFETY & RISK MANAGEMENT
SUMMARY TERMS OF REFERENCE FROM JULY 2017

Body	Purpose	Functions	Authority	Membership	Tenure	Chair	Quorum	Meetings	Reporting	Minutes
Patient Safety & Risk Management Cttee	**Provide assurance that all matters relating to patient safety and clinical risk are effectively monitored and managed**	**Lead and promote a culture of continuous quality improvement and patient safety Ensure effective systems are in place and used to appropriately capture, analyse, manage and report issues associated with patient safety and clinical risk Recommend approriate strategies, policies and actions that will enhance patient safety and reduce/remove areas of clinical risk Initiate improvement projects and/or training programmes as appropriate Oversee and monitor activities and delegated responsibilities of relevant AGs**	**Provide advice and recommendations to Clinical Council on strategy, systems, processes and policy Delegated authority from Clinical Council to run training/workshops and make decisions on individual events/issues relating to patient safety or clinical risk**	**Chairs of AGs - Infection Prevention and Control; Falls; Clinical Events; Restraint; Clinical Risk; Patient at Risk; Family Violence; Trauma; Morbidity & Mortality Review Exec Dir People & Quality; Medical Director QIPS; Consumer Council Rep; Health Services Directors - Service, Nursing Medical/Surgical**		**Appointed by CC CC Member or Executive Clinical Leader**	**Two thirds of the appointed members**	**Quarterly (or as required by the Chair)**	**Following each meeting Formal Annual report**	**QIPS Patient Safety Administrator Circulated within 1 week of meeting**
ADVISORY GROUPS										
Clinical Events AG										
Clinical Risk AG										
Falls AG	Provide advice on strategies and actions that will minimise the incidence and impact of injuries resulting from falls	Monitor and advise on the incidence and trends in the number and severity of injury from falls Develop and maintain a plan that includes a vision, strategies, objectives and actions to reduce/minimise the incidence and impact of injuries from falls Monitor the effectiveness of this paln	Provide advice and make recommendations to patient Safety and Risk Cttee Delegated authority to request reports and presentations from particular groups and/or co-opt people from time to time for a particular purpose	CNO; Physician/Geriatrician; CNM; SM Older People; QIPS Rep; Physio Team Leader; Senior Physio; ARC Rep; CNS Gerontology ARC; CNS Gerontology Older Persons: Pop Health Rep; PHO Rep		CNO	8	Generally monthly (at least 10 times per year)	Recommend as required Formal report 6 monthly	PA to CNO Circulated within 1 week of meeting
Family Violence AG										

Infection Prevention & Control AG										
Morbidity & mortality Review AG										
Patient at Risk AG										
Restraint AG										
Trauma AG										

CLINICAL EFFECTIVENESS & AUDIT
SUMMARY TERMS OF REFERENCE FROM JULY 2017

Body	Purpose	Functions	Authority	Membership	Tenure	Chair	Quorum	Meetings	Reporting	Minutes
Clinical Effectiveness & Audit Cttee	**Provide advice and guidance to ensure that quality clinical practice is delivered by all publicly funded health service, diagnostic, pharmaceutical and therapeutic providers.**	**Ensure an appropriate clinical audit programme is developed, implemented, monitored and managed, with associated learnings and quality improvements shared and implemented as appropriate Provide advice and guidance of what constitutes 'best practice' within HB health system Oversee clinical practice integration initiatives, including clinical pathways Endorse and/or recommend guidelines and directives relating to referrals and delivery of diagnostic services, and presribing and delivery of pharmaceutical and therapeutic services. Oversee and monitor activities and delegated responsibilities of relevant AGs**	**Provide advice and recommendations to Clinical Council on strategy, systems, processes, policy and major changes to clinical practice Delegated authority from Clinical Council to require minor quality improvement changes to clinical practice and approve appropriate clinical pathways**	**Chairs of AGs - Audit; Clinical Pathways; Laboratory; Radiology; Pharmacy & Therapeuditics; Trauma Exec Dir People & Quality; Medical Director QIPS; Consumer Council Rep; Health Services Directors - Service, Nursing Medical/Surgical**		**Appointed by CC CC Member or Executive Clinical Leader**	**Two thirds of the appointed members**	**Quarterly (or as required by the Chair)**	**Following each meeting Formal Annual report**	**QIPS Patient Safety Administrator Circulated within 1 week of meeting**
ADVISORY GROUPS										
Clinical Audit AG										
Clinical Pathways AG	Champion, co-ordinate, govern and approve the development and maintenance of specific clinical pathways, and provide advice on process, resource requirements, priorities and other relevant matters relating to the implementation of clinical pathways within HB.	Advise on priorities, systems, processes, structures and resource requirements to effectively implement clinical pathways in HB Approve the development of new and maintenance of existing pathways Report on the effectiveness, efficiency and benefits of the operation of clinical pathways within HB Engage the HB clinical community to gain commitment to the clinical pathways concept and programme	Approve new and amended clinical pathways for implementation Oversee and direct the activities of any management resource engaged to facilitate clinical pathways Provide advice and make recommendations to the Clinical Effectiveness and Audit Cttee	CMO Primary Care; CMO Hospital; CNO; CAHPO; Head of Strategic Services HBDHB; Rep HHB Ltd; Rep HB Health Consumer Council; Rep HBDHB Maori Health Services	Reps appointed by CC on nominations received from respective bodies.	CMO primary care	6	As required with minimum of 4 times per year	Following each meeting Formal annual report	PA to CMO Primary Care Minutes circulated within 1 week of meeting
Laboratory AG	Provide strategic and operational advice on how best to meet stakeholder requirements for efficient and effective medical laboratory services in HB, ensuring good clinical practice and consistency across primary, community and hospital services and the timely availability of electronic, integrated and accurate test results	Advise on strategic direction for laboratory services Develop policies, procedures and processes relating to the evaluation, selection, funding and reporting of particular laboratory tests, including any restrictions on who can request and how requests for tests may be made Provide educational programmes designed to meet the needs of clinical staff for complete current knowledge on matters related to laboratory test requesting and appropriate use of results.	Provide advice and make recommendations to Clinical Effectiveness & Audit Cttee Delegated authority to request reports and presentations from particular groups and/or co-opt people from time to time for a particular purpose	Clinical Council Member; SMO x 3; Pathologist; GP x 2; Experienced RMO; Experienced Nurse; Midwife; Hospital Laboratory Manager; Community Laboratory Manager ; Person Responsible for HBDHB POCT	Non specific appointment holders - 1 year May be reappointed for up to 5 years	Appointed by CC annually	Majority (7) at least one of whom shall be a laboratory manager	As required with minimum of 4 times per year	Following each meeting Formal 6 monthly reports	Secretary appointed by HBDHB Minutes circulated within 1 week of meeting

Pharmacy & Therapeutics AG										
Radiology AG	Provide strategic and operational advice on how best to meet stakeholder requirements for efficient and effective medical radiology services in HB, ensuring good clinical practice and consistency across primary, community and hospital services and the timely availability of electronic, integrated and accurate test results	Advise on strategic direction for radiology services Develop policies, procedures and processes relating to the evaluation, selection, funding and reporting of particular radiology imaging, including any restrictions on who can request and how requests for imaging may be made Provide educational programmes designed to meet the needs of clinical staff for complete current knowledge on matters related to radiology imaging requesting and appropriate use of results.	Provide advice and make recommendations to Clinical Effectiveness & Audit Cttee Delegated authority to request reports and presentations from particular groups and/or co-opt people from time to time for a particular purpose	Clinical Council Member; SMO x 2; Hospital Radiologists x 2; Community Radiologist; GP x 2; Experienced RMO; Experienced Nurse; Midwife; Hospital Radiology Manager; Representative from each HB radiology service provider	Non specific appointment holders - 1 year May be reappointed for up to 5 years	Appointed by CC annually	Majority (8)	As required with minimum of 4 times per year	Following each meeting Formal 6 monthly reports	Secretary appointed by HBDHB Minutes circulated within 1 week of meeting
Maternity Governance Group										

INFORMATION MANAGEMENT
SUMMARY TERMS OF REFERENCE FROM JULY 2017

Body	Purpose	Functions	Authority	Membership	Tenure	Chair	Quorum	Meetings	Reporting	Minutes
Information Management Cttee	**Provide advice and clinical advocacy for the provision of appropriate ICT systems, processes and data, to aid effective clinical decision making and the provision of quality care**	**Identify & document the clinical and patient care benefits of appropriate ICT systems, processes and data. Liaise as necessary and advocate for the provision of such identified systems, processes and data Ensure all data used for clinical decision making and the provision of care is current and accurate, with one single 'source of the truth'.**	**Provide advice and recommendations to Clinical Council on strategy, systems, processes and policy Delegated authority from Clinical Council to liaise internally as required and advocate for the provision of appropriate systems, processes and data.**	**????**		**Appointed by CC CC Member or Executive Clinical Leader**	**Two thirds of the appointed members**	**Quarterly (or as required by the Chair)**	**Following each meeting Formal Annual report**	**QIPS Patient Safety Administrator Circulated within 1 week of meeting**
ADVISORY GROUPS										
Forms & Documents										
Policy										
Privacy										
Clinical records management										

PATIENT EXPERIENCE
SUMMARY TERMS OF REFERENCE FROM JULY 2017

Body	Purpose	Functions	Authority	Membership	Tenure	Chair	Quorum	Meetings	Reporting	Minutes
Patient Experience Cttee	Jointly develop and recommend strategies, systems, policies, processes and actions that will contibute to the continuous improvement of patient's experience within the HB health system.	Develop/enhance/confirm appropriate systems and surveys to be used to gather indicators of patient experience Agree targets, monitor and analyse performance Report on performance and recommend improvement initiatives and actions	Provide advice and recommendations to Clinical and Consumer Councils on strategy, systems, processes, policy, clinical practice and customer service	Four members from each of Clinical Council and Consumer Council Executive Director of People and Quality		Jointly agreed between Clinical and Consumer Councils	Minimum of two members from each Council	Quarterly (or as required by the Chair)	Following each meeting Formal Annual report	Consumer Engagement Administrator Circulated within 1 week of meeting
ADVISORY GROUPS										

CLINICAL GOVERNANCE STRUCTURES
Expressions of Interest from Clinical Council Members

Professional Standards & Performance Cttee			
ADVISORY GROUPS			
Credentialling; SMO, Nursing, Allied Health	Robin	Chris	Andy
Pre-Vocation/RMO Training AG	Russell		
Allied Health Profession Forum	Andy	Billy	Anne
Nursing & Midwifery Council	David W		
Education & Professional Development	Anne		
Research AG	John		
Patient Safety & Risk Management Cttee			
ADVISORY GROUPS			
Clinical Events AG	John	Andy	
Clinical Risk AG			
Falls AG	Chris	Andy	
Family Violence AG	Russell	Jules	Debs
Infection Prevention & Control AG	Chris		
Morbidity & Mortality			
Patient at Risk AG			
Restraint AG			
Trauma			
Clinical Effectiveness & Audit Cttee			
ADVISORY GROUPS			
Clinical Audit AG			
Clinical Pathways AG	Mark	Andy	David R
Laboratory AG	Kiri		
Pharmacy & Therapeutics AG	Billy		
Radiology AG	Mark		
Maternity Governance Group	Jules		
Information Management Cttee			
ADVISORY GROUPS			
Data Quality & Integrity AG	David R		
Patient Experience Cttee			
ADVISORY GROUPS			
Complaints & Compliments, National Survey, local Survey	Russell		

HAWKE'S BAY District Health Board Whakawāteatia	**Travel Plan Update**
	For the attention of: **Māori Relationship Board, HB Clinical and HB Health Consumer Council**
Document Owner: Document Author(s):	Sharon Mason (Chief Operating Officer) Andrea Beattie (Property and Service Contracts Manager)
Reviewed by:	Executive Management Team
Month:	March, 2017
Consideration:	For Information

RECOMMENDATION

That MRB, Clinical and Consumer Council:

Note the contents of the report

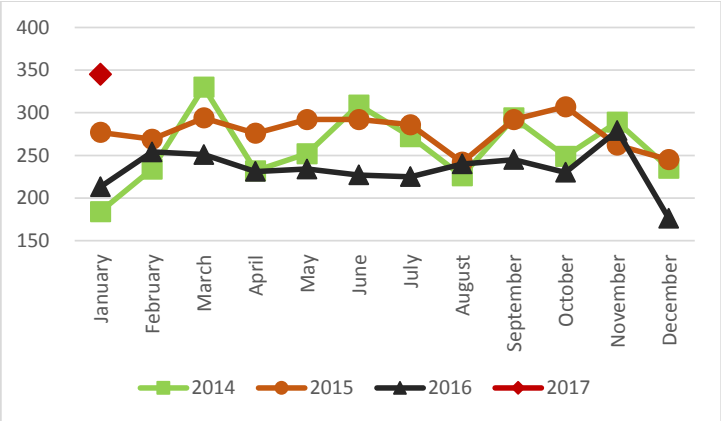
Overview

The purpose of this report is to provide an update on progress since the previous update in November 2016.

Bus Services

Free patient bus transport across on all urban networks in Napier and Hastings commenced on 1 January 2017.

Ridership for January 2017 was 345 pax. This is an increase of 61% on January 2016.



Complaints

The total number of complaints for 2016 was 63 compared with 88 in 2015.

Complaint numbers to date for 2017 stands at 3.

Cycling

In March a new secure lock-up will be in place in place near the old Wards Block entrance and can accommodate up to 20 cycles.

HBDHB hosted a Commuter Challenge breakfast in February, with 73 participants.

Guaranteed Ride Home Scheme

A guaranteed ride home scheme has been established which guarantees a staff member a ride home (by bus, fleet car or taxi) in the event of an emergency, if let down by carpool buddy, required to work unscheduled overtime, etc.

Parking Improvements

There has been a lot of activity around parking since November, including:

- Re-marking of Hospital parking.
- Car parks are now colour-coded to differing user groups.
- Parking signage has been installed.
- Additional car pool parks have been established due to demand.
- Minor civil works providing a further 20 parks have been tendered and awarded.

Parking Controls / Management

- Installation of pay and display machines is complete.
- Payment for parking will launch 1 March (soft launch).
- Additional support personnel for first month of the parking launch are in place including parking attendant and administration staff.
- HBDHB Carpark Officer will commence 13 March 2017.

Parking – Back-end Processes

A number of back-end processes have been implemented and are on-going:

- The car parking policy has been circulated for feedback with approx. 55 individual and group responses.
- 75 staff registered to date for free carpooling.
- Parking permit and payroll registrations are occurring.
- Communications is rolling out via staff notices, radio, newspaper, flyers, facebook, webpage, etc.
- Further face-to-face meetings have taken place with staff groups and services, and community groups.

Parking – Fee Exemptions

A number of agreed parking fee exemptions include:

- Long-term user of health services
- Frequent user of health services
- Staff paid below “living” wage
- HBDHB volunteers (including Friends of the Emergency Department)
- On call parking at Gate 4
- Staff carpooling groups
- Renal patients driving themselves to an appointment
- Time limited parking areas

HAWKE'S BAY District Health Board Whakawāteatia	**DRAFT Hawke's Bay District Health Board Annual Plan 2017/18**
	For the attention of: **Māori Relationship Board, HB Clinical Council and HB Health Consumer Council**
Document Owner: Document Author(s):	Tim Evans, Tracee Te Huia Carina Burgess, Head of Planning; Robyn Richardson, Health Services Planner
Reviewed by:	**Executive Management Team**
Month:	March, 2017
Consideration:	For Information

RECOMMENDATION

That MRB, Clinical and Consumer Council:

- Note the draft contents, timeline and process for the Hawke's Bay DHB Annual Plan 2017/18 and provide feedback to Carina Burgess
- Approve the Draft Annual Plan subject to any changes discussed

OVERVIEW

The first draft of the Hawke's Bay DHB Annual Plan is currently under development and is due to the Ministry of Health by 31st March. It is being shared with you at this stage to gather any feedback as it develops.

It is important to note that we are still awaiting the final guidance from the Ministry of Health which is due in early March.

For 2017/18, Annual Plans and Māori Health Annual Plans have been fully integrated nationally so we will no longer have a Māori Health Annual Plan. The Minister has also requested that Annual plans follow a template so they are more streamlined and focussed on the Minister's priorities.

We are not required to prepare a Statement of Intent (SOI) in 2017, this will be retained for every third year (last SOI prepared in 2016).

Timeline

Presented to EMT	21st February
MoH Planning Guidance & NZ Health Strategy finalised	Early March
MRB	8th March
Clinical Council	8th March
Consumer Council	9th March
Board	29th March
Ministry of Health (MoH)	31st March

Process

Despite changes to the Annual Plan, the process to develop it has been very similar to 2016/17. Planning, Strategic Services, the PHO, Population Health, Maori Health and Health Services are working closely to develop this plan. Each priority in ***Section 2: Delivering on Priorities***, has a small working group who are responsible for agreeing actions, leads and timeframes which will lead to better ownership of reporting going forward. Due to lack of information from the Ministry of Health and conflicting priorities, not all of these groups have been able to meet but they are all scheduled to occur in the next few weeks. There are also a number of activities which are to be confirmed (TBC) as more time is required to understand what activities will be carried out in the coming year.

Changes since 2016/17

Priorities

Through the new streamlined annual planning process, there is more emphasis on meeting our obligations to the Minister across the twenty-two priority areas identified and less on our local strategy and priorities.

HBDHB has had an integrated Annual Plan and Māori Health Annual Plan for three years now so the national move to integrating the plans is not new to us. However, we are now restricted to only the Minister's priorities so we will need to ensure that our local equity priorities are included in Regional, portfolio and service level planning.

In the Minister's letter of expectations sent in December 2016, he identified fiscal discipline, working across government and achieving the National Health Targets as areas of priority. All of these areas have been addressed in the Annual Plan.

Reporting

A number of new Performance Measures have been added to the Non-Financial Performance Framework from the MoH. All of 2016/17 Maori Health Annual Plan priority measures (e.g Breastfeeding, SUDI, Breast Screening, PHO enrolment etc) are now included. This means that for the first time we will need to report against performance on these measures to the MoH quarterly. A new measure ***PP38: Delivery of response actions agreed in annual plan*** has been added which means from Q1, we will be required to report on all activity in the annual plan to the MoH quarterly.

Due to the increased number of MoH performance measures, I have indicated in ***Appendix 1: Statement of Performance Expectations***, where we are currently in discussion about removing some measures

System Level Measures

The System Level Measures Improvement Plan is to be included as an appendix to the Annual Plan 2017/18. The first workshop for developing the plan was held in February. From this, smaller working groups have been formed to develop the plan. A draft is not available at this early stage in the process however EMT feedback will be sought as the plan develops.

ATTACHMENTS

Hawke's Bay District Health Board Annual Plan 2017/18 Draft v0.3

E83

Hawke's Bay District Health Board

Annual Plan and Statement of Performance Expectations 2017/18

10.1

Draft v0.3

OUR VISION

"HEALTHY HAWKE'S BAY"

"TE HAUORA O TE MATAU-A-MAUI"

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

OUR VALUES

TAUWHIRO

Delivering high quality care to patients and consumers

RĀRANGA TE TIRA

Working together in partnership across the community

HE KAUANUANU

Showing respect for each other, our staff, patients and consumers

ĀKINA

Continuously improving everything we do

Hawke's Bay District Health Board Annual Plan 2017/18

DHB Contact Information:
Planning, Informatics & Finance
Hawke's Bay District Health Board
Private Bag 9014
HASTINGS
Ph: 06-878 8109
www.hawkesbay.health.nz

CONTENTS

10.1

1 OVERVIEW OF STRATEGIC PRIORITIES

1.1 Strategic Intentions

Hawke's Bay District Health Board (HBDHB) is a Crown Entity and is the Government's funder and provider of public health and disability services for the population in our defined district. Our Statement of Intent 2016-19 outlines our strategic intentions for the next four years and shows how local outputs impact on our population and contribute to local, regional and system-level outcomes.

As a sector we have a common vision: "Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community." We face challenges such as the growth in chronic illness, our aging population and vulnerability in a large sector of our community. Our strategy, Transform and Sustain, seeks to overcome these challenges. Our three long term goals are: everyone experiences consistent, high quality care; the health system is efficient and sustainable; and people live longer, healthier lives.

In 2016 Transform and Sustain was refreshed to ensure that we are closely aligned to the New Zealand Health Strategy and it's themes as shown in figure 1 below.

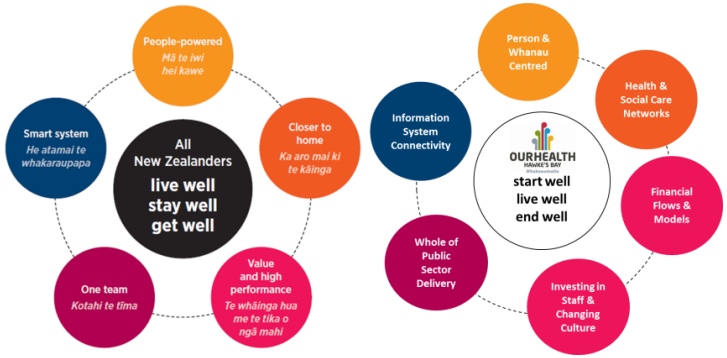


Figure 1: Transform and Sustain linked to the New Zealand Health Strategy themes.

We work collaboratively with our Central Region partners, our local primary health organisation (PHO), Health Hawke's Bay and other sectors for optimal arrangements. Using these relationships we have planned our contribution to the Government's priorities for the health system, which include fiscal discipline, working across government, and achieving the National Health Target.

1.2 Our Population

The population of Hawke's Bay district has some unique characteristics compared to the rest of New Zealand in terms of health status and socio-demographics, and this provides us with some specific challenges. We have a higher proportion of Māori (26% vs 16%), more people aged over 65 years (18% vs 15%) and more people living in areas with relatively high material deprivation (28% vs 20%).

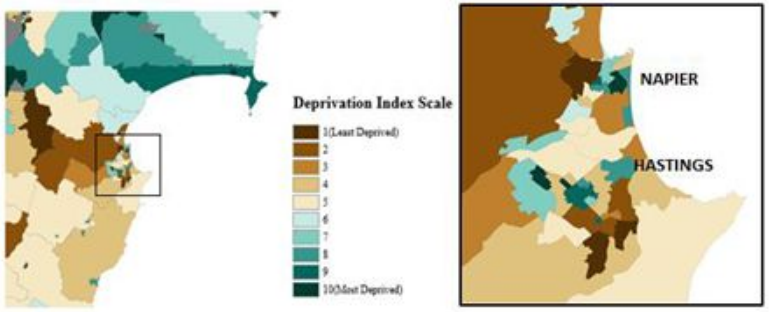


Figure 2: Hawke's Bay District relative deprivation NZDep13

Growth in the population is being driven by a younger age profile in the Māori and Pasifika population, which results in a higher birth rate, plus increased life expectancy across our whole population.

These projected population changes emphasise the need for HBDHB to maintain our focus on improving Māori and Pasifika health and to reorient our services to address and manage age-related health issues as guided by the New Zealand Healthy Ageing Strategy

Te Tiriti o Waitangi guarantees equitable health and social outcomes for everyone, and all Government agencies have a role in making sure that happens. The role and expectations of District Health Boards (DHBs) is emphasised in the New Zealand Public Health and Disability Act, 2000 (NZPHD Act) and our DHB partners with Health Hawke's Bay to co-ordinate the delivery of publicly funded health care and wellness support services. DHB responsibilities are based on:

- **Partnership** – working together with Iwi, hapū, whānau and Māori communities to develop strategies for improving the health status of Māori.
- **Participation** – involving Māori at all levels of the sector in planning, developing and delivering of health and disability services that are put in place to improve the health status of Māori.
- **Protection** – ensuring Māori well-being is protected and improved, and safeguarding Māori cultural concepts, values and practices. This includes the elimination of Māori health disparities by improving access to services and health outcomes for Māori.

Mai, our Māori Health Strategy 2014-19 and our Pacific Health Action Plan 2014-2018 have been developed to align with; the above principles and Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018.

In 2016 we updated the Health Equity in Hawke's Bay report, an analysis and report on health status in Hawke's Bay. The main focus of the report is equity because health inequities are differences in health status that are avoidable or preventable and therefore unfair.

The report finds many inequities in health in Hawke's Bay, particularly for Māori, Pasifika and people living in more-deprived areas. There are also areas where, with determined and focused effort, we have improved outcomes and reduced inequities. This demonstrates that inequities are not inevitable. We can change them if we have the courage and determination to do so.

The Health Equity Report concludes that inequity affects everyone and, for a difference to be made, we must tackle this collectively and take responsibility as a community. Since release, the findings of the report have been widely shared. The level of interest has been very positive and has led to the Hawke's Bay Intersectoral Forum, LIFT Hawke's Bay,[1] taking a role in developing a Social Inclusion Strategy to address priority areas. This multi-agency approach aims to bring a full range of relevant providers together with public, philanthropic and private funders to implement novel opportunities to integrate efforts that will address inequity as a community.

1.3 Long Term Investment

As a District Health Board, we have worked hard to create financial stability and use our internally generated funds to systematically invest in improved health services for our population. Looking forward, we aim to maintain this stability and continue to make smart investment decisions to meet the changing needs of the population.

Our Long Term Investment Plan (LTIP) outlines Hawke's Bay District Health Board's ten year investment plan based on a simplified outlook to the future from a local, regional and National perspective. In 2017/18 a Clinical Services Plan.is being developed to best inform where we will need to prioritise future investment and the LTIP will be updated accordingly.

[1] Includes Mayors, Members of Parliament, Iwi, Local and Regional Councils, Business HB, EIT, Government agencies – Housing NZ; Police, Corrections, Ministry of Social Development, Ministry of Education, Te Puni Kokiri, DHB

1.4 Statement from the Chair and Chief Executive

X_____ X_____

Dr Kevin Snee, Chief Executive
Hawke's Bay District Health Board

Kevin Atkinson, Board Chair
Hawke's Bay District Health Board

MINISTER OF HEALTH

X_____
Hon. Dr Jonathan Coleman, Minister of Health

THE PRIMARY HEALTHCARE ORGANISATION

X_____
Wayne Woolrich, General Manager Health Hawke's Bay – Te Oranga Hawke's Bay

MĀORI RELATIONSHIP BOARD

X_____
Ngahiwi Tomoana, Chair - HBDHB Māori Relationship Board

ALLIANCE LEADERSHIP TEAM

X_____
Bayden Barber, Member – Hawke's Bay Alliance Leadership Team

2 DELIVERING ON PRIORITIES

This section outlines activity to improve performance against Government priorities, and our contribution to the Central Region's priorities. It provides a sense of our commitment of resources to implementing those priorities, how we coordinate our efforts, and how we will measure success.

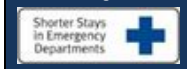
Acknowledgement

The 2017/18 planning process for this Annual Plan included setting up groups of stakeholders around each priority area. Accountability for collating each section was shared between co-leads from Health Hawke's Bay and HBDHB to ensure that there was PHO participation in the preparation of this plan. The public health unit and frontline clinicians played a vital role in developing the sections over the planning period in 2017.

Leaders from Māori and Pacific Health were consulted with at various stages in the planning process. Māori health priorities are indicated throughout the document and where possible, all measures will be reported on by ethnicity.

2.1 Government Planning Priorities

Government Planning Priority	Focus Expected for Hawke's Bay DHB	Link to NZ Health Strategy	Hawke's Bay DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Requirements TBC by MoH	TBC.			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered	1. All School Based Health Service (SBHS) nurses are trained to use advanced standing orders for contraception 2. All nurses, both SBHS and primary and community, working under standing orders, have an annual update and assessment 3. Develop initiatives within the Sexual Health Governance Group action plan to better engage males in their reproductive health.	Q4 100% trained Q4 100% completion Q4 5% increase in males accessing	PP38: Delivery of response actions agreed in annual plan
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team	1. Family Violence Intervention (VIP) working group to increase training of Health Services staff in family violence and improve clarity of recorded data 2. Develop a family violence screening KPI for Health Services to be implemented in 18/19	Q2 TBC Q4	PP27: Supporting Vulnerable Children

	Note that this target may change and further advice will be provided as decisions are made.		3. Extend scope of multi-agency maternal wellbeing and child protection group to provide support for pregnant women with children up to 2 years(as opposed to 6 weeks as in the past) 4. TBC activity from PHO on referral guidelines and training for primary care staff 5. Establish a Pregnancy and Parenting Service: Assertive Outreach to vulnerable whānau experiencing drug and alcohol issues	Q1-4 Q2	
Reducing Rheumatic Fever BPS Target	Sustain reduction in rheumatic fever through the delivery of rheumatic fever prevention plans.	Value and high performance	1. Extend the Healthy Homes programme to 500 annual referrals *(subject to allocation of funding)* 2. Continue with Say Ahh programme in targeted schools, and primary care *(subject to allocation of funding)* 3. Continue to monitor time between admission and notification of a new cases of rheumatic fever to the Medical Officer of Health. 4. Undertake case reviews of all Rheumatic Fever cases and address identified system failures	Q4 500 referrals Q1-4 Q1-4	PP28: Reducing Rheumatic Fever
Increased Immunisation BPS and Health Target 	Continue current activity, in accordance with national immunisation strategies and service specifications, to maintain high (target) coverage rates for all immunisation milestones.	Value and high performance	1. Survey all child birth educators on their knowledge, confidence and activity around educating people of all cultures on immunisation 2. Meet all major milestones on the HPV immunisation communication plan are achieved to ensure a systematic process and avoid gaps in service delivery. 3. Work with Māori providers and other organisations to improve their capability by: Providing educations sessions; Ensuring there are authorised vaccinators; and Providing support with the cold chain 4. Develop a how to guide for general practice to enable correct recording of influenza vaccines to ensure these link to the National Immunisation Register (NIR) 5. Work with Kahungunu Executive to explore opportunities to increase capacity and capability for immunisation in Wairoa	Q2 Q1-4 Q3, Q4 Q3 Q4	Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target 	Provide a prioritised list of the service improvement activities you will implement in 2017/18 to improve acute patient flow within your hospital(s).	Value and high performance	1. Implement Internal Professional Standards (Medical Staff) 2. Implementation of a Nurse Practitioner led model of care 3. Complete implementation of ED Quality Framework and ensure processes and systems are in place to enable monitoring of mandatory and non – mandatory measures 4. Primary Care ED Co-Operative Programme (PDED) to case manage high ED attendance patients in order to understand triggers and reduce attendance 5. TBC Patient Flow Activity	Q2 Q2 Q4 Q4	ED Health Target

			6. TBC Activity re establishment of Operations Centre 7. TBC Activity on Capacity and Resource Planning		
Improved Access to Elective Surgery Health Target 	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance	1. Deliver TBC elective discharges in 2017/18 2. TBC activity for Increasing surgical capacity once indicative business case approved 3. Continue to monitor theatre productivity via Theatre Management committee 4. Deliver TBC Major Joint, TBC Orthopaedic other and TBC General Surgery discharges in 2017/18 5. Deliver TBC Major Joint Replacement per 10,000 and TBC Cataract Procedures: per 10,000 6. TBC 4000 bed days and FLOW project alignment 7. TBC ambulatory volumes 8. TBC bariatric discharges 9. Review patient flow pathways specialty by specialty to identify blockages and areas where efficiencies can be made 10. Carry out Service Review for vascular service	Q4 TBC Q1-4 Q4 Q4 TBC Q4 Q4 Q3 Q2	Electives Health Target Additional Orthopaedic and General Surgery Initiative SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target 	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team	1. Increase the use of electronic referral system, by GPs, for suspicion of cancer TBC 2. Establish internal standards for: • Time frames from date of referral to multi-disciplinary meeting (MDM) and from MDM to decision to treat • Timeframes from referral to CT and from CT to CT report 3. Develop a protocol for consistent involvement of Clinical Nurse Co-ordinators in referral prioritisation to support identification of high suspicion cancer. 4. Develop and implement an alternative pathway for benign breast in collaboration with primary care 5. Broaden attendance (medical, surgical, radiology) at MDMs 6. Support or comply with Central Cancer Network (CCN) activities 7. Review options to establish a FCT navigator role in primary care to identify the at risk populations and to develop diagnostic pathways that enable equitable access.	Q3 Q2 Q1 Q2 Q2 Q2 Q3	Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Strengthening the DHB smoking cessation plan with input from	Value and high perfo	1. Implement the co-created Regional Tobacco Strategy 2. Review forms used in Primary Care Patient Management System to embed mandatory Smokefree fields	Q1-4 Q2 Progress Report	Tobacco Health Target

10.1

	primary care and smoking cessation providers.		3. Provide benchmarking data and audit support for governance reporting to manage performance of the Health Target 4. Support high prevalence populations by providing sufficient training in Wairoa, expanding incentivised programme for young Maori women, monitoring referrals from GPs following the Early Engagement roll out and investigating cessation support tools e.g. 'vaping' 5. Support the establishment of the aligned cessation service, using input from providers by providing project support and developing training and communication plans 6. Continue to screen inpatients in maternity services, offering support to quit for mothers and whanau and monitor Smokefree rates at discharge from Maternity Unit	Q1-4 Draft Report Q2 Q1	PP31: Better Help for Smokers to Quit in Public Hospitals
Raising Healthy Kids Health Target 	Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017.	Closer to home	1. Close monitoring of progress against the Health Target 2. Monitor implementation of Healthy Conversation tools 3. Support collective action to reduce childhood obesity by implementing the Best Start: healthy eating and activity Plan 4. Monitor family-based nutrition and lifestyle interventions 5. TBC	Q1 Meet target Q2 Q3 Q2, Q4	Healthy Kids Health Target
Bowel Screening	Contribute to development activities for the national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.	Value and high performance	TBC		PP29: Improving waiting times for diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the rate of child and youth with transition plans.	One team	TBC		PP7: Improving mental health services using transition (discharge) planning
	Additional requirements TBC.	TBC.			TBC.

Healthy Ageing	Guidance TBC – but will focus on implementation of the Healthy Ageing Strategy, in particular implementation of the outcomes of the IBT settlement agreement and the equal pay negotiations and investment in the home and community sector workforce to develop service and funding models that support a sustainable, culturally appropriate and person-centred approach to the support of older people, including people with long-term conditions. To achieve best value and high performance, interRAI assessment data will be used to identify quality indicators and service development opportunities.	TBC.			PP23: Improving Wrap Around Services – Health of Older People
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards r Diabetes Care.	**Closer to home**	1. The Stanford Programme for self-management of chronic disease will be offered by general practice to people who are diagnosed with pre-diabetes 2. Pre-diabetes patients will be offered participation in the PIP programme (primary care nurses offering nutrition and lifestyle support) 3. Establish audit and reporting processes for both retinal screening and podiatry services for medium to high risk patients 4. All general practices will develop an annual Diabetes Care Improvement Plan (DCIP) with a focus on the delivery of quality care to their respective diabetes population. 5. Build capability of our primary care nursing work force by developing outcomes based goals and a role structure for CNS shared care with primary care 6. TBC activity on information sharing across sector 7. TBC activity on care of diabetics in hospital and discharge processes	Q2 4 sessions Q1-4 Q2 Q2 Q2 Q4	PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services
Childhood Obesity Plan	Commit to progress DHB-led initiatives from the *childhood obesity plan*.	**Closer to home**	Implement the activities identified for 2017/18 from the Best Start Plan (Childhood Obesity Plan for HBDHB)		PP38: Delivery of response actions agreed in annual plan

Child Health	TBC - decisions regarding the new vulnerable children's entity and required activity are not yet finalised. As the Government makes decisions and expectations of DHBs become clearer, further guidance will be provided.	TBC.			TBC.
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances).	One team	1. Representatives for physical and sensory disability and also for intellectual and neurological disability are required on Consumer Council 2. Co-location of Mental Health Emergency services with Emergency Department 3. All new reception builds have a lower section 4. Allied health departments have tools to support communication, movement, and activities of daily living but use is dependent on request from staff for support tools or assessment	N/A	PP38: Delivery of response actions agreed in annual plan
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector	Closer to home	1. Develop a guideline for transferal of resource to support capability and capacity in primary care 2. Chief Information Officer(CIO) HBDHB, with input from Health Hawkes Bay, to inform future integration platforms for Information Technology 3. Initiate project to Investigate ways of incentivising improved Primary Care outcomes 4. Promote joint sector wide clinical leadership and clinically led decision-making through the HB Clinical Council monthly meetings, on behalf of the Alliance Leadership Team 5. Under the Transform and Sustain programme; further develop a structure for implementing localised prioritised projects: Health and Social Care Localities. 6. TBC activity on Clinical Pathways	Q4 Q1 Q3 Q1-4 Q4	PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix	Value and high performance	7. Work with our stakeholders toward our jointly developed and agreed System Level Measure Improvement Plan. See Appendix	Q2	PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to	One team	1. Support local implementation of national pharmacy contract Integrated Pharmacist Services in the Community (85% signed up)	Q1	PP38: Delivery of response actions agreed in annual plan

	the Community Pharmacy Services Agreement.		2. Align Community Based Pharmacy Services in Hawke's Bay Strategic Direction 2016 – 2020 with the Ministry of Health's Pharmacy Action Plan (PAP) 3. Work with the HHB to strengthen pharmacy representation at governance and service development level 4. Work with the HHB to strengthen pharmacy representation at governance and service development level	Q2 Q2 Q4	
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	**Value and high performance**	1. Maintain front-line ownership of improvement targets driven by directorate leadership and oversight provided by Clinical Council representing sector wide clinical leadership 2. Support the ongoing inpatient National Patient Experience Survey and the roll out in Primary Care. 3. Develop and implement a local patient experience survey, and set of processes to utilise results alongside the National Patient Survey 4. Develop and implement a Consumer Engagement Framework to ensure the voice of the consumer is utilised in the right way on a consistent basis across the health sector 5. Implementation and initiation of Health Literacy programme of work 6. Maintain and support Consumer Council to advise HBDHB board	Q1-4 Q3 Q3 Q1 Q1 Q1-4	PP38: Delivery of response actions agreed in annual plan
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	**Value and high performance**	TBC		Agreed financial templates.
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C.	**NA.**	1. Work with the Cardiac Network to design and implement consistent initiatives that address barriers for Māori accessing primary care, commencing with atrial fibrillation and heart failure. TBC 2. Achieve 8% of more of eligible patients thrombolysed TBC 3. Develop agreed regional clinical guidelines and inter-hospital transfer processes to manage major trauma patients within the region. TBC 4. Work with Central Region community Hepatitis C service to ensure all people living with or at risk of Hepatitis C have access to information, testing, assessment and treatment if appropriate TBC	Q4 Q1-4 Q2, Q4 Q1-4	NA.

2.2 Financial Performance Summary

Financials due to be completed by end of February

This needs to include the consolidated statement of comprehensive income (previous year's actual, current year's forecast and three years plan), and the prospective summary of revenue and expenses by output class for the next three years.

2.3 Local and Regional Enablers

Local and Regional Enabler	Focus Expected for Hawke's Bay DHB	Link to NZ Health Strategy	Hawke's Bay DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	State when CPOE will be implemented. Complete ePA and nursing documentation implementations.	Smart system	1. Engage with Central TAS to agree on an implementation plan and timeline for Orion Clinical Portal	Q2	Quarterly reports from regional leads.
			2. Develop a timeline for commencing implementation of ePA (Medchart)	Q2	
			3. Primary care Clinical Portal:Roll out implementation of the provider portal for district nurses, to additional providers and their services	Q4	
			4. Event Reporting System; Select preferred provider and initiate project	Q2	
			5. Telephone Successor System: Initiate planning work for co-design and contract activities	Q4	
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	Value and high performance	TBC		NA.

3 SERVICE CONFIGURATION

3.1 Service Change

The table below is a high-level indication of some potential changes.

Change	Description	Expected Benefits	Local, Regional or National
Urgent Care	In partnership with general practices and emergency department implement Urgent Care Service improvements.	More consistent and effective access to appropriate urgent care across the district. Reduce hospital admissions and improve equity.	Local
Primary Mental Health	A redesign of primary mental health services is underway and this will change current delivery.	Earlier access for mild and moderate mental health concerns targeting under-served populations. Better links between primary, community and secondary mental health services.	Local
Adults Alcohol and Other Drugs (AOD) model of care implementation	Implementation of change management plan for an Adult AOD Model of Care pathway across six Central Region DHB's. As well as residential options, the model includes: Withdrawal management; Respite/stabilisation; Adult AOD peer support; Whānau Ora approaches to care.	Improved care continuity for AOD service consumers Improved access for Māori and Pacific populations Enable provision of services under the proposed Substance Addiction (Compulsory Assessment and Treatment) Bill to be implemented in 2017/18.	Regional
Community Pharmacy and Pharmacist services	Implement the national Community Pharmacy Services Agreement and develop local services.	More integration across the primary care team. Improved access to pharmacist services by consumers. Consumer empowerment. Safe supply of medicines to the consumer. Improved support for vulnerable populations. More use of pharmacists as a first point of contact within primary care.	National
Laboratory Services	Maintaining safe, accessible laboratory services may lead to a change in the range of laboratory services available 24/7 at all current delivery sites.	Service coverage expectations for clinically-appropriate laboratory tests will be emphasised. Better use of health system resources.	Local
Surgical Expansion Project	Project to expand HBDHB surgical in-house capacity to better meet elective health targets and HB population surgical needs.	HBDHB able to better meet elective health targets and population surgical needs in-house and within in budget.	Local
Ophthalmology – Glaucoma	Utilising community optometrists via a shared care model to conduct glaucoma follow ups.	Increased clinic capacity and reduced clinical risk for glaucoma patients	Local
Youth Services	Youth service redesign process continues from 2016 and is a focus for 2017/19. This is based on the HBDHB youth health strategy 2016-19	Better access for youth. Services designed with input from youth and stakeholders.	Local
	U18 free access to General Practice Services for high needs youth population i.e. Maori, Pasifika.	67% of the 13-17 year population will have access to free primary care (in and out of hours).	Local
	Completion by General Practice of Youth Friendly Primary Care assessment tool.	General practice can be more responsive and receptive to the needs of Youth population.	Local

Model of Care (primary)	Funding allocated by PHO/DHB to support the development of models of care that support patient / relationship centred practice.	Patient care models that demonstrate – consumer input into model of care and priority areas that will lead to heightened self-management and reduced health outcomes particularly for Long Term Conditions Models will demonstrate utilisation of multidisciplinary and interdisciplinary team approaches and increased utilisation of the nursing workforce as clinical leads in primary care provision	Local
Long Term Conditions (LTC) Management	LTC Framework developed for implementation to begin May 2017	More consistent and effective approach to manage LTC and support self-management	Regional
Health and Social Care Localities	Providing integrated service models specific to geographical localities based on local identified health needs	Consumers accessing appropriate services closer to their home	Local
Faster Cancer Treatment	From 1/07/2017 HBDHB will be repatriating from MidCentral DHB all Hawke's Bay delivered volumes. This will involve the; Redesigining of our oncology service model and Redesigning and refurbishing our buildings.	More streamlined services working toward meeting the FCT target	Regional

Service Integration

In line with Transform and Sustain and the National drive to shift services out of the specialised hospital setting and into the community, HBDHB are continually reviewing services and considering where these could be provided in the community and/or with better integration with primary care.

Procurement of Health & Disability Services

HBDHB periodically undertakes competitive processes (Registration of Interest, Request for Proposals etc.), in accordance with the Ministry of Business Innovation and Employments Government Rules of Sourcing. Competitive processes may be undertaken for several reasons including, the time since the last competitive process and changes in service design. Competitive processes ensure cost effective services, increase innovation and can enhance efficient service provision. Competitive processes may result in a change of provider

Note A: HBDHB is permitted and empowered under Section 25 of the New Zealand Public Health and Disability Act 2000 (the Act) to negotiate and enter into any service agreements (and amendments to service agreements) which it considers necessary in fulfilling its objectives and/or performing its functions pursuant to the Act.

Note A: HBDHB is permitted and empowered under Section 25 of the New Zealand Public Health and Disability Act 2000 (the Act) to negotiate and enter into any service agreements (and amendments to service agreements) which it considers necessary in fulfilling its objectives and/or performing its functions pursuant to the Act.

4 STEWARDSHIP

Our transform and sustain programme is showing good results. We are making significant improvements in delivering services for patients, achieving more equitable health outcomes and improving staff engagement. Initiatives such as Acute Inpatient Management 24/7 (AIM 24/7) and others focusing on our after-hours services, theatre productivity, mental health model of care and health of older persons services, are all delivering significant improvement across the sector. These improvements are being achieved within our current funding. In addition, our engagement with and commitment to the Health Quality and Safety Commission's programmes – specifically, Quality and Safety Markers (QSMs), Quality Accounts, and Patient Experience Indicators – provide the public with evidence and transparent links comparing our performance to national benchmarks and declarations about the quality of the services we fund and provide.

4.1 Managing our Business

Processes for Achieving Regular Financial Surpluses

Closing the gap between planned expenditure and expected income is normal business in the health system. As the world economic environment puts even more pressure on all Government spending, Hawke's Bay DHB, as the lead Government agent for the Hawke's Bay public health budget, must continually look for ways to live within an expectation of lower funding growth.

Hawke's Bay DHB continues with its strategic direction to provide a $3m year-on-year surplus. This surplus is required to enable us to continue to invest in various infrastructure initiatives required to meet the needs of our community.

We continue with our strategy of responsible reduction in our cost base by

- Stopping doing things that are clinically ineffective of for which there is insufficient supporting evidence
- Doing things more efficiently by redesigning processes to drive out waste or errors
- Embracing opportunity to enhance quality by providing better care with the available resources

Our focus on reducing our cost base together with opportunities to increase our revenues will produce additional resources for our transformation program.

Shifting Resources

To ensure that our change in focus is also matched by a shift of resources, we have agreed measures to monitor changes in deploying resources over time. Figure 3 illustrates a model for measuring and managing a shift of resources. The aim is to measure, monitor and realign expenditure in these categories and to shift resources purposely.

The shape of the curve will change, with the care models fundamentally transformed to enable more effective deployment of resources. This is not about shifting resources from one provider to another, but rather it is about changing the service model.

Investment and Asset Management

Regional capital investment approaches are outlined in RSP and individual sections contain capital investment plans. HBDHB is committed to working with the regional capital planning committee on the development of our local plans and assisting our regional colleagues in development of the regional capital plan and its implementation.

Formal asset management planning is undertaken at HBDHB. We have developed a 10 year long term investment plan which outlines our planed asset expenditure in the absence of a clinical services plan.

Approvals at regional and national level are sought depending on the threshold of any proposed investment to help ensure that there is some national consistency in development of the health assets. We will continue to work nationally with the development of the various national initiatives and regionally on the development of a regional solution for our information technology applications.

4.2 Building Capability

Workforce

The health system needs skilled clinical leaders, team leaders and managers in place to support team performance so that we can achieve transformation. Our teams must continually focus on providing excellent services, improving health and well-being, working in partnership and improving equity, and they must be empowered to try new ways of doing things. This applies to service delivery and support functions. We are working together to support and develop the workforce and the organisations.

Development of a new workforce development framework and strategy focussing on our medical, nursing, allied, support and management and administration workforces.Our Child Protection Policies comply with the requirements of the Vulnerable Children Act, 2014. A copy is available from our website: www.Hawke'sbay.health.nz

Communications

The communications team is committed to looking at new and fresh ways to engage successfully with our community and our staff. We challenge our staff to think about effective strategies and how best to communicate them so people can better manage their way through the complexities of the health system. We are always looking to help staff promote new ideas and new initiatives through more effective and compelling communication.

Health Information

In transforming the health system, one of the biggest challenges we face is developing an information system that matches our ambitions for service integration. We are working with our regional partners to deliver a regional health informatics strategy to support improvements in Information Communication Technology (ICT) over the outlook period. The Central Region ICT vision is about the efficient delivery of the right information to the right people at the right time, on an anywhere, anyhow basis to achieve the desired health outcomes and improved organisational performance

Achieving the region's vision for health informatics will contribute to improved consumer experience, better support for clinicians and other health professionals and more integrated care.

There are many areas that require better ICT support and we recognise the importance of rigorous investment to achieve this. We have developed and information systems strategy and a business intelligence work plan to underpin and complement Transform and Sustain.

Inter-Agency Collaboration

Hawke's Bay District Health Board is working closely with other agencies to improve outcomes for the population through 'LIFT Hawke's Bay – Kia Tapatahi'. The group is working towards a common vision: Hawke's Bay is a vibrant, cohesive and diverse community, where every household and every whānau is actively engaged in, contributing to, and benefiting from, a thriving Hawke's Bay". Two strategies being developed and implemented through this forum are the Regional Economic Development Strategy and a Social Inclusion Strategy.

Note A: Subsidiary Companies and Investments

Currently, there are no subsidiary companies in which HBDHB has a controlling interest[2] and HBDHB has no plans to acquire shares or interests in terms of section 100 of the Crown Entities Act 2004. HBDHB has an interest in one multi-parent subsidiary: Allied Laundry Services Limited. Other shareholders are MidCentral DHB, Taranaki DHB, Whanganui DHB, Capital and Coast DHB and Hutt Valley DHB. Allied Laundry Services Limited has an exemption from producing a Statement of Intent (SOI). MidCentral DHB will report on Allied Laundry Services Limited in its SOI, on behalf of Hawke's Bay, Taranaki and Whanganui DHB

Note B: HBDHB has a Health and Safety Policy detailing our commitment to providing a safe and healthy environment for all persons on our sites and business. The policy incorporates the Board-approved Health and Safety Statement which is reviewed every 2 years. The last review was in April 2014.

[2] As defined in section 58 of the Companies Act 1993

5 PERFORMANCE MEASURES

5.1 2017/18 Performance Measures

The DHB monitoring framework aims to provide a view of performance using a range of performance markers. Four dimensions are identified reflecting DHB functions as owners, funders and providers of health and disability services. The four identified dimensions of DHB performance cover:

- Achieving Government's priority goals/objectives and targets or 'Policy Priorities'
- Meeting service coverage requirements and supporting sector inter-connectedness or 'System Integration'
- Providing quality services efficiently or 'Ownership'
- Purchasing the right mix and level of services within acceptable financial performance or 'Outputs'.

It is intended that the structure of the framework and associated reports assists stakeholders to 'see at a glance' how well DHBs are performing across the breadth of their activity, including in relation to legislative requirements, but with the balance of measures focused on Government priorities. Each performance measure has a nomenclature to assist with classification as follows:

Code	Dimension
PP	Policy Priorities
SI	System Integration
OP	Outputs
OS	Ownership
DV	Developmental – establishment of baseline (no target/performance expectation is set)
SLM	Inclusion of 'SLM' in the measure title indicates a measure that is part of the 'System Level Measures' identified for 2017/18.

TABLE TO BE SUPPLIED BY MoH

Performance measure	Performance expectation
HS: Supporting delivery of the New Zealand Health Strategy	
PP6: Improving the health status of people with severe mental illness through improved access	
PP7: Improving mental health services using wellness and transition (discharge) planning	
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	
PP10: Oral Health- Mean DMFT score at Year 8	
PP11: Children caries-free at five years of age	
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	
PP13: Improving the number of children enrolled in DHB funded dental services	
PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	
PP21: Immunisation coverage	
PP22: Delivery of actions to improve system integration including SLMs	
PP23: Improving Wrap Around Services for Older People	
PP25: Prime Minister's youth mental health initiative	

Performance measure	Performance expectation
PP26: The Mental Health & Addiction Service Development Plan	
PP27: Supporting vulnerable children	
PP28: Reducing Rheumatic fever	
PP29: Improving waiting times for diagnostic services	
PP30: Faster cancer treatment	
PP31: Better help for smokers to quit in public hospitals	
PP32: Improving the accuracy of ethnicity reporting in PHO registers	
PP33: Improving Māori enrolment in PHOs	
PP34: Improving the percentage of women who are smoke free at two weeks postnatal	
PP35: Reducing SUDI infant deaths	
PP36: Reduce the rate of Māori on the mental health Act: section 29 community treatment orders relative to other ethnicities.	
PP37: Improving breastfeeding rates	
PP38: Delivery of response actions agreed in annual plan	
SI1: Ambulatory sensitive hospitalisations	
SI2: Delivery of Regional Service Plans	

Performance measure	Performance expectation
SI3: Ensuring delivery of Service Coverage	
SI4: Standardised Intervention Rates (SIRs)	
SI5: Delivery of Whānau Ora	
SI7: SLM total acute hospital bed days per capita	
SI8: SLM patient experience of care	
SI9: SLM amenable mortality	
SI10: Improving cervical Screening coverage	
SI11: Improving breast screening rates	
OS3: Inpatient Length of Stay	
OS8: Reducing Acute Readmissions to Hospital	
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	
Output 1: Mental health output Delivery Against Plan	
DV4: Improving patient experience	
DV6: SLM youth access to and utilisation of youth appropriate health services	
DV7: SLM number of babies who live in a smoke-free household at six weeks post natal	

APPENDIX A: STATEMENT OF PERFORMANCE EXPECTATIONS & FINANCIAL PERFORMANCE

1 Statement of Performance Expectations

This section includes information about the measures and standards against which Hawke's Bay District Health Board's (HBDHB) service performance will be assessed. For the purpose of our Statement Performance Expectations (SPE), our services are grouped into four reportable Output Classes:

- **Prevention Services;**
- **Early Detection and Management Services;**
- **Intensive Assessment and Treatment Services;**
- **Rehabilitation and Support Services.**

The SPE describes information in respect of the first financial year of our Statement of Intent and the performance measures are forecast to provide accountability. The outputs and measures presented are a reasonable representation of the full range of services provided by the organisation. Where possible, we have included past performance (baseline data) and the performance target to give the context of what we are trying to achieve and to enable better evaluation of our performance.

Service Performance

Explaining the contribution that our services make towards achieving the population and system level outcomes and impacts outlined in our Statement of Intent above, requires consideration of service performance. For each output class, we will assess performance in terms of the New Zealand Triple Aim (Figure 2). Maintaining a balance of focus across the Triple Aim is at the core of the Health Quality and Safety Commission's drive for quality improvement across the health sector.

The system dimension: Best value for public health system resources

For each output class we show expected funding and expenditure to demonstrate how output class performance will contribute to the outcome of a financially sustainable system.

The population dimension: Improved health and equity for all populations

Services may target the whole population or specified sub-populations. In either case we select measures that apply to the relevant group. These measures usually refer to rates of coverage or proportions of targeted populations who are served and are indicative or responsiveness to need.

The individual dimension: Improved quality, safety and experience of care

Ensuring quality and safety, within hospitals and wider health services, is a fundamental responsibility of DHBs. Measurements in this dimension indicate how well the system responds to expected standards and contributes to patient and consumer satisfaction.

Note: all targets are an annual target or, where monitored quarterly, show the expected performance by the end of quarter four. Targets are set at the total population level and monitored, where appropriate, across different population groups to gauge the equity of results. A detailed technical description of each indicator is available in a data dictionary maintained by our information services.

The HBDHB Statement of Performance Expectations for the 2016/17 year follows:

X_____ X_____

Board Member Board Member

Code		Description
MH		Māori Health Plan Targets
HT		Health Targets
MoH Performance Measures - see Appendix 4	**PP**	Policy Priorities
	SI	System Integration
	OP	Outputs
	OS	Ownership
	DV	Developmental
N/A		Data not available

10.1

1.2 OUTPUT CLASS 1: Prevention Services

Prevention Services are publicly funded services that protect and promote good health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population, as distinct from treatment services which repair or support health and disability dysfunction. Prevention Services address individual behaviours by targeting population-wide physical and social environments to influence health and well-being. Prevention Services include: health promotion and education services; statutory and regulatory services; population based screening programmes; immunisation services; and, well child and school services.

On the continuum of care, Prevention Services are population-wide and are designed to focus attention on wellness of the general population and on keeping the "at risk" population healthy. It is important to emphasise that the concept of wellness extends to the entire population, including those who already have a health condition or disability.

Objective: People are better protected from harm and more informed to support healthier lifestyles and maintenance of wellness

Through collective action with communities and other sectors, we aim to protect the general population from harm and keep them informed about good health so that they are supported to be healthy and empowered to take control of their well-being. We aim to reduce inequities in health outcomes as quickly as practicable and we recognise that they often arise out of issues that originate outside the health system. Prevention programmes include the use of legislation, policy, education and community action to increase the adoption of healthy practices amongst the population and to overcome environmental barriers to good health.

How will we assess performance?

Short Term Outcome	Indicator	MoH Measure	Baseline					2016/17 Target
			Period	Māori	Pacific	Other	Total	
Better help for smokers to quit	% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	PP31	Oct-Dec 2016	99.2%	100%	98.7%	99.0%	≥95%
	% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	HT	Oct-Dec 2016	85.1%	82.2%	89.8%	87.4%	≥90%
	% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking	HT	Oct-Dec 2016	78.8%	N/A	N/A	88.5%	≥90%
	% of pregnant Māori women that are smokefree at 2 weeks postnatal	SI5	Jul-Dec 2015	65.6%	93.5%	92.1%	80.0%	≥95%
Increase Immunisation coverage in Children	% of 8 month olds who complete their primary course of Immunisations	HT	Oct-Dec 2016	94.4%	100%	95.9%	95.3%	≥95%

Short Term Outcome	Indicator	MoH Measure	Baseline					2016/17 Target
			Period	Māori	Pacific	Other	Total	
	% of 2 year olds fully immunised	PP21	Oct-Dec 2016	95.4%	100%	93.6%	94.7%	≥95%
	% of 4 year olds fully immunised by age 5	PP21	Oct-Dec 2016	95.8%	91.2%	91.8%	93.5%	≥95%
Increase HPV immunisation rates	% of girls that have received HPV dose three	PP21	Jun 2016	87.8%	73.3%	54.9%	68.4%	≥75%
Increase the rate of seasonal influenza immunisations in over 65 year olds	% of high needs 65 years olds and over influenza immunisation rate	PP21						≥75%
Reduced incidence of first episode Rheumatic Fever	Acute rheumatic fever initial hospitalisation rate per 100,000	PP28H						TBC
More women are screened for cancer	% of women aged 50-69 years receiving breast screening in the last 2 years	SI11	2 Years to Sep 2016	64.7%	65.4%	75.0%	73.6%	≥70%
	% of women aged 25–69 years who have had a cervical screening event in the past 36 months	SI10	3 Years to Sep 2016	72.8%	74.8%	78.9%	76.7%	≥80%
Reduce the rate of Sudden Unexplained Death of Infants (SUDI)	Rate of SUDI deaths per 1,000 live births	PP35						TBC
	% of caregivers of Māori infants are provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1 (REMOVE?)							100%
Better rates of breastfeeding	% of infants that are exclusively or fully breastfed at 6 weeks of age (REMOVE?)		6 months to Dec 2015	66%	82%	N/A	72%	75%
	% of infants that are exclusively or fully breastfed at 3 months of age	PP37	6 months to Jun 2016	39%	46%	N/A	51%	60%
	% of infants that are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed) (REMOVE?)		6 months to Jun 2016	50%	67%	N/A	61%	65%

10.1

1.3 OUTPUT CLASS 2: Early Detection and Management Services

Early Detection and Management services are delivered by a range of health and allied health professionals in various private, not-for-profit and Government service settings to individuals and small groups of individuals. The Output Class includes primary health care, primary and community care programmes, child and adolescent oral health and dental services, pharmacist services, and community referred tests and diagnostic services. The services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the district.

On the continuum of care these services are mostly concerned with the "at risk" population and those with health and disability conditions at all stages.

Objective: People's health issues and risks are detected early and treated to maximise well-being

For people who are at risk of illness and or injury, we will undertake activities that raise awareness and recognition of risky behaviours and practices and improve the opportunity of early detection of health conditions. If people are assisted to identify risk early, and those at risk are screened to detect health conditions early, then behavioural changes and treatment interventions are often easier with less complications and greater chances of returning to a state of good health or of slowing the progression of the disease, injury or illness. Targeting environmental barriers to good health and connecting people with health services earlier is the intention because early detection of health issues or risks leads to better opportunities to influence long-term outcomes.

How will we assess performance?

Short Term Outcome	Indicator	MoH Measure	Baseline					2016/17 Target
			Period	Māori	Pacific	Other	Total	
Improved access primary care	% of the population enrolled in the PHO	PP33	Oct-16	96.8%	89.9%	97.5%	97.1%	90%
Avoidable hospitalisation is reduced	Ambulatory sensitive hospitalisation rate per 100,000 0-4 years	SI1 / SI5 / PP22(SLM)	12m to Sep-16	5,755		4,469	5,272	TBC[3]
	Ambulatory sensitive hospitalisation rate per 100,000 45-64 years	SI1		7,801		3,167	4,063	TBC
More pregnant women under the care of a Lead Maternity Carer (LMC)	% of women booked with an LMC by week 12 of their pregnancy (REMOVE?)		Jul to Sep 2016	49.2%	54.5%	75.9%	65.7%	≥80%
Hospital service users are reconnected with primary care	Rate of high intensive users of hospital ED as a proportion of Total ED visits (CHECK ALIGNS WITH WORK PROGRAMME)		12m to Dec-16	5.93%	6.42%	4.67%	5.17%	≤5.4%
Better oral health	% of eligible pre-school enrolments in DHB-funded oral health services	PP13						≥95%
	% of children who are carries free at 5 years of age	PP11 / SI5						≥69%

[3] *This target will be set as part of the System Level Measures process*

Short Term Outcome	Indicator	MoH Measure	Baseline					2016/17 Target
			Period	Māori	Pacific	Other	Total	
	% of enrolled preschool and primary school children not examined according to planned recall	PP13						≤4.7%
	% of adolescents using DHB-funded dental services	PP12						≥87%
	Mean 'decayed, missing or filled teeth (DMFT)' score at Year 8	PP10						≤0.88
Improved management of long-term conditions	Proportion of people with diabetes who have good or acceptable glycaemic control	PP20	12m to Dec-16	46.2%	39.3%	79.2%	65.4%	TBC
	% of the eligible population having had a CVD risk assessment in the last 5 years	PP20	5y to Dec-16	84.5%	84.0%	88.9%	87.8%	≥90%
Less waiting for diagnostic services	% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days	PP29	Dec-16				95.1%	≥95%
	% of accepted referrals for MRI scans who receive their scans within 6 weeks	PP29	Dec-16				48.0%	≥85%
More pre-schoolers receive Before School Checks	% of 4-year olds that receive a B4 School Check (REMOVE?)		12m to Jum-16	101%	101%	113%	107%	≥90%
Increase refferals of obese children to clinical assessment and family based nutrition, activity and lifestyle interventions	% 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.	HT / SI5	6m to Nov-16	44%	43%	31%	40%	≥95%

1.4 OUTPUT CLASS 3: Intensive Assessment and Treatment Services

Intensive Assessment and Treatment Services are delivered by a range of secondary, tertiary and quaternary providers to individuals. This Output Class includes: Mental Health services; Elective and Acute services (including outpatients, inpatients, surgical and medical services); Maternity services; and, Assessment, Treatment and Rehabilitation (AT&R) services. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment, such as a 'hospital', and they are generally complex in nature and provided by specialists and other health care professionals who work closely together. There are also important links with community-based services before people come into hospital services and after they are discharged – these links must be well coordinated and work as seamlessly as possible.

HBDHB provides most of this Output Class through the Provider Arm, Health Services. However, some more specialised hospital services are funded by HBDHB to be provided by other DHBs, private hospitals, or other providers. Where this happens, other providers are monitored in terms of the Operational Policy Framework or specific contracts and in accordance with industry standards. On the continuum of care these services are at the complex end of "conditions" and are focussed on individuals with health conditions and prioritised to those identified as most in need.

Objective: Complications of health conditions are minimised and illness progression is slowed down

People who are suffering from injury or illness will be diagnosed accurately and offered the most effective treatment available as early as possible. We will coordinate activities that support people to reduce the complications of disease, injury and illness progression so that they have better health, in terms of survival, and are also able to participate effectively in society and be more independent. It is important that identified disparities are also reduced as quickly as practicable

How will we assess performance?

Short Term Outcome	Indicator	MoH Measure	Baseline					2016/17 Target
			Period	Māori	Pacific	Other	Total	
Less waiting for ED treatment	% of patients admitted, discharged or transferred from an ED within 6 hours	HT	Oct-Dec 2016	94.7%	95.7%	96.5%	94.7%	≥95%
Faster cancer treatment	% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks from Q1 2016/17	HT	6m to Dec-16				65.4%	≥90%
More elective surgery	Number of elective surgery discharges[4]	HT	12m to Jun-16	N/A	N/A	N/A	7,469	TBC
	% of high-risk patients will receiving an angiogram within 3 days of admission.	PP20	Oct to Dec-16	61.1%	100%	75.3%	73.1%	≥70%

[4] Health Target Elective Discharges is a number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB district.

Short Term Outcome	Indicator	MoH Measure	Baseline					2016/17 Target
			Period	Māori	Pacific	Other	Total	
Patients with ACS receive seamless, coordinated care across the clinical pathway	% of angiography patients whose data is recorded on national databases	PP20	Oct to Dec-16	95.0%	66.7%	96.8%	95.5%	≥95%
Equitable access to care for stroke patients	% of potentially eligible stroke patients who are thrombolysed	PP20	Oct to Dec 16				10.2%	≥8%
	% of patients admitted to the demonstrated stroke pathway	PP20	Oct to Dec 16				88.1%	≥80%
	% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	PP20	Oct to Dec 16					≥80%
Equitable access to surgery - Standardised intervention rates for surgery per 10,000 population for:	Major joint replacement	SI4	12m to Sep-16	N/A	N/A	N/A	21.5	TBC
	Cataract procedures			N/A	N/A	N/A	58.7	TBC
	Cardiac surgery			N/A	N/A	N/A	6.6	TBC
	Percutaneous revascularisation			N/A	N/A	N/A	13.1	TBC
	Coronary angiography			N/A	N/A	N/A	39.0	TBC
Shorter stays in hospital	Average length of stay Elective (days)	OS3	12m to Sep-16	N/A	N/A	N/A	1.56	TBC
	Average length of stay Acute (days)	OS3	12m to Sep-16	N/A	N/A	N/A	2.48	TBC
Fewer readmissions	Acute readmissions to hospital	OS8						TBC
Quicker access to diagnostics	% accepted referrals for elective coronary angiography completed within 90 days	PP29						TBC
	% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks	PP29	Dec-16	100%	N/A	90.9%	91.7%	TBC
	% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)	PP29	Dec-16	100%	100%	92.7%	93.9%	TBC
	70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date	PP29	Dec-16	100%	-	97.6%	98.1%	TBC

Short Term Outcome	Indicator		MoH Measure	Baseline					2016/17 Target
				Period	Māori	Pacific	Other	Total	
Fewer missed outpatient appointments	Did not attend (DNA) rate across first specialist assessments			Oct-Dec 2016	14.2%	22.1%	3.8%	6.7%	≤7.5%
Better mental health services Improving access Better access to mental health and addiction services	Proportion of the) population seen by mental health and addiction services	Child & youth (0-19	PP6	Oct 2015 – Sep 2016	4.92%	2.14%	3.79%	4.26%	TBC
		Adult (20-64)	PP6		9.26%	2.14%	3.83%	5.11%	TBC
		Older adult (65+)	PP6		1.19%	1.00%	1.11%	1.12%	TBC
Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	% of 0-19 year olds seen within 3 weeks of referral	Mental Health Provider Arm	PP8	Oct 2015 – Sep 2016	74.1%	68.4%	71.1%	72.3%	≥80%
		Addictions (Provider Arm and NGO)	PP8		80.5%	-	83.9%	81.1%	≥80%
	% of 0-19 year olds seen within 8 weeks of referral	Mental Health Provider Arm	PP8		93.6%	94.7%	90.0%	91.7%	≥95%
		Addictions (Provider Arm and NGO)	PP8		93.6%	-	96.8%	94.6%	≥95%
Improving mental health services using discharge planning	% children and youth with a transition (discharge) or wellness plan		PP7	Jan-Dec 2016				92.5%	≥95%
Increasing consumer focus More equitable use of Mental Health Act: Section 29 community treatment orders	Rate of s29 orders per 100,000 population		PP36 / SI5	Oct-Dec 2016	179.9	-	62.1	90.1	≤81.5

1.5 OUTPUT CLASS 4: Rehabilitation and Support Services

This output class includes: Needs Assessment and Service Coordination (NASC); palliative care; rehabilitation; home-based support; aged residential care; respite care and day care for adults. Many of these services are delivered following a 'needs assessment' process and involve coordination of input from a range of providers. Rehabilitation and Support services assist people with enduring conditions and disabilities to live independently or to receive the support that they need either temporarily or over the rest of their lives. HBDHB provides NASC services through Options Hawke's Bay - a unit that reports to our General Manager, Integrated Care Services. Other services are provided by our Provider Arm, General Practice and a number of community-based NGOs and private organisations. On the continuum of care these services provide support for individuals who have complex, complicated or end-stage conditions.

Objective: People maintain maximum functional independence and have choices throughout life.

Where returning to full health is not possible we will work with our stakeholders to support and care for people so that they are able to maintain maximum function with the least restriction and the most independence. For people in our population who have end-stage conditions, it is important that they and their family or whānau are supported to cope with the situation, so that the person is able to live comfortably and to die without undue pain or suffering.

How will we assess performance?

OUTPUT CLASS 4 TO BE REVIEWED ONCE HEALTHY AGING PRIORITY GUIDANCE IS RECEIVED FROM MOH

Short Term Outcome	Indicator		MoH Measure	Baseline					2016/17 Target
				Period	Māori	Pacific	Other	Total	
Better access to acute care for older people	Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population)	75-79 years		Jan 2016 – Dec 2016	164.3	175.0	111.2	124.0	≤139.5
		80-84 years			208.3	300.0	167.0	167.8	≤183.1
		85+ years			136.4	0	237.7	216.6	≤231.0
Better community support for older people	Acute readmission rate: 75 years +								<10%
	% of people receiving home support who have a comprehensive clinical assessment and a completed care plan		PP23						≥95%
	Percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of the previous assessment.		PP23						77%
	The percentage of LTCF clients admitted to an Aged Residential Care (ARC) facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first long term care facility (LTCF) assessment.		PP23						improve on current performance

Increased capacity and efficiency in needs assessment and service coordination services	Clients with a CHESS score (Change in Health, End-stage disease, signs and symptoms) of 4 or 5 at first assessment							<13.8%
Prompt response to palliative care referrals	Time from referral receipt to initial Cranford Hospice contact within 48 hours		Oct-Dec 2016	N/A	N/A	N/A	100%	>80%
More day services	Number of day services							≥21,791
More older patients receive falls risk assessment and care plan	% of older patients given a falls risk assessment % of older patients assessed as at risk of falling receive an individualised care plan		Oct-Dec 2016	N/A	N/A	N/A	96.7% 98.0%	90% 98%

2 Financial Performance

In accordance with the Crown Entities Act 2004, this module contains projected financial statements prepared in accordance with generally accepted accounting practice, and for each reportable class of outputs identifies the expected revenue and proposed expenses. The module also includes all significant assumptions underlying the projected financial statements, and additional information and explanations to fairly reflect the projected financial performance and financial position of the DHB. Summary financial performance statements for funding services, providing services, and governance and funding administration are also included in this module.

Performance against the 2017/18 financial year projections will be reported in the 2017/18 Annual Report.

2.1 PROJECTED FINANCIAL STATEMENTS

Introduction

Hawke's Bay District Health Board is planning to deliver a surplus of $2 million this year. This is consistent with the $9 million over the three years ending 30 June 19 agreed with MOH in 2016/17. It enables the DHB to fund a proportionate capital programme, including in the plan period the completion of an endoscopy facility, radiology equipment upgrade and surgical expansion, all associated with service redesign.

The financial numbers are also consistent with the DHB's "Transform and Sustain" strategy. Resource deployment and assumed efficiencies are focussed on our three strategic challenges: responding to our population and patients; systematically ensuring quality in all of our services; and increasing our productivity.

Projected Financial Statements

Reporting entity

The financial statements of the District Health Board comprise the District Health Board, its 19% interest in Allied Laundry Services Limited, and its 16.7% interest in Central Region's Technical Advisory Services Limited. The District Health Board has no subsidiaries.

Cautionary Note

The prospective financial information presented in this section is based on one or more hypothetical but realistic assumptions that reflect possible courses of action for the reported periods concerned, as at the date the information was prepared. Actual results achieved for the period covered are likely to vary from the information presented, and the variations may be material.

The underlying assumptions were adopted on 25 May 2016.

Accounting Policies

The projected financial statements in this plan have been prepared in accordance with the Crown Entities Act 2004, which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP). They projected financial statements have been prepared in accordance with tier 1 Public Benefit Entity Standards (PBE) accounting standards.

The accounting policies applied in the projected financial statements are consistent with those used in the 2015/16 Annual Report. The report is available on the DHB's website at www.hawkesbay.health.nz.

10.1

Projected Statement of Revenue and Expense

in thousands of New Zealand Dollars

For the year ended 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Ministry of Health - devolved funding	454,822	484,024	504,227	509,208	518,463	527,744
Ministry of Health - non devolved contracts	14,180	4,039	3,732	3,805	3,886	3,969
Other District Health Boards	11,821	11,598	11,549	11,774	12,024	12,283
Other government and Crown agency sourced	6,421	5,680	6,394	6,519	6,658	6,801
Patient and consumer sourced	1,484	1,211	1,377	1,403	1,433	1,464
Other	7,691	5,964	4,920	4,113	4,201	4,291
Operating revenue	496,420	512,517	532,199	536,822	546,665	556,552
Employee benefit costs	179,099	188,050	199,028	203,507	209,309	216,375
Outsourced services	13,233	12,812	12,248	12,488	12,754	13,029
Clinical supplies	45,967	39,758	34,619	32,523	31,184	27,241
Infrastructure and non clinical supplies	44,937	44,110	50,042	51,016	52,101	53,224
Payments to non-health board providers	210,131	223,798	231,261	235,288	239,317	243,683
Operating expenditure	493,366	508,527	527,199	534,822	544,665	553,552
Surplus for the period	3,054	3,990	5,000	2,000	2,000	3,000
Revaluation of land and buildings	37,444	(1,795)	-	-	-	-
Other comprehensive revenue and expense	37,444	(1,795)	-	-	-	-
Total comprehensive revenue and expense	**40,498**	**2,195**	**5,000**	**2,000**	**2,000**	**3,000**

Table 1 – Projected Statement of Comprehensive Revenue and Expense TO BE UPDATED

Projected Statement of Movements in Equity

in thousands of New Zealand Dollars

For the year ended 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Equity as at 1 July	**49,140**	**87,626**	**89,465**	**94,108**	**95,750**	**97,393**
Total comprehensive revenue and expense:						
Funding of health and disability services	7,481	5,186	5,000	2,000	2,000	3,000
Governance and funding administration	148	478	0	-	-	-
Provision of health services	(4,575)	(1,675)	(0)	-	-	-
Gain on disposal of assets held for sale	-	-	-	-	-	-
Revaluation of land and buildings	37,444	(1,795)	-	-	-	-
	40,498	2,195	5,000	2,000	2,000	3,000
Contributions from the Crown (equity injections)	-	-	-	-	-	-
Repayments to the Crown (equity repayments)	(357)	(356)	(358)	(357)	(357)	(357)
Transfer of the Chatham Is. to Canterbury DHB	(1,655)	-	-	-	-	-
Equity as at 30 June	**87,626**	**89,465**	**94,107**	**95,750**	**97,393**	**100,036**

Table 2 - Projected Statement of Movements in Equity TO BE UPDATED

10.1

Projected Statement of Financial Position

in thousands of New Zealand Dollars

As at 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Equity						
Paid in equity	35,573	35,216	34,859	34,502	34,145	33,788
Asset revaluation reserve	69,187	67,392	67,392	67,392	67,392	67,392
Asset replacement reserve	15,253	-	-	-	-	-
Trust and special funds (no restricted use)	3,125	3,125	3,125	3,125	3,125	3,125
Accumulated deficit	(35,511)	(16,268)	(11,269)	(9,269)	(7,269)	(4,269)
	87,626	**89,465**	**94,107**	**95,750**	**97,393**	**100,036**
Represented by:						
Current assets						
Cash	9	7	7	7	7	7
Short term investments	13,538	3,146	7,661	2,259	1,926	1,832
Short term investments (special funds/clinical trials)	3,124	3,095	3,095	3,095	3,095	3,095
Receivables and prepayments	17,855	18,225	18,607	18,969	19,371	19,788
Loans (Hawke's Bay Helicopter Rescue Trust)	10	11	11	12	13	13
Inventories	3,881	3,961	4,044	4,123	4,211	4,301
Assets classified as held for sale	1,220	1,220	-	-	-	-
	39,637	29,665	33,425	28,465	28,622	29,036
Non current assets						
Property, plant and equipment	148,303	157,877	166,028	173,575	174,177	176,699
Intangible assets	2,298	1,213	665	58	(620)	(1,325)
Investment property	131	131	131	131	131	131
Investment in NZ Health Partnerships Limited	2,504	2,504	2,504	2,504	2,504	2,504
Investment in associates	4,742	5,804	6,943	8,082	8,481	8,481
Loans (Hawke's Bay Helicopter Rescue Trust)	55	42	29	15	-	-
	158,033	167,572	176,299	184,365	184,673	186,490
Total assets	**197,670**	**197,237**	**209,724**	**212,829**	**213,295**	**215,525**
Less:						
Current liabilities						
Payables and accruals	29,953	30,582	31,194	31,826	29,573	27,511
Employee entitlements	35,248	32,317	34,485	35,260	36,265	37,859
Loans and borrowings	-	-	6,000	11,500	-	10,000
	65,201	62,900	71,679	78,586	65,838	75,370
Non current liabilities						
Employee entitlements	2,342	2,372	2,438	2,493	2,564	2,619
Loans and borrowings	42,500	42,500	41,500	36,000	47,500	37,500
	44,842	44,872	43,938	38,493	50,064	40,119
Total liabilities	**110,044**	**107,772**	**115,617**	**117,079**	**115,902**	**115,489**
Net assets	**87,626**	**89,465**	**94,108**	**95,750**	**97,393**	**100,036**

Table 3 - Projected Statements of Financial Position TO BE UPDATED

Projected Statement of Cash Flows

in thousands of New Zealand Dollars

For the year ended 30 June

	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Cash flow from operating activities						
Cash receipts from MOH, Crown agencies & patients	494,548	518,808	531,229	537,058	547,169	557,331
Cash paid to suppliers and service providers	(299,064)	(314,352)	(303,309)	(307,582)	(312,624)	(313,221)
Cash paid to employees	(176,194)	(186,766)	(198,449)	(202,914)	(208,698)	(215,741)
Cash generated from operations	**19,289**	**17,690**	**29,471**	**26,562**	**25,847**	**28,369**
Interest received	1,628	1,360	885	-	-	-
Interest paid	(2,419)	(2,236)	(2,476)	(2,562)	(2,397)	(2,476)
Capital charge paid	(3,740)	(3,971)	(7,186)	(7,326)	(7,482)	(7,642)
Cash flow from investing activities	14,757	12,844	20,694	16,674	15,969	18,251
Proceeds from sale of property, plant and equipment	2,236	1,263	1,220	-	-	-
Acquisition of property, plant and equipment	(15,608)	(23,117)	(22,042)	(21,719)	(15,945)	(17,988)
Acquisition of intangible assets	(921)	(1,094)	-	-	-	-
Acquisition of investments	(1,752)	-	-	-	-	-
Cash flow from financing activities	(16,045)	(22,949)	(20,822)	(21,719)	(15,945)	(17,988)
Proceeds from borrowings	-	-	5,000	-	-	-
Proceeds from equity injections	(1,655)	-	-	-	-	-
Repayment of borrowings	-	-	-	-	-	-
Repayment of finance lease liabilities	(268)	-	-	-	-	-
Equity repayment to the Crown	(357)	(357)	(357)	(357)	(357)	(357)
	(2,280)	(357)	4,643	(357)	(357)	(357)
Net increase/(decrease) in cash and cash equivalents	(3,567)	(10,462)	4,515	(5,402)	(333)	(94)
Cash and cash equivalents at beginning of year	18,536	14,969	4,507	9,022	3,620	3,286
Cash and cash equivalents at end of year	14,969	4,507	9,022	3,620	3,286	3,192
Represented by:						
Cash	9	7	7	7	7	7
Short term investments	14,960	4,500	9,015	3,612	3,279	3,185
	14,969	4,507	9,022	3,619	3,286	3,192

Table 4 - Projected Statement of Cash Flows TO BE UPDATED

10.1

Projected Funder Arm Operating Results

in thousands of New Zealand Dollars

For the year ended 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Revenue						
Ministry of Health - devolved funding	454,822	484,024	504,227	509,208	518,463	527,744
Inter district patient inflows	7,696	7,486	7,545	7,692	7,855	8,024
Other revenue	202	151	30	31	32	33
	462,719	**491,662**	**511,803**	**516,931**	**526,350**	**535,801**
Expenditure						
Governance and funding administration	2,781	3,140	3,220	3,283	3,353	3,425
Own DHB provided services						
Personal health	207,692	214,874	229,142	232,338	236,721	239,766
Mental health	24,366	25,005	24,259	24,732	25,258	25,801
Disability support	9,169	14,701	13,796	14,066	14,367	14,675
Public health	520	4,357	4,523	4,611	4,708	4,811
Maori health	579	601	601	613	626	640
	242,326	259,538	272,321	276,360	281,680	285,693
Other DHB provided services (Inter district outflows)						
Personal health	45,156	46,843	45,317	46,201	47,183	48,197
Mental health	2,342	2,391	2,410	2,457	2,509	2,563
Disability support	3,210	3,000	3,232	3,295	3,365	3,437
Public health	-	-	-	-	-	-
Maori health	-	-	-	-	-	-
	50,709	52,234	50,959	51,953	53,057	54,197
Other provider services						
Personal health	87,818	99,483	104,187	105,735	107,014	108,539
Mental health	10,888	11,088	11,164	11,383	11,624	11,874
Disability support	56,101	56,071	59,392	60,549	61,833	63,161
Public health	1,248	1,185	1,578	1,608	1,643	1,677
Maori health	3,368	3,737	3,982	4,060	4,146	4,235
	159,422	171,564	180,302	183,335	186,260	189,486
Total Expenditure	**455,238**	**486,476**	**506,803**	**514,931**	**524,350**	**532,801**
Net Result	**7,481**	**5,186**	**5,000**	**2,000**	**2,000**	**3,000**

Table 5 - Projected Funder Arm Operating Results TO BE UPDATED

Projected Governance and Funding Administration Operating Results

in thousands of New Zealand Dollars

For the year ended 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Revenue						
Funding	2,781	3,140	3,220	3,283	3,353	3,425
Other government and Crown agency sourced	-	-	-	-	-	-
Other revenue	23	39	30	31	32	33
	2,804	3,179	3,250	3,314	3,385	3,458
Expenditure						
Employee benefit costs	677	729	954	975	1,003	1,038
Outsourced services	414	457	472	481	491	501
Clinical supplies	0	1	1	1	1	1
Infrastructure and non clinical supplies	632	580	878	895	914	933
	1,723	1,767	2,305	2,352	2,409	2,473
Plus: allocated from Provider Arm	933	933	945	962	976	985
Net Result	**148**	**478**	**0**	**-**	**-**	**-**

Table 6 - Projected Governance and Funding Administration Operating Results TO BE UPDATED

10.1

Projected Provider Arm Operating Results

in thousands of New Zealand Dollars

For the year ended 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Revenue						
Funding	242,326	259,538	272,241	276,278	281,596	285,607
Ministry of Health - non devolved contracts	14,180	4,039	3,732	3,805	3,886	3,969
Other District Health Boards	4,126	4,112	4,004	4,082	4,169	4,259
Accident Insurance	5,931	5,291	5,980	6,097	6,227	6,361
Other government and Crown agency sourced	490	389	414	422	431	440
Patient and consumer sourced	1,484	1,211	1,377	1,403	1,433	1,464
Other revenue	7,466	5,774	4,859	4,051	4,137	4,225
	276,004	280,355	292,608	296,138	301,879	306,325
Expenditure						
Employee benefit costs	178,422	187,320	198,075	202,532	208,306	215,337
Outsourced services	12,818	12,355	11,696	11,925	12,179	12,442
Clinical Supplies	45,966	39,757	34,618	32,522	31,183	27,240
Infrastructure and non clinical supplies	44,305	43,530	49,163	50,121	51,187	52,291
	281,512	282,963	293,553	297,100	302,855	307,310
Less: allocated to Governance & Funding Admin	933	933	945	962	976	985
Surplus for the period	**(4,575)**	**(1,675)**	**(0)**	**-**	**-**	**-**
Revaluation of land and buildings	(37,444)	1,795	-	-	-	-
Net Result	**32,869**	**(3,470)**	**(0)**	**-**	**-**	**-**

Table 7 – Projected Provider Arm Operating Results – TO BE UPDATED

2.2 Significant Assumptions

General

- Revenue and expenditure has been budgeted on current Government policy settings and known health service initiatives.
- No allowance has been made for any new regulatory or legislative changes which increase compliance costs.
- No allowance has been made for the costs of unusual emergency events e.g. pandemic or earthquake.
- Allowance has been made for the implementation costs of and net savings from regional and national entity initiatives as advised by the Ministry of Health.
- No allowance has been made for any additional capital or operating costs that may be required by the National Oracle Solution (NOS) shared financial platform solution managed by New Zealand Health Partnerships Limited (NZHPL).
- Allowance has been made for net additional costs arising from the Regional Health Information Project (RHIP) of $1.1 million in each of 2016/17 and 2017/18, and $0.4 million in 2018/19.
- The full year impact of ongoing transformation expenditure has required a $10.8 million efficiency programme for the 2016/17 year. Nominal increases in funding (excluding revenue banking), and inflationary increases in expenditure will require further savings of $2.7 million, $2.0 million and $4.6 million in 2017/18, 2018/19, and 2019/20 respectively. No allowance has been made for a new investment programme in the plan, however such programmes are likely and will require increases in the savings targets. Detailed plans for the new investment and efficiency programmes have yet to be defined, and the impact of the two programmes on financial performance have been recognised in clinical supplies.
- Unless otherwise stated, increases in revenue and expenditure due to changes in price levels have been allowed for at 2.1%, 2.0% and 2.1% for 2018/19, 2019/20 and 2020/21 respectively based on Treasury forecasts for CPI inflation in the Half Year Economic and Fiscal Update 2016 published 8 December 2016).

Revenue

- Crown funding under the national population based funding formula, including adjustments, will be $472.2 million for 2017/18. Funding for the 2018/19, 2019/20 and 2020/21 years will include nominal increases of $8.5 million per annum.
- Crown funding for non-devolved services of $35.8 million is based on agreements already in place with the appropriate Ministry of Health directorates, and assumes receipt of the DHB's full entitlement to elective services funding.
- Inter district flows revenue is in accordance with Ministry of Health advice.
- Other income has been budgeted at the District Health Board's best estimates of likely income.

Personnel Costs and Outsourced Services

- Workforce costs for 2017/18 have been budgeted at actual known costs, including step increases where appropriate. Increases to Multi Employer Collective Agreements have been budgeted in accordance with settlements, or where no settlement has occurred, at the District Health Board's best estimate of the likely increase. Personnel cost increases have been allowed for at 2.8%, 3.1% and 3.0% for 2018/19, 2019/20 and 2020/21 respectively based on Treasury forecasts for wage inflation in the Half Year Economic and Fiscal Update 2016 published 8 December 2016).
- Establishment numbers for management and administration staff have been capped by the Minister of Health at 417 FTEs, the same as 2016/17. The District Health Board is managing internally to a cap of 400 FTEs.

Supplies and Infrastructural Costs

- The cost of goods and services has been budgeted the District Health Board's best estimates of likely cost.
- No allowance has been made for cost increases/decreases relating to fluctuations in the value of the New Zealand Dollar.

Services Provided by Other DHB's

- Inter district flows expenditure is in accordance with MoH advice.

Other Provider Payments

- Other provider payments have been budgeted at the District Health Board's best estimate of likely costs

Capital Servicing

- Depreciation has been calculated to write off the cost or fair value of property, plant, and equipment assets, and amortisation has been calculated to write off the cost or fair value of intangible assets (software) less their estimated residual values, over their useful lives. The investment in NZHPL gives the DHB a right to use the systems they provide, so they are considered to have indefinite lives, and consequently no amortisation has been allowed for.
- Borrowings from MOH to all DHBs converted to equity on 15 February 2017. No costs related to borrowings have been recognised for Hawke's Bay DHB after 2016/17.
- The capital charge rate has been allowed for at 6% from 2017/18. The decrease in capital charge is offset by a compensating reduction in revenue from the Crown.

Investment

- The purchase of class B shares in New Zealand Health Partnerships Limited (NZHPL), relating to the Finance, Procurement and Supply Chain shared service, was completed in 2014/15 and took the total investment to $2,504,071. No allowance has been made for any further investment. No allowance has been made for any impairment of the asset over the time horizon of the plan.
- The District Health Board's share of the assets in RHIP will be amortised over their useful lives. The cost of amortisation is included in infrastructural costs. No allowance has been made for any impairment of the asset before 2021/22.
- No collaborative regional or sub-regional initiatives have been included other than RHIP.
- No increase in funding for existing associate organisations, Allied Laundry Services Limited and Central Technical Advisory Services have been allowed for.
- Property, plant, equipment, intangible asset expenditure, and investments in other entities are in accordance with the table below :

Investment	2016/17 $'m	2017/18 $'m	2018/19 $'m	2019/20 $'m
Buildings and Plant	5,710	8,619	4,800	5,500
Clinical Equipment	9,407	6,040	4,500	3,900
Other Equipment	2,800	3,510	3,545	4,588
Information Technology	3,125	2,550	2,100	3,000
Capital Investment	**21,042**	**20,719**	**14,945**	**16,988**
New technologies/Investments	1,000	1,000	1,000	1,000
Investment in RHIP	1,139	1,139	0.399	-
Total Investment	**23,181**	**22,858**	**13,344**	**17,988**

Capital Investment Funding

- Capital investment will be funded from a number of sources including working capital in accordance with the following table:

10.1

Investment Funding	2016/17 $'m	2017/18 $'m	2018/19 $'m	2019/20 $'m
Total Investment	23,181	22,858	13,344	17,988
Funded by:				
Depreciation and amortisation	14,440	14,779	16,021	16,433
Operating surplus	5,000	2,000	2,000	3,000
Cash holdings	3,741	6,079	(4,677)	(1,445)
Capital Investment Funding	**23,181**	**22,858**	**13,344**	**17,988**

Property, Plant and Equipment

- Hawke's Bay District Health Board is required to revalue land and buildings when the fair value differs materially from the carrying amount, and at least every five years. The last revaluation was at 30 June 2015, and the next is likely at 30 June 2018. The effect of a revaluation is unknown, and no adjustment has been made to asset values as a consequence.

Debt and Equity

- Borrowings from MOH to all DHBs converted to equity on 15 February 2017. No borrowings have been recognised for Hawke's Bay DHB after 2016/17.
- Equity movements will be in accordance with the table below.

Equity	2016/17 $'m	2017/18 $'m	2018/19 $'m	2019/20 $'m
Opening equity	89.5	94.1	95.8	97.4
Surplus	5.0	2.0	2.0	3.0
Equity repayments (FRS3)	(0.4)	(0.3)	(0.4)	(0.4)
Closing equity	**94.1**	**95.8**	**97.4**	**100.0**

Additional Information and Explanations:

Disposal of Land

- Disposal of land is subject to current legislative requirement and protection mechanisms. Hawke's Bay District Health Board is required to notify land declared surplus to previous owners for offer back prior to offering it to the Office of Treaty Settlements, and before any sale on the open market.

APPENDIX B: SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

Currently in Development

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Breastfeeding (National Indicator)**
	For the attention of: **Executive Management Team**
Document Owner: Document Author(s):	Chris McKenna, Chief Nursing Officer Nicky Skerman, Population Health Strategist Charrissa Keenan, Health Gains Advisor, Māori Health Tracy Ashworth, Maternal, Child and Youth Portfolio Advisor Jules Arthur, Midwifery Director
Reviewed by:	N/A
Month:	March 2017
Consideration:	For approval

RECOMMENDATION

That EMT:

1. Endorse the content of this report

OVERVIEW

Te Ara Whakawaiora (TAW) is an exception based report, drawn from AMHP 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 Chris McKenna, Champion for the Breastfeeding National 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
Breastfeeding *National Indicator*	Improve breastfeeding rates for children at 6 weeks, 3 months and 6 months:		Chris McKenna	Nicky Skerman	**MAR 2017** **16 Feb 2017** to Kathy
	1. % of infants that are exclusively or fully breastfed at 6 weeks of age;	>75%			
	2. % of infants that are exclusively or fully breastfed at 3 months of age;	>60%			
	3. % of infants that are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)	>65%			

MĀORI PLAN INDICATOR:

Full and exclusive breastfeeding of infants at 6 weeks (≥ 75%), 3 months (≥ 60%) and full, exclusive and partial at 6 months (≥ 65%).

WHY IS THIS INDICATOR IMPORTANT?

The HBDHB is committed to non-differential targets to demonstrate and compare progress across populations groups. This indicator is important because it shows the health systems performance in the early years of a child's life. The breastfeeding indicator is reported to the Ministry of Health through the District Annual Plan and Annual Māori Health Plan and is a key component in the HBDHB Maternal Child Youth Strategic Framework 2015-18.

The HBDHB acknowledges breastfeeding as a key priority for improved infant and maternal health outcomes. Breastfeeding provides the optimum nutrition from birth, and is a foundation for later health and well-being. Breastfeeding has a range of advantages for both mother and pēpi/baby. These benefits include; health, nutrition, immunological, developmental, psychological, social and economic benefits. Research shows that children who are exclusively breastfed for around six months are less likely to suffer from childhood illnesses such as respiratory tract infections, gastroenteritis and otitis media as well as reducing the risk of SUDI and asthma. Breastfeeding is also linked to children maintaining healthy weight across their lifetime and reduced risk of obesity.

The HBDHB is an accredited Baby Friendly Hospital (BFHI) which means strategies to promote, protect and support breastfeeding are important to us. Improving breastfeeding rates in Hawke's Bay would significantly improve the health and well-being of our pēpi/babies now and into the future.

Despite the health benefits for both mother and child, breastfeeding rates in New Zealand remain low compared to those in the early 20th century. Breastfeeding research identifies that several common factors impact on a women's breastfeeding experience; the influence of a women's whānau; conflicting breastfeeding advice and insensitive cultural practices by health professionals; early breastfeeding issues, and negative community and societal responses to breastfeeding.

The Hawke's Bay Maternity Services Annual Report shows for the twelve-month period from 1 January to 31 December 2015, 1877 babies were born to 1858 mothers, of which 37.4% (695 women) were of Māori ethnicity. Of these mothers, 15% or 102 were young Māori mothers aged <20 years. The Hawke's Bay birthing population has a significantly higher proportion of Māori women compared to the national average.

BACKGROUND

There is no central place for monitoring progress in breastfeeding nationally. Currently, breastfeeding data is collected at discharge post-delivery at each DHB, and breastfeeding rates at two weeks are collected by Lead Maternity Carers and are reported directly to the Ministry of Health under Section 88. The Lead Maternity Carers data is only provided to DHBs bi-annually with at least a 12 month data delay. Well Child/Tamariki Ora (WC/TO) collection has improved to now include all providers for the 3 months and 6 months data sets but this also has a 6 month delay.

We acknowledge that we are struggling to meet the Ministry's targets for breastfeeding across both the age bands and ethnicities. We are especially disappointed that our efforts have not produced positive results to increase breastfeeding rates for Māori mothers. Clearly, our current systems and supports are not responding well enough to the needs of Māori mothers and their whānau.

The Māori Health Service and the Women, Child and Youth Portfolio are working closely to critically analyse our current efforts to address barriers that are impacting on breastfeeding uptake by Māori.

We also revisited literature about experiences and barriers to breastfeeding for Māori women and their whānau.[1]

These studies showed that mothers and whānau felt positively toward breastfeeding and generally expected to exclusively breastfeed, but main barriers that prevented whānau from achieving this goal included:

- lack of support when establishing breastfeeding, especially within the first 6 weeks
- lack of timely and culturally relevant advice
- comprehensible information

Based on these learnings, Māori Health have committed investment in a Community Breastfeeding Service. In response to this gain we need to investigate service redesign models within Hawkes Bay Maternity Services to work towards a more comprehensive and aligned Breastfeeding Support Service.

HAWKE'S BAY DISTRIBUTION AND TRENDS

Breastfeeding data as reported for the annual Māori Health Plan

The most recent data provided for the Māori Health Plan by the Ministry is shown below. As per the charts and tables, December 2015 breastfeeding rates for Māori at two weeks have remained the same compared to June 2015. The latest data set enables us to calculate the rate for 'Other' ethnicities (non-Māori and non-Pacific) for the first time and shows the breastfeeding rate for other ethnicities is 8.1% higher than Māori.

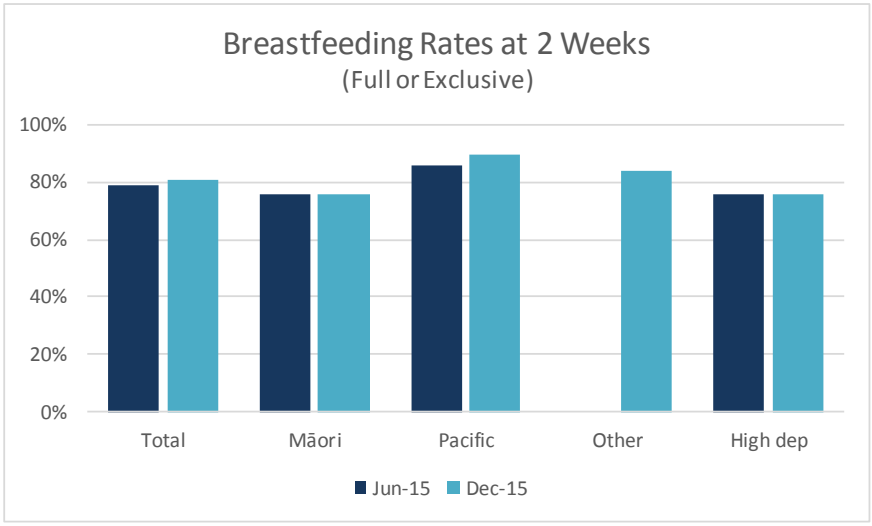
December 2015 breastfeeding rates for Māori at 6 weeks have remained at similar levels compared to June 2015. Māori are currently at 66% compared with an 'Other' ethnicities rate of 78% and a target of 75%.

There is currently no improvement in Māori breastfeeding at 3 months between December 2015 and June 2016. Data shows a clear drop off between 6 weeks and 3 months. Breastfeeding rates at 3 months currently sits at 39% for Māori, compared to a total rate of 51%, and significantly below the target of 60%. The data is not currently available to calculate the rate for 'Other' ethnicity for either 3 months or 6 months data.

These rates demonstrate a clear drop off between 6 weeks and 3 months.

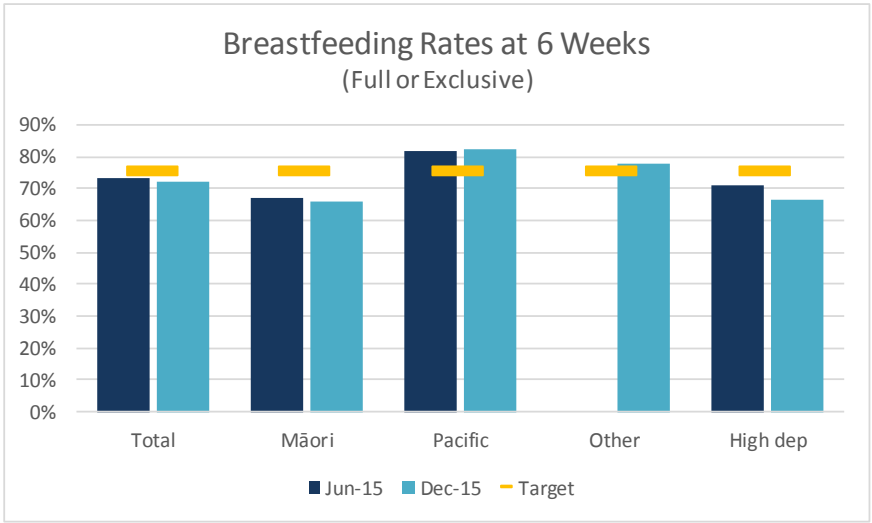
Breastfeeding at 6 months (which unlike 6 weeks and 3 months includes partial) has seen a slight increase from December 2015 to June 2016. Māori rates have increased by 2% and currently sit at a rate of 50% with the target being 65%. There has also been an increase for the total population of 3% and it now sits at 61%, 11% more than Māori.

[1] Manaena-Biddle, H; Waldon, J and Glover, M. Influences that affect Māori women breastfeeding [online]. Breastfeeding Review, Vol. 15, No. 2, 2007 Jul: 5-14. Availability: <http://search.informit.com.au/documentSummary;dn=439931119210257;res=IELHEA> ISSN: 0729-2759. [cited 14 Feb 17]



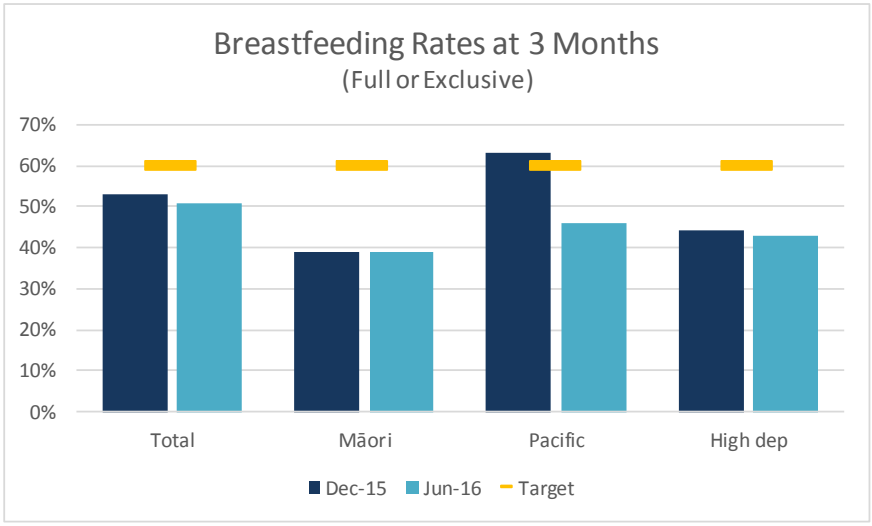
Breastfeeding at 2 Weeks

	Total	Māori	Pacific	Other	High dep
Jun-15	79%	76%	86%	-	76%
Dec-15	81%	76%	90%	84%	76%

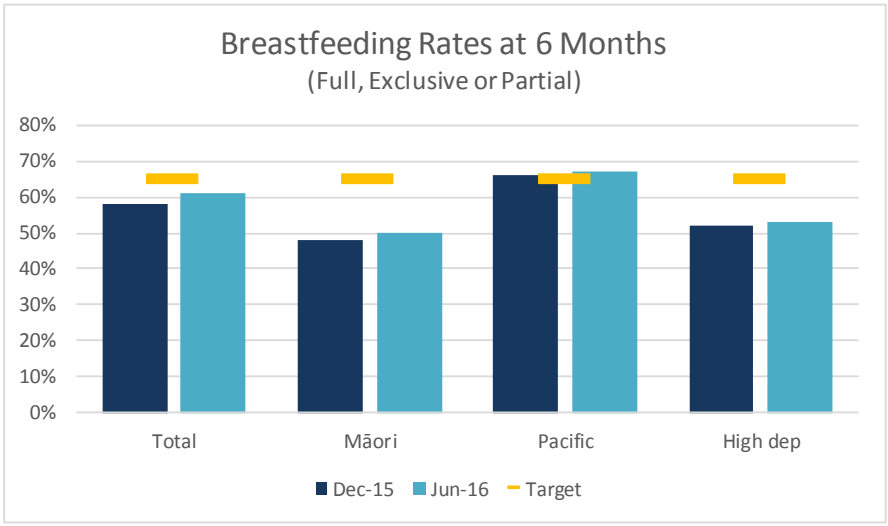


Breastfeeding at 6 weeks

	Total	Māori	Pacific	Other	High dep
Target	75%	75%	75%	75%	75%
Jun-15	73%	67%	82%	-	71%
Dec-15	72%	66%	82%	78%	67%



	Total	Māori	Pacific	High dep
Target	60%	60%	60%	60%
Dec-15	53%	39%	63%	44%
Jun-16	51%	39%	46%	43%



Breastfeeding at 6 months

	Total	Māori	Pacific	High dep
Target	65%	65%	65%	65%
Dec-15	58%	48%	66%	52%
Jun-16	61%	50%	67%	53%

REVIEW OF CURRENT AND PLANNED ACTIVITY RELEVANT TO SUPPORT THE INDICATORS

Breastfeeding Support Service

The Breastfeeding Support Service is comprised of two components; the antenatal to six weeks and the Community model from 6 weeks to 6 months of age. These two components are vital to ensure a holistic, seamless pathway of breastfeeding support for mothers and their whānau, and to maximise opportunities to support mothers who need help to establish breastfeeding. The community breastfeeding service is already in the process of being established and we anticipate the new service to be fully operational by 1 July 2017. The early breastfeeding component of the service is limited in funding and some suggestions as to models for improvement are detailed in this paper.

However it must be acknowledged that real commitment to improving breastfeeding rates would mean some new investment in the model of care for the hospital service to provide an outreach focused service from the antenatal period through to handover to WC/TO providers.

Further detail is provided below:

Antenatal to six weeks: Early Breastfeeding Service Component

It is proposed that the HBDHB investigate options regarding the current Hospital Breastfeeding Service to maximise the opportunity to provide breastfeeding support for mothers and their whānau from the antenatal period through to the first six weeks of life. The intention is to identify early issues with breastfeeding, to provide mothers and whānau in their home or community clinic with the additional support and help they need to breastfeed.

As with any change in Model of Care resource is needed to make improvements. A more comprehensive approach (based on other DHB models) originally proposed is not feasible in this current funding environment so alternative options have been discussed with the Children Woman and Community directorate and need to be considered.

1) An investigation undertaken looking at what breastfeeding support mothers and whānau receive from their LMC under section 88. This will look at what could be done differently to support new mothers and whānau regarding advice, information, and where required support to pregnant women during the ante-natal period as their main care providers.

2) We also propose a movement of funding to look at a peer support/kaiawhina role, and the ability to provide home visiting options. This option would increase capacity in client contact in the hospital beyond the Hospital Breastfeeding Advisor (LC). Currently a large proportion (60%) of the breastfeeding advisor role is dedicated to maintaining BFHI requirements. The focus on BFHI is essential for our DHB and our commitment to breastfeeding, however it does mean that there is less time and resource to focus on other areas that could give us greater traction to progress our breastfeeding activities. The potential to consider a peer support/kaiawhina role will enable us to triage support to mothers and whānau to establish breastfeeding post-birth, and to put in place a plan that is responsive to her needs for when she is discharged whilst allowing the LC resource to deal with the more technical clinical cases.

   This focused support will especially benefit those mothers who leave the maternity unit in the first 48 hours post-delivery. Hawke's Bay Maternity Services Annual Report, indicates the average stay in Maternity was 1.9 days in 2015, this is before breastfeeding is established. The drop off rate for breastfeeding is particularly significant for Māori on post-natal discharge, so this new approach has the potential to benefit these mothers, and intervene at a time when the decision to continue to breastfeed may be vulnerable. These initiative will not only compliment and provide alignment via relationships and referrals with the community service component but will strengthen continuity between hospital and community for mothers, and attempt to remove barriers to access to breastfeeding support.

3) The third option would be to increase the length of stay in Maternity Services to allow mothers milk to come in and connection with support staff to establish breastfeeding.

We need to ensure we provide aligned hospital/community service that responds to consumers and works in partnership with Lead Maternity Carers and WC/TO providers in order to optimise the health and well-being of our pēpi/babies now and into the future.

Six weeks to six months: Community Breastfeeding Service Component
Funding has been secured from the Māori Health Portfolio for a Community Breastfeeding Support Service. The aim of this initiative is to provide specialised community breastfeeding support to Māori mothers and their whānau, post-discharge from Lead Maternity Care (LMC) services to 6 months of age. This service involves a specialised lactation consultant who will be responsible for working closely with mothers and whānau who are experiencing difficulties in establishing and maintaining breastfeeding in the home. This service is not intended to be a universal service, or an expansion of existing initiatives, but is a direct investment in specialised breastfeeding help for our Māori mothers and their whānau.

A key expectation of this service is that the lactation consultant must have the capability, experience, and relationships to prioritise the needs and expectations of Māori and therefore, the ability to relate and work in a Māori cultural context. Importantly, there is a clear expectation that this service will work closely with smoking cessation and safe sleeping programmes to maximum the health gain. We also understand that our experiences with pēpi and waiū cannot be seen in isolation of hapūtanga and whānau mai, and so, exploring opportunities to engage with mothers and their Lead Maternity Carers will be a focus.

Other breastfeeding supports:

Hawke's Bay Breastfeeding Governance Group
The Breastfeeding Governance Group meets quarterly. Their role is to provide a collaborative approach to improving breastfeeding rates in Hawke's Bay. This is supported by the long standing Hawkes Bay Breastfeeding Group which meets bi-monthly contributing to the promotion of breastfeeding in the community, providing resourcing and updates to health professionals and ensuring that the World Health Organisation Breastfeeding Code is upheld and responding to breaches. The Breastfeeding Governance Group has representation from across the hospital and community sectors, and also includes Wairoa participation.

Lead Maternity Carers Involvement
A concerted effort has been made during the past year to engage Lead Maternity Carers/midwives in both governance and operational forums to ensure the messages we convey amongst this critical workforce. We currently have several Lead Maternity Carer representatives on both the Hawke's Bay Breastfeeding Group and Governance Group including Nga Maia o Aotearoa representation, the professional organisation representing Māori in the area of maternity services.

Lead Maternity Carers / WC/TO collaboration – Working Better Together
A recent review of the transfer of care from Lead Maternity Carers to WC/TO highlighted some recommendations with the aim of informing any service linkage improvements between Lead Maternity Carers WC/TO service providers and improve early engagement and enrolment into WC/TO services including antenatal referrals and support shared models of care, this would also enhance breastfeeding support.

A collaborative symposium is planned for May 2017 which Hawke's Bay WC/TO providers and Lead Maternity Carer representatives are jointly planning, specifically to support and workshop 'Working Better Together' and awareness of the services and integration particularly for vulnerable women and whānau during the first 1000 days of life.

Mama Aroha
Work is well underway to embed consistent, culturally appropriate breastfeeding messaging and practices across the health, social support workforce and the wider whānau and community in response to the main theme identified in a breastfeeding stakeholder workshop held in 2014 to ensure "consistent messaging around breastfeeding resources and advice". A take home parent reference card covering breastfeeding, SUDI and smokefree has been locally developed with a Māori midwife, and lactation consultant and developer of the Mama Aroha Breastfeeding talk cards. This resource is now available to every women and her whānau birthing in Hawke's Bay. Consistent messaging has reached across the central region with MidCentral DHB ordering 5000 copies and Whanganui looking to purchase.

Alongside this, a number of the Lead Maternity Carers/DHB midwifery and WC/TO workforce have attended Mama Aroha training and carry comprehensive sets of highly visual Talk and Troubleshooting breastfeeding cards to support mothers and whānau throughout their breastfeeding experience. A 2016 feedback survey indicated these are well used with 81% of respondents using them in their practice.

Well Child/Tamariki Ora (WC/TO)
WC/TO providers have been developing Plan, Do, Study, and Act (PDSA) cycles on Breastfeeding. As an example, Te Tai Whenua O Heretaunga (TToH), for their PDSA decided to follow up the talk cards use in their consults with mothers. Of the 43 visits made to mothers in the following two week period, the study found 32 mothers were breastfeeding and the cards were used 22 times. Of the 10 visits where the cards were not used, the individual health worker had established the mother had her breastfeeding technique well in control. "The mama aroha cards are now the main resource used to highlight the benefits of breastfeeding and these are well received by the ladies and whānau".

There are also loan schemes in place at Kahungunu Executive and Te Taiwhenua o Heretaunga funded by the HBDHB for breastfeeding equipment. These loan schemes ensure all women can access breastfeeding pumps and equipment regardless of cost. Central Hawke's Bay Plunket also have six sets of breast pumps they hire out regularly.

Plunket's breastfeeding support in Central Hawke's Bay includes seven breastfeeding peer counsellors that are La Leche League trained. The service receives referrals from the Central Hawke's Bay lactation consultant, Lead Maternity Carers, as well as self-referrals.

Baby Friendly Hospital Initiative (BFHI)
The HBDHB underwent re-accreditation in February 2017 for Ata Rangi, Waioha and Wairoa maternity facilities. In New Zealand, all maternity services are required to achieve and maintain BFHI accreditation. The standards of care and services provided are audited by the New Zealand Breastfeeding Alliance (NZBA) every three years. The BFHI aims to improve exclusive breastfeeding rates and ensure evidenced-based best practice standards of care are offered by maternity services. Baby friendly facilities work to see that all women, regardless of their feeding method, receive unbiased information, support and professional advice in their decision to feed their babies.

Hapū Māmā Programme
The Māori Health Improvement Team is in the early stages of exploring a Kaupapa Māori ante-natal education programme. Ante-natal education enables and empowers pregnant women and their whānau to make informed decisions about their pregnancy care, the birth of their baby, and early parenting. We intend that waiū/breastfeeding will be a key focus of a Kaupapa Māori ante-natal education programme as evidence has shown that specific antenatal and early post natal education programs that focused on improving exclusive breastfeeding rates led to improved rates of such feeding[2] (Su LL, Chong YS, Chan YH, et al, 2007).

[2] Su LL, Chong YS, Chan YH, et al. Antenatal education and postnatal support strategies for improving rates of exclusive breast feeding: randomised controlled trial. *BMJ* 2007; **335:** 596–612.

FINANCIAL IMPLICATIONS OR OTHER KEY ISSUES AS REQUIRED

The current breastfeeding resource within Maternity services is comprised of a .9FTE Breastfeeding Advisor (LC) and a small additional contact volumes budget which supports Baby Café (drop in breastfeeding community clinic with LC in attendance 12 hours per week), ward contacts (providing and responding to requests for any women currently breastfeeding who may require hospital treatment – not necessary inpatients in maternity) and a once a month breastfeeding antenatal education class. Any changes proposed would require disinvestment in one or all of the above areas which will not necessarily correspond to improvements in breastfeeding rates. Our preference would be to seek new investment to increase service provision by including additional peer support resource and outreach resource for mothers to access. In terms of our current performance rates and the importance of breastfeeding as a key priority for improved infant and maternal health outcomes some further discussion is required.

RECOMMENDATIONS FROM TARGET CHAMPION

The first six weeks after a baby is born is critical to establishing successful breastfeeding. There are multiple factors that impact whether this occurs, for example; consistent messaging, health professional engagement and enrolment processes, and access to support from whānau and health professionals. It is essential that for any sustainable change to occur in the rates of breastfeeding, and to make gains in breastfeeding rates for Māori, efforts must be focussed in the antenatal and early postnatal periods (in addition to other activities already established).

We have reviewed our current approaches and have identified areas where we can do things differently to improve breastfeeding rates and particularly focus on achieving the 6 week target.

With a focus on developing strong relationships and providing consistent messages at the instigation of the breastfeeding journey, we aim to provide appropriate, effective, timely breastfeeding support in the crucial initiation stage of breastfeeding. We need to ensure greater alignment and ensure our services are tailored to support Māori mothers and whānau whilst continuing capacity building that has occurred through use of the Mama Aroha resources, collaborative engagement initiatives between Lead Maternity Carers, HBDHB and WC/TO providers and promotional supports for breastfeeding.

CONCLUSION

A comprehensive Breastfeeding Support Service comprising both a community and hospital component will significantly strengthen the DHB's efforts to improve breastfeeding rates, especially for Māori mothers and their whānau. The impact of not considering improvements and better alignment potential from the hospital service component service is that opportunities to provide appropriate support to mothers and their whānau in the ante-natal period will be lost, as well as the continuity from birth, post-natal discharge to community.

HAWKE'S BAY District Health Board Whakawāteatia	**Maternity Clinical Governance Group July to December 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:	February, 2017
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 were all achieved up to this point. From January 2017 onwards the Maternity Quality and Safety Programme will no longer have a specifically appointed programme coordinator and the responsibility of the programme will move solely to the Midwifery Director

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 three-quarters of the way through executing the two year plan of the current "Establishing Contract", however the disestablishment of the specific Maternity Governance Coordinator role will most likely see a change in productivity and elements of the two year plan not being fulfilled in the timeframe previously identified

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 2015 MOH 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 2015 national average as well as our internal data trends for 1st January to 31st August 2016 can be found on page 8 of this report.

Acknowledgement of our 2015 Annual Clinical Report was received from the Ministry of Health and National Maternity Monitoring Group (NMMG). The report was commented on with regards to its comprehensiveness, clear demonstrating of quality activities and the highly visible consumer engagement and thread throughout the report.

The NMMG have recently published their 2016 report highlighting the activity that has occurred over the year and providing their focus maternity services for 2017.

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

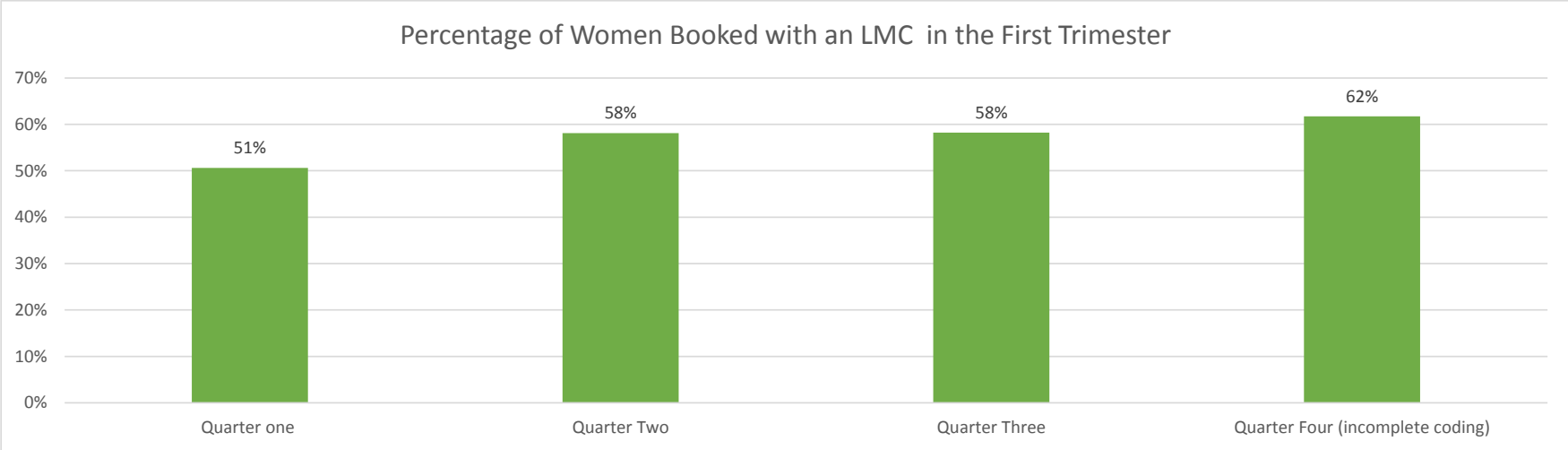
- Waioha has been open for its first 6 months (Jul-Dec 16) and the data has been manually captured during this time and demonstrated in the table below
- Consumers complete the survey monkey prior to discharge which is providing up to date quarterly information to be able to acknowledge and respond to. Feedback is overwhelmingly positive from consumers; particularly in relation to the calm and relaxed atmosphere, the provisions made for support persons and whanau and being able to stay in one room throughout the whole episode of care
- Planning for the Official opening ceremony for Waioha on 1st March commenced with Bronwen Pelvin, Senior Maternity Advisor for MOH officiating
- Final project report is underway highlighting strengths and lessons learnt during the life of the project
- Ongoing focus on changing birth culture is underway with an initial meeting of those who expressed interest in continuing to support active labour and birth – a new campaign called Your Birth, Your Power is being developed and planned to be launched in March/April 2017.
- Early trends demonstrate a decrease in C Section rate, an increase in physiological labour and birth methods and a decrease in the use of Epidural as a form of pain relief

Manually collated data for the primary birthing centre have been analysed from the outset, with six months from July to December inclusive available for this report. Early figures are very encouraging with a birth rate percentage of 30.1% of the total births for the months of July to December as demonstrated in the table below. The expectation is that a third of the births occur in Waioha of the total birthing population. The other element of note is a 10% increase in birth rate in the latter half of 2016 in comparison to the previous two years.

Waioha July to November 2016		
Births	Total number of births across the whole service during this 6 month period	983
	Number of women birthing in Waioha this during this 6 month period	296
	Number of Primiparous women birthing in Waioha during this 6 month period	79 (26.1%)
	Percentage of total births during this 6 month period occurring in Waioha	30.1%
Transfers	Total number of women transferring from Waioha (AN, PN, Neonatal) during this 6 month period	77
	Transfer in labour rate of all women who commenced labour in Waioha during this 6 month period	19%
	Overall transfer rate of labouring women from Waioha to secondary services from ALL women who birthed during this 6 month period	7.1 %
Utilisation	Total number of women accessing Waioha (assessments/births/transfers) during this 6 month period	440
	Number of water births in Waioha during this 6 month period	91

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).**

- Promotional material has been finalised and commenced distribution with shared appointments with smoke free liaison midwife to launch the early engagement campaign – My Baby, my midwife and me starting in October.
- 12 GP practices have been visited with positive response and good opportunities for discussion and how to work better together. Training on the use of the Find your midwife website and promoting it to be available on every desktop has been informative and enlightening for many
- Utilisation of Napier maternity resource centre is ongoing and awaiting the annual 2016 report for final figures
- The booking triage group are ensuring accuracy of data in relation to registration with an LMC date which should ensuring confidence in the accuracy of the information being reported.



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 twelve months, members of the maternity clinical governance group, involvement in our key quality initiatives identified in 2 year MOH action plan. The consumers are considered an integral part of operational and strategic direction with involvement in discussion and planning for maternity services.

During the last six months the consumers have evolved or embedded links with:

- Te Kupenga Hauora Ahuriri kaimahi
- CHB practice nurses.
- Bump, Birth and Beyond:
- New contacts made with Parent Centre + multiple Hawke's Bay childcare providers
- Homebirth support group and La Leche League members.
- HBDHB Maternity Service and Paediatric health professionals, LMC's,
- Taupo/Rotorua/Lakes District consumer members
- SCBU clinicians and managers.
- Flaxmere Plunket, Napier Hub also, U-Turn trust, HBDHB Social Workers, TTOH, FASD awareness working group,
- ISO's wings, Veronica's Place, Wellington Hospital and Ronald McDonald House

The consumer members have also undertaken activity with:

- MQSP consumer forum, established links with consumer members all over New Zealand. This network is to be set up and we both found it very inspiring. The Taupo / Rotorua consumer members are really onto it and linked in well with their marae/ people, so we can learn from them
- Attendance and Presentations at the HB Maternity Services Annual Clinical Report Day.
- Te Taiwhenua O Heretaunga consumer coffee forum
- Napier Family Centre Post Natal Adjustment Program, Mums and infants.
- Maternal Mental Health: engagement with three mum's, all of whom are seeking support in the area of maternal mental health
- Adhoc promotion and conversations regarding Maternity Services and Maternity Services Consumer Member role, during day to day activities.
- Supporting 'Nan' regarding her daughter, a teen Mum-to-be, to overcome barriers in accessing teen antenatal class
- supporting an understanding of the midwifery role across the community
- Maintaining engagement with 'Grandma' regarding the antenatal/postnatal journey of her daughter with a problematic pregnancy, premature delivery at a tertiary hospital and Hastings SCBU transition.
- Continued fostering relationship with mother who experienced premature birth (23 weeks) and her experience of Hastings SCBU with her infant.
- SPACE (MOH-funded parent/child activity Supporting Parent and Child Education – for under 1's) – Napier, and also Hastings.
- Mums at Parent and Child Havelock North.
- Waioha: connected / connecting with mums birthing during July/August 2016.
- Mum of first baby born in Waioha.
- Provided feedback to Midwifery Director for projects.
- Sharing online survey's (General Consumer & Waioha) via Out and About.

Both consumers have additionally:

- Provided commentary for submission to the HBDHB Maternity Services restructure and proposal to disestablish the Maternity Governance Coordinator role.
- Provided "What we (Maternity Services Consumer Members) have been doing" for staff noticeboard, Maternity Services monthly bulletin and Maternity Services Social Media page to maintain consumer/staff engagement and visibility as per MoH directives.
- Fed back on the "My Baby, my midwife and me" early engagement campaign.

- Worked with Midwifery Director/Waioha Clinical Midwife Coordinators on 'What is birth', Waioha's 'Your Birth, Your Power' campaign.

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 had their blogs posted on the maternity Facebook page.

Clinical Indicator Internal Data Overview - based on most current internal reporting (1st Sept 2016)

Indicator	KEY: U Unfavourable; S Static; F Favourable	MOH National average 2015	2015 Internal Data	2016 internal Data Jan – Aug (incl)	Trend Direction against the 2015 National Average	Current Performance against the 2015 National Average
1: Registration with a Lead Maternity Carer in the first trimester of pregnancy- All Women MOH target		70.0%	58.0%	62%	↓	U
2: Spontaneous vaginal birth among standard primiparae		68.7%	60.2%	67.8%	↓	U
3: Instrumental vaginal birth among standard primiparae		16.3%	19.3%	11.2%	↓	F
4: Caesarean section among standard primiparae		14.9%	20.2%	16.8%	↑	U
5: Induction of labour among standard primiparae		5.7%	8.6%	9.0%	↑	U
6: Intact lower genital tract among standard primiparae giving birth vaginally		28.3%	44.2%	40.6%	↑	F
7: Episiotomy and no third- or fourth-degree tear among standard primiparae giving birth vaginally		22.7%	15.9%	12.5%	↓	F
8: Third- or fourth-degree tear and no episiotomy among standard primiparae giving birth vaginally		4.4%	6.1%	5.1%	↑	U
9: Episiotomy and third- or fourth-degree tear among standard primiparae giving birth vaginally		1.5%	2.9%	2.1%	↑	U
10: General anaesthetic for all women giving birth by Caesarean Section		8.8%	11.5%	10.2%	↑	U
11: Blood transfusion for all women giving birth by Caesarean Section		2.9%	3.8%	3.2%	↑	S
12: Blood transfusion during birth admission for vaginal birth for all women		2.0%	2.4%	1.5%	↓	F
13: Diagnosis of eclampsia during birth admission for all women		n/a	0%	0%	=	F
14. Peripartum hysterectomy		n/a	0.05%	0.14%	↓	S
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		12.0%	21.6%	23.1%	↑	U
17. Women giving birth with a BMI over 35 at registration		9.3%	10.9%	10.4%		U
18: Preterm births, 32 to 36 weeks gestation, for all women		7.3%	8.9%	8.1%	↑	U
19. Small babies at term (37–42 weeks gestation)		3.1%	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		1.9%	1.8%	2.4%	=	S

Please note that the trend direction is the comparison of our 2016 internal data with the latest MOH 2015 national average data from all maternity facilities

OURHEALTH HAWKE'S BAY Whakawateatia	**Falls Minimisation Committee Update**
	For the attention of: **HB Clinical Council**
Document Owner:	Chris McKenna, Chief Nursing Officer
Reviewed by:	Andy Phillips, Chief Allied Health Professions Officer
Month:	March 2017
Consideration:	For Discussion

13

RECOMMENDATION

That Clinical Council:

- Note the contents of this report.
- Acknowledge the concerns raised regarding adequate resource within the QIPS team and on the wards to minimise harm from falls.

Membership

As part of review of Advisory Groups in strengthening clinical governance arrangements the TOR and membership of this group will be reviewed. The Committee have discussed this and agreed on the following:-

- Falls in the hospital have decreased and focus has changed to minimisation of harm from falls, rather than minimising falls.
- The Committee needs to have a focus on minimising falls occurring both in the hospital and community and membership will continue to include stakeholders from the DHB and Community.
- With the new clinical committee structure this group may have a different reporting line to Clinical Council in future
- The chair of this committee is CNMO who is also the Regional Lead for Falls – so appropriate for CNMO to continue as chair.

ACC Business Case for Fracture Liaison Service

ACC and the DHB have agreed in principle on the details and this will proceed to formal sign off. The contract has a three years term from date of sign off.

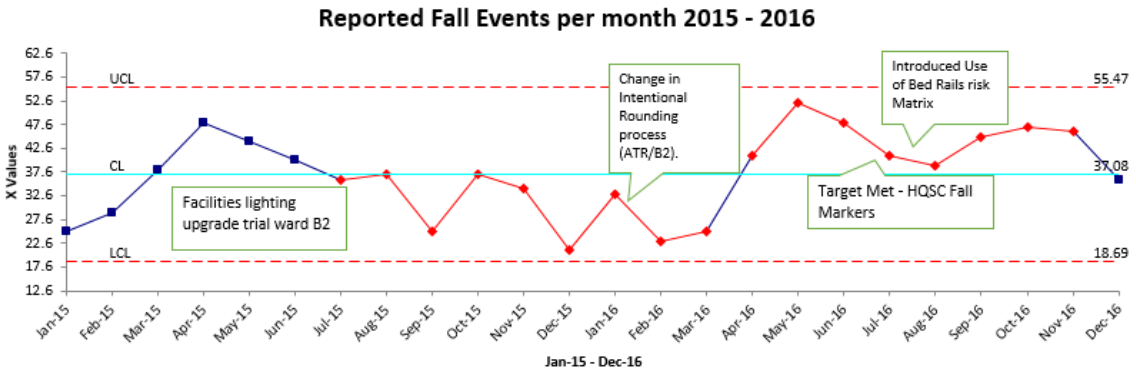
A single point of entry for referrals will facilitate effective flow to right service. Key focus is home based care and the DHB can refer in after a patient has been discharged, the patient will then be contacted directly.

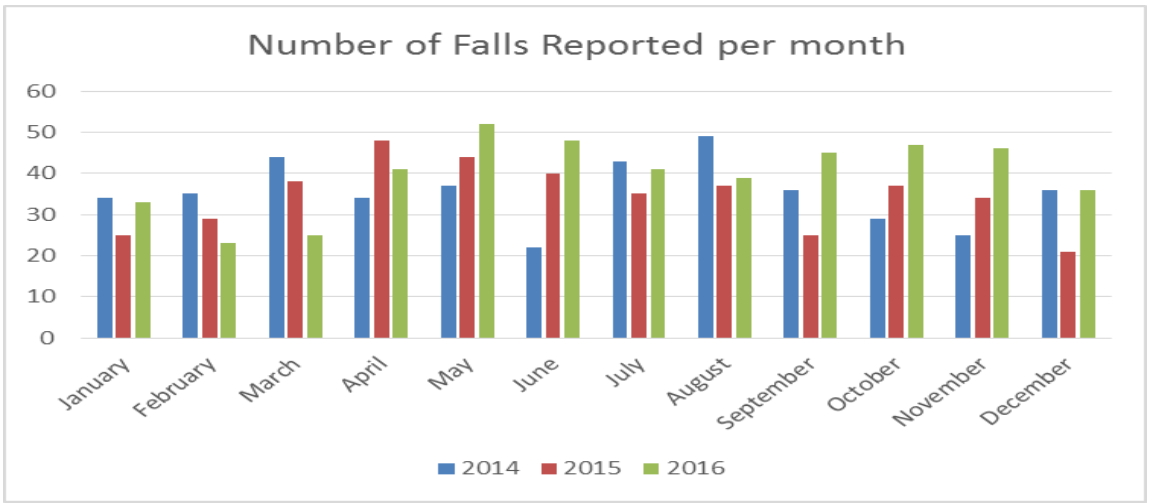
MRFRAT Tool

The Medicine Related Falls Risk Assessment Tool (MrFRAT) developed by clinical pharmacists Brendan Duck and Peter McIntosh, has been socialised throughout Hawke's Bay Age Related Residential Care (ARRC) Facilities during 2015 and 2016, supported by an ARRC Registered Nurse (RN) guide and Prescriber guide written by Health Hawke's Bay Clinical Advisory Pharmacist, Di Vicary. This screening tool is completed by the ARRC RN during care plan development as well as being reviewed following a fall. Clinician awareness of medicines contributing to falls is increased following a MrFRAT screen and enables strategies to be considered, including reviewing medicines proactively, to minimise the risk. An unexpected positive consequences has been the raised knowledge around a national standard for falls measurement and increased falls monitoring. The MrFRAT tool has recently been placed onto InterRAI, this will enable the NASC team use as well as by ARRC RNs. MrFRAT has been shared with NHS Scotland via Dr Anne Hendry and an American nursing student has approached Health Hawke's Bay for permission to use MrFRAT in her postgraduate research. This project is now completed.

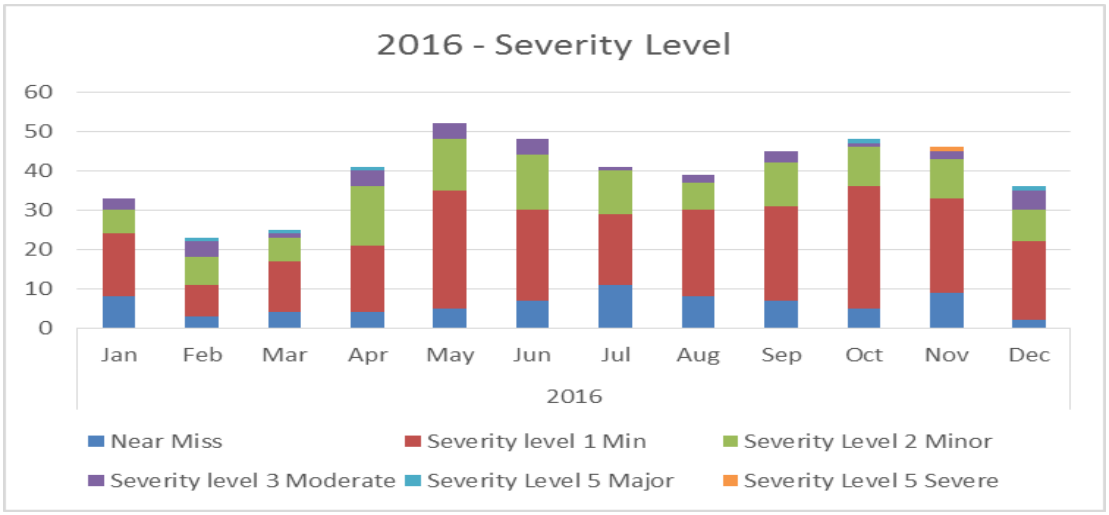
QUARTERLY REPORT FOR FALLS

Although there has been an increase in falls assessment, the Committee has serious concerns about the risk of patient harm occurring from falls. There is currently an issue in providing data analysis due to resourcing limitations. Some wards do have a falls champion, however this is not a resourced role. There is a lack of visibility of patient fall indicators such as safety crosses





Since July 2016 there have been 3 SAC2 events where significant harm has occurred to patients falling in the hospital. This is the same number as occurred in the previous 12 months.

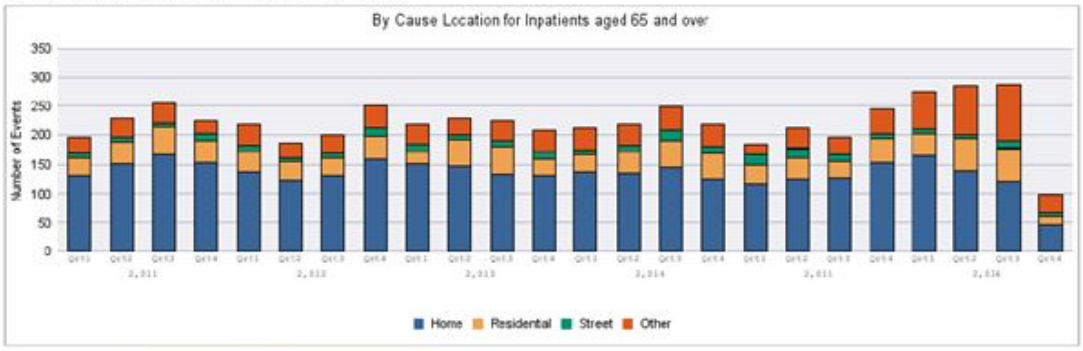


Patients Aged 65 and Over who have been Admitted as an Inpatient with a Fall Listed as External Cause - 0210002

Report from 01/01/11 to 31/12/16

HAWKE'S BAY District Health Board
Business Performance & Intelligence

Falls for Patients 65 and over who have been Admitted



	2011	2012	2013	2014	2015	2016
Home	604	551	564	544	524	472
Residential	151	137	142	157	139	164
Street	32	38	39	46	52	33
Other	118	130	135	152	122	278
Total	905	856	880	899	837	947

Created By: Aaron Turpin
Last Refreshed: 3/01/17

Cause Location Page 1 of 1

13

OURHEALTH
HAWKE'S BAY
Whakawateatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

15. Minutes of Previous Meeting (Public Excluded)

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

17. High Level Budget Review Presentation

18. Member Topics of Interest – Member issues / updates

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

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