Hawke's Bay Clinical Council Meeting

Date: **Wednesday, 13 July 2016**

Meeting: **3.00pm to 5.30pm**

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

Council Members:

Chris McKenna
Dr Mark Peterson
Dr John Gommans
David Warrington
Billy Allan
Dr Andy Phillips
Dr Robin Whyman
Dr Caroline McElnay (on leave returns October)
Robyn O'Dwyer
Jules Arthur
Dr Kiri Bird
Dr Tae Richardson
Dr Malcolm Arnold
Dr David Rodgers
Debs Higgins
Anne McLeod

Apologies: Dr Andy Phillips, Caroline McElnay and Anne McLeod

In Attendance:

Nicholas Jones (Public Health Specialist) Acting for Dr Caroline McElnay
Dr Kevin Snee, Chief Executive Officer, Hawke's Bay District Health Board
Ken Foote, Company Secretary
Kate Coley, Director of Quality Improvement & Patient Safety
Tracy Fricker, Council Administrator and PA to DQIPS
Graeme Norton, Chair HB Health Consumer Council

PUBLIC MEETING

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

5.	Clinical Council Workplan	
	Section 2 – For Endorsement	
6.	Health and Social Care Networks - Liz Stockley & Belinda Sleight (Project Manager) • Purpose and Principles • Geographic Localities proposal Health & Social Care Networks • Business Case	**3.10**
	Section 3 – For Discussion	
7.	Primary Care Smokefree Verbal Update – Liz Stockley & Victoria Speers, Health HB	**3.25**
8.	Implementation of HB Clinical Governance Committee Structures – Kate Coley	**3.35**
9.	Renal State 4 – Facility Development Update – Paula Jones and Megan Knowles • Appendix 1: Floor Plans • Appendix 2: Timeline	**4.05**
10.	Reducing Alcohol Related Harm – Rachel Eyre • Position Statement example	**4.15**
11.	Last Days of Life - Leigh White, Portfolio Manager Long Term Conditions • Care Plan • Toolkit	**4.35**
12.	Transform & Sustain Refresh - Presentation – Tim Evans (GM PIF)	**4.45**
	Section 4 – Reporting Committees / Monitoring	
13.	Aim 24/7 verbal update – Dr John Gommans	**4.55**
14.	Laboratory Services Committee - Dr Kiri Bird, Chair • Laboratory Testing Guidelines • Point of Care Testing • Update on IANZ Report	**5.00**
15.	Radiology Services Committee – Dr Mark Peterson, Chair • National Criteria Access to Community Radiology	**5.10**
16.	Clinical Advisory & Governance Committee - Dr Tae Richardson • engAGE Well	**5.15**
	Section 5 – For Information only	
17.	Business Case Healthy Eating and Activity Programme	**-**
18.	Business Case 2015/16 Clinical Midwife Specialist – Diabetes	**-**
19.	**Recommendation to Exclude the Public**	

PUBLIC EXCLUDED

Item	**Section 6 – Routine**	
20.	Minutes of Previous Meeting	**5.20**
21.	Matters Arising - Review Actions	
	Section 7 – General	
22.	Member Topics of Interest	

NEXT MEETING AGM, Wednesday 10 August 2016, commencing at 1.00pm Lunch at 12.30pm VENUE tbc

Interests Register

8 June 2016

Hawke's Bay Clinical Council

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

17/06/2016

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

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Dr Malcolm Arnold (SMO Physician - Gastroenterology)	NZ Society of Gastroenterology	Executive member	Provision of Gastroenteorlogy expertise throughout NZ, study of relevant conditions	No	
	NEQIP (National Endoscopy Quality Improvement Programme)	Clincal Support Lead	Standardising and improving quality of endoscopy services and training throughout the country	No	
	Endoscopy Users Group, HBDHB	Chairman	Assessing and improving provision of Endoscopy services in HB	Yes	Potential to influence budget/spending/provision of services
	Hawke's Bay Medical Research Foundation	Member of Scientific Advisory Group	Advising HBMRF on use of funds for research projects	No	
	NZ Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy (since June 2015)	Chairman		No	
David Warrington (Nurse Director - Older Persons)	Havelock North Chiropractic	Wife is Practitioner and Co-owner	Chriopractic care and treatment, primary and preventative	Yes	Low
	Pilates Works	Wife is CE and Co-owner	Rehabilitation, Primary and preventative.	Yes	Low
	National Directors of Mental Health Nursing	Member		No	Low
Dr Tae Richardson (GP and Chair of Clinical Quality Advisory Committee)	Loco Ltd	Shareholding Director	Private business	No	
	Dr Bryn Jones employee of MoH	Husband	Role with Ministry of Health as Chief Advisor in Sector Capability and Implementation	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Report on CQAC meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Life Education Trust Hawke's Bay	Trustee		No	
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	

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

MINUTES OF THE HAWKE'S BAY CLINICAL COUNCIL MEETING
HELD IN THE HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE
ON WEDNESDAY, 8 JUNE 2016 AT 3.00 PM

PUBLIC

Present:	Dr Mark Peterson (Co-Chair) Dr John Gommans Dr Tae Richardson Dr Andy Phillips Dr David Rodgers Billy Allan Debs Higgins Dr Malcolm Arnold Jules Arthur Dr Robin Whyman Dr Caroline McElnay (left at 5.10pm) Robyn O'Dwyer Dr Kiri Bird
Apology:	Anne McLeod and Chris McKenna
In Attendance:	Kate Coley (Director – Quality Improvement & Patient Safety) Graeme Norton (Chair HB Health Consumer Council) Brenda Crene (Board Administrator)

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Dr Mark Peterson (Chair) welcomed everyone to the meeting, noting apologies had been received from Anne McLeod and Chris McKenna.

Meeting apologies:
- Please ensure meeting apologies are advised in advanced of papers being issued.
- A number of Council members will likely not be available to attend the 14 September meeting (with a number attending APAC in Sydney).

We need to be mindful that a quorum is required / or preferences for decision purposes may need to be advised in advance.

2. INTERESTS REGISTER

A change to the Interest Register was noted for Dr Malcolm Arnold to remove his role as "Medical Director HOD" and replace it with "SMO Physician – Gastroenterology". **Actioned.**

Referring to the Health Equity Update 2016, Dr Kiri Bird noted her partner Lee Grace was a trustee for Iron Maori (Te Timatanga Ararau Trust). Other changes to Dr Bird's interests would be advised by email. **Actioned.**

3. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Clinical Council meeting held on 11 May 2016 (at Te Taiwhenua o Heretaunga), were confirmed as a correct record pending one change:
- Page 8 of the document, 6th bullet point - remove "Women, Child & Youth" and replace with "Maternity". **Actioned**

Moved and carried.

Unconfirmed

The minutes of the meeting of the combined Consumer and Clinical Council meeting that followed the above meeting held on 11 May 2016, were confirmed as a correct record of the meeting.

Moved and carried.

4. MATTERS ARISING, ACTIONS AND PROGRESS

Item 1: Clinical Council Member Portfolios / Plan

Areas of interest have not been forthcoming.

Members were asked to review the document provided under agenda item 20 and this will likely link into the "**Governance Structures Committee Review**" for inspiration (note item 3 below), once this has been finalised.

Refer to item 20 for the Clinical Council Annual Plan 2015/16.

Item 2: Alternative Health Provider (Complementary Therapies Policy)
The draft provided in March would be revised and provided to Council in July for sign off.

Item 3: Clinical Council Governance Structures / Committees Review
Feedback sought in May and has been work in progress for the five core groups. This will come back to Council in July.

5. CLINICAL COUNCIL WORK PLAN

One change to the workplan was noted by Kate Coley:

- The "Person and Whanau Centred Culture" paper will move to September as a Draft with the Final scheduled for November. **Actioned**

SECTION 2: DECISION

6. YOUTH HEALTH STRATEGY 2016-19

Dr Caroline McElnay conveyed Nicky Skerman's apology.

Council noted the feedback received from various groups which had been summarised in the report, together with references on how these were managed. MRB had an active discussion earlier in the day and were happy with the report and that their particular concerns had been addressed.

Feedback:

- The level of input from Primary Care had been very limited. At the time the programme(s) are implemented, the team must ensure connections with primary care
- Referring to page 30 of the document (page 50 of the Council papers) in the "Glossary" the Acronym/Definition for COPMIA was now "supporting healthy children, healthy parents.
- Dr Gommans recommended when refreshing the document next time, that the "Definition of Youth" be better defined. Youth should not be treated as one but as subsets. A discussion around the different groups would be helpful at that time.

With the comments received, Council members approved the following recommendation for the Youth Health Strategy 2016-19 "Creating Healthy Opportunities for Youth 2016-10" to go through to the Board.

RECOMMENDATION

That HB Clinical Council

Endorse the Youth Health Strategy 2016-19 to go to the Board for final endorsement.

Approved

7. BUSINESS CASE 2015-16 NURSE PRACTITIONER – HEART FAILURE

The Chair advised that at the time of prioritisation last year, this position was approved subject to the business case being provided. The funding allocation matched what was signed off for the 2015/16 year, however due to the delay in submitting this business case timelines have been extended for recruitment (in July 2016). This will make no difference to the funding which had already been committed as it met the requirements of council when it was first approved.

Feedback:

- Found the business case well presented.
- This role is a good example of where measures and outcomes could be incorporated.
- Feel key accountabilities should be strengthened for the 'population we most need to serve'.
- Hiring on cultural competency measures should be valued and weighing criteria included around key aspects of the role.
- Would be powerful if a Māori Nurse Practitioner was hired. If not possible growing capability through succession planning was suggested.

The Business case was endorsed by Clinical Council with funding protected in the 2016/17 financial year.

RECOMMENDATION

That HB Clinical Council:

- **Approve** the business case for the 2015/16 new investment application for Nurse Practitioner – Heart Failure, application number 59. Prioritised and approved in principle with the 2015/16 funding applications, demonstrating stronger links with primary care.
- **Approve** recruitment to the new senior nursing position of Nurse Practitioner, Heart Failure. 1.0 FTE salary plus associated ongoing full annual cost of $141,484.
- **Note** feedback received from Council members around measures, outcomes, accountabilities, cultural competencies etc. for the populations we most need to serve.

Endorsed

8. REQUEST TO ACCESS PRIORITISATION BIDS CONTINGENCY FUND

(NB THIS DISCUSSION FOLLOWED THE SUICIDE PREVENTION REPORT)

The Investigating Coroners' Recommendations in relation to Youth Suicides in Flaxmere was received with funds being sought to move forward and evaluate the recommendations. The funding bid did not get above the line during the recent prioritisation process. On the day Clinical Council met to discuss prioritisation, the Coroner released her findings.

The proposal presented sought funding to employ the existing 0.5 FTE Suicide Prevention Coordinator for an additional 0.5 FTE for a six month period, to establish and lead a working group to investigate the Coroner's recommendations, and to develop a detailed proposal for future direction.

If additional funding is required to implement that future direction, then a new funding bid would be presented to Council during the 2017 Prioritisation process.

Feedback:

- Suicide was associated with family violence.
- The leading cause of maternal death is suicide.
- There was support for the Coroner's recommendations, with the suggestion that work proceed quickly.
- When doing research – ensure you tap into resources that are already there.
- Other agencies linking together were seen as crucial to enable the opportunity to intervene earlier.
- How do we tap in to undetected depression?
- Building community "resilience" seen as crucial.
- The Coroner's recommendations are not binding, however we would need to have very good reason(s) to reject.
- Great to have an investigation undertaken which is evidence based and at the same time ascertain what we need going forward.

Following discussions the recommendation was approved.

RECOMMENDATION

That Clinical Council:

- Recommend that the Board approve $26,000 during 2016/17 (June-December 2016) to investigate the recommendations of the Coroner's report into four suicides in Flaxmere.

Approved

SECTION 3: INFORMATION / DISCUSSION

9. SUICIDE PREVENTION AND POSTVENTION PLAN REPORT

Dr Caroline McElnay welcomed Penny Thompson (Suicide Postvention Co-ordinator) who summarised (as below) what had been undertaken since the Plan was developed in June 2015. A year on, the network of agencies participating in suicide prevention have worked together and linked consumers to agencies; agencies to agencies; improved information sharing processes; reviewed the support model to include prevention; and provided access to training and maintaining interagency commitment to suicide prevention.

The update would be provided to the Ministry of Health in July 2016 covering:

A. *"Resilience building activities in the region – activities to respond to early risks, promote mental health and wellbeing and help prevent suicide.*
B. *Information on workforce development for health workers and key community gatekeepers to respond to distressed people in the community.*
C. *Approaches specific to at risk groups includes mental health users, male, youth and Māori.*
D. *Multi-agency postvention response in cluster and contagion situation and postvention approaches for in-cluster situations."*

Feedback:

- QPR (what is QPR?) training for GPs and public and health professionals. The next session was planned for 15 June.
- Suicide prevention workshops have been held. There had been little uptake for training and awareness from primary care. It will be **important** to ensure messaging is disseminated appropriately to GPs and Primary Care.

- Adverse childhood experiences - any link? Good ability to identify those at risk and it certainly fits with research in the US showing evidence linked. CDC document shows actions you can take.
- Inside the coroner's report a consistent factor noted was family violence. Coordinators in the region / Maternal wellbeing group work together to ensure any risks are noted across agencies. Frailty also an area which needs focus.

10. FOOD SERVICE OPTIMISATION REVIEW

The Chair welcomed Gavin Carey-Smith (acting Facilities Manager) and Jill Foley (Food Service Dietician) to the meeting. The report provided analysed food services following a decision by HBDHB (in 2015) to have the Nutrition Service for the HBDHB to remain in-house and not be aligned with Health Benefits Ltd (HBL) national programme at the time.

The Food Services Optimisation Project Team in conjunction with other Food Service Experts undertook to work with the Nutrition and Food Service Department to determine opportunities for financial savings or opportunities to improve the current systems and processes.

Following the completion of this comprehensive review an action plan containing resulted containing 31 items (with some completed, some underway and others involving capital funding).

Discussion:

- The process undertaken could not be faulted however Jill Foley was asked "were we providing clinically nutritional food?"

  In response we have been benchmarked against other DHBs and our food came out very well. HBL provided specifications and HB's menus fall in-line with those. We are very lucky with food here in HB.
- There was some discussion around Zac's plan to improve coffee services. In response they were not planning to compete with Café's nearby, merely provide a more prominent area, better quality coffee and improved service.
- It was noted we don't have patients registered in an inpatient system for example: ED and Maternity. This was being looked at.
- Implementation of a menu management system was discussed. In response, not as simple as several areas cannot utilise. No costing had been done at this time.

Feedback:

- Suggested the improvements/actions within the Review be prioritised as the MoH would likely be interested in HBDHB's food service.
- Hutt DHB's food service was very competitive and probably worth a look.

RECOMMENDATION

That HB Clinical Council

1. Support the Food Service team in investigating and implementing the recommendations whilst also considering feedback from Council.
2. Note capital applications that arise from recommendations will need to be put through the capital plan process for approval.

Endorsed

11. HEALTH EQUITY UPDATE 2016

The Health Equity Update 2016 report was received, together with a presentation by Dr Caroline McElnay who outlined progress made in some key areas and the ongoing challenges.

- 18 indicators updated compared to 49 previously

- Some incomplete data, therefore it was more a snapshot of equity rather than a complete picture of health equity

Progress has definitely been made but not enough. Some fascinating new data had been received from statistics NZ. There is not much difference in non-Māori life expectancy across NZ but there are significant variations for Maori. The differences appear to depend on where Maori live with economic factors being a huge driver.

Need to continue to focus on tackling "behaviour" and "risk" as well as "social and economic factors".

Presentation slides VISION "Equality versus Equity" relayed three pictures with the third picture showing the systemic barrier removed – this is our vision but how do we get there?

Action: Provide the "Health Equity in HB presentation" with the minutes.

Members were asked for feedback and recommendations.

Feedback:

- Are we able to use data on Healthy life expectancy? Used a lot in the UK but have not yet been able to do that locally.
- Tobacco use remains a key focus area especially smoking before and during pregnancy = 40% of young Maori women smoke with no real change in this percentage over recent years.
- Pleased to see conversation is about eliminating health inequities, not just reducing them.
- Inequity in life expectancy for Maori is also related to history of colonisation and racism in our country.
- Tackling behaviours - Iron Māori used as example of empowerment model. Need to explore in these models in order to achieve sustainable behaviour change.

12. ACTION PLAN – LEARNINGS FROM ICU REVIEW 2013

The Action Plan provided key recommendations, the responsible owner and timeframes for completion. Quarterly updates will be provided to Clinical Council and FRAC until completion.

Acute and medical directorate teams are comfortable with the timeframes and should see implementation by February 2017, at the latest.

The foundation document was not well articulated and as a consequence we need to get the TOR and governance structures right. Get in place and have reviews that are achievable.

Come back to update on progress.

Feedback:

- Mark noted that annual performance reviews were not discussed in the document and it would be helpful to have this occur; not just for ICU but for other areas also.

13. IMPROVED ENDOSCOPY SERVICES - FACILITY DEVELOPMENT UPDATE

An overview was provided around the Preliminary design, geotechnical conditions, and capacity of the facility as well as procurement planning and the preliminary design estimates as follows:

Preliminary design Cost estimate:

- Total Cost, indicated at **$8,500,000** *excluding* the Furniture, Fixtures and Fittings (FF&E).
- Total estimate for the FF&E component is **$1,050,000**
- This brings the total cost for the project to $**9,550,000 representing a +/- of 8% degree of accuracy.**

The initial cost estimate from November 2015 at concept design had indicated $9,630,000 with a +/- of 10% degree of accuracy.

Unconfirmed

Key milestones ahead for 2016:

Developed design completed	20th June
Developed design cost estimate	8th July
Detailed design completed.	22nd August
Building consent Lodged.	5th September
Tender completed	4th November
Board approval.	25th November

An update would be provided to FRAC once the preliminary design phase has been completed.

The Geotech issue had been resolved.

This is a significant build and will be clearly visible to the public.

Discussion:

- Blending the consumers and clinicians (discussions/feedback) together during this project has gone well, albeit different from that of the mental health facility build.
- With the announcement of bowel screening recently, it was noted Wairarapa and Hutt will next roll out screening. HBDHB will likely be involved after March 2017 and timing should work well.
- It was suggested, the location of the facility with a south facing elevation will leave the paediatric ward in a dark area on the ground floor.
- Responded the building would be 7 metres away and privacy and lighting are being worked through including light reflection from the new build.
- There was some discussion around architecture styles on the hospital site, blending the new and the old.

14. MOBILITY ACTION PLAN – PRESENTATION

Drs Phillips and Richardson provided an enlightening overview of the background and funding request for submission to the MoH in July.

Musculoskeletal health conditions and lower back pain are **a** leading cause of disability and pain and have significant influence on health and quality of life. The aim of the proposed programme is to increase local community capacity to ensure sustainability. The proposal aligns to the Transform and Sustain which was endorsed by Clinical Council in May through the prioritisation process.

Looking ahead:

- RFP to be submitted to MoH by 7 July 2016
- Ongoing co-design and capacity building with communities
- A two year pilot envisaged
- Plan to submit through the prioritisation process for permanent funding
- MoH spread successful models to other locations

The challenges noted related to IT capability and included: Shared patient records and “Virtual” GP consult”

15. UPDATE ON PRIMARY SMOKE-FREE

David Rodgers member and GP Primary Care

- Contracted nurses working within practices,
- Improving towards the target
- PHO does have the ability to do the checks along the way.
- Will need to resource this well.
- Looking to have pharmacists more involved and providing advice. Not sure how this would be captured yet but this is being looked at.

Unconfirmed

- Noted that the "smoking target" was likely to change. Hopefully it will reflect a more meaningful measure.

16. TE ARA WHAKAWAIORA / ORAL HEALTH

Dr Robin Whyman advised this was an area of significant challenge and a health equity issue where the gap was not closing. Inequity remains the same with Māori and Pacific children, and those living in socioeconomic disadvantage experiencing poorer outcomes for oral health.

The community oral health service has focused on primary school children. The real goal now is to start early in the first 12 months and have meaningful engagement in the very early years.

In addition to the recommendations below, child oral health will be influenced by the following programmes: Best Start Healthy Eating and Activity; Healthy Housing; Breastfeeding; Smoking cessation; Water Policy and community water fluoridation.

The initiatives recommended are expected to result in gradual improvements to the indicator based on current international advice, and strategies in place in other areas.

RECOMMENDATION

That HB Clinical Council:

Approve the Target Champions recommendations:

1. That Maori health provider contracts are changed to focus on engagement of hard to reach whanau with oral health services in the early pre-school years (by June 2017)
2. That Community Oral Health Services achieve the preventative practice targets (by December 2017)
3. To implement Maternal Nutrition Programme activities and implement healthy eating/sugar reduction programmes/policies as planned in the Best Start: Healthy Eating and Activity Plan (Reported annually until 2020)
4. That Hawke's Bay DHB implements community water fluoridation as soon as necessary legislative changes enabling the DHB to act are in place. To be confirmed, dependent upon legislative changes.

Approved

SECTION 4: REPORTING COMMITTEES

17. HB NURSING MIDWIFERY LEADERSHIP COUNCIL UPDATE

David Warrington spoke to the report and advised with the new Nursing and Midwifery Dashboard we were now able to measure against the strategy.

18. HB CLINICAL RESEARCH COMMITTEE UPDATE - VERBAL

Dr John Gommans advised the council had met and there were no concerns to report. The HB Research Committee's Annual Report was available for viewing on the website by following this link. http://www.hawkesbay.health.nz/page/pageid/2145884116/Hawkes_Bay_Clinical_Research_Committee

19. URGENT CARE ALLIANCE UPDATE - VERBAL

Graeme Norton advised the RFP process was on track (for Napier and Hastings), much the same as the month prior. Those providers who had registered have met and are talking with each other in advance of proposals coming forward.

The advanced practitioner workforce including nursing were strongly engaged to work better at top of scope training on how to best support. Have produced a set of principles into which aged residential care came into the group. Aged Residential care are being involved with very productive conversations taking place on how they can work more collaboratively with those who may be more

isolated.

GENERAL BUSINESS

20. CLINICAL COUNCIL'S ANNUAL PLAN

The annual plan document provided for 2015/16 has historically been refreshed each year, ideally prior to the Annual Meeting of Council held in August. Members were asked to review the plan provided with the Council papers, being mindful of areas that may need expanding or changing.

Kate advised it was important to remember the work progressing around Clinical Governance Structures and Committee Reviews (ongoing since February 2016) as this will likely feed into the Plan. This document will be provided to Council in July.

Action: **Members are asked how the Annual Plan for 2016/17 may look and what Clinical Council's focus should be.**

This should be considered in conjunction with the Clinical Governance Structures and Committee Review document (available in July)

Any feedback/input should be provided to tracy.fricker@hbdhb.govt.nz

Note: **This will be an Agenda item for discussion in July to hopefully enable a draft to be prepared for review at the Clinical Council Annual Meeting in August.**

21. RECOMMENDATION TO EXCLUDE THE PUBLIC

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

22. **Minutes of Previous Meeting**
    - Public Excluded
23. **Matters Arising – Review of Actions**
    - Public Excluded

Carried.

The public section of the meeting closed at 5.25pm

Confirmed: _____
Chair

Date: _____

Unconfirmed

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

Action No	Date issue raised	Action to be Taken	By Whom	By When	Status
1	10/2/16 8/6/16 8/6/16	***Clinical Council Member Portfolios within the Council's Annual Plan review*** Members were asked how the Annual Plan for 2016/17 may look and what Clinical Council's focus should be? Members to consider the Annual Plan in conjunction with the **"Clinical Governance Structures and Committee Review"** document (due to Council in July) refer to item 3 below.	All	July	Deferred until August meeting Agenda Item 8.
2	9/3/16	***Alternative Health Provider*** (**Complementary Therapies Policy)** New draft Policy reviewed under item 8 "Draft Complementary Therapies Policy". Revised version considering feedback to be provided for sign off.	A Phillips	July	Deferred until August Meeting as Andy is on leave
3	8/6/16	Health Equity Update presentation to be provided with the minutes	Admin		Actioned
4	8/6/16	**Meeting Attendance (Quorum)**: Members are to ensure they advise their non-attendance prior to Council meetings - especially for the September meeting (due to APAC).	All		Noted

OURHEALTH HAWKE'S BAY Whakawateatia

HB CLINICAL COUNCIL WORKPLAN 2016-2017

5

Meetings 2016	Papers and Topics	Lead(s)
10 Aug	**HB Clinical Council Annual Meeting from 12.30pm**	**Venue to be confirmed**
	Plus ordinary meeting:	
	Complementary Therapies Policy FROM JULY (matter arising March 2016)	Andy Phillips
	Laboratory Testing Guidelines (per email 17/5)	Andy Phillips
	HB Integrated Palliative Care FROM JULY	Mary Wills
	Draft Quality Accounts	Kate Coley
	Event / Complaint / Hazard /Risk Management System	Kate Coley
	ICU Learnings – Action Plan update Qtly	Kate Coley
	Governing for Quality FROM JULY	Kate Coley
	Quality Annual Plan FROM JULY	Kate Coley
	Council's Annual Plan 2016/17 Development FROM JULY	Kate Coley
	Operation Productivity Update	Sharon Mason
	Travel Plan Update – verbal	Sharon Mason
	Monitoring	
	Primary Care Smoke Free	Liz Stockley
	Urgent Care Project	Liz Stockley
	Clinical Pathways Committee (4 monthly update)	Mark Peterson
	No CAG report this month combined report for Aug+Sept	-
	Annual Maori Plan Q4 15/16 Dashboard	Tracee TeHuia
	Te Ara Whakawaiora / Culturally Competent Workforce (local indicator)	Chris and Andy
	Te Ara Whakawaiora / Mental Health and AOD (national and local indicators)	Sharon, Alison S
12 Aug	**Health Award Entries accepted up to 12 August 2016**	
14 Sept	Orthopaedic Review – closure of phase 1	Andy Phillips
	Draft – Orthopaedic Review – phase 2	Andy Phillips
	Draft – Family Violence – Strategy Effectiveness for noting	Caroline McElnay
	Draft – Reducing Alcohol-Related Harm	Caroline McElnay
	Draft – Developing a Person Whanau Centred Culture	Kate Coley
	Final – Quality Accounts (co-ord with Annual Report)	Kate Coley
	Monitoring	
	Falls Minimisation Committee Update	Chris McKenna
	Maternity Clinical Governance Group Update	Chris McKenna
	Draft – Serious Adverse Events (annual)	Kate Coley
	Health and Social Care Networks Update	Liz Stockley
	Urgent Care Monthly Report	Liz Stockley
	Clinical Advisory & Governance Committee (joint Aug-Sept)	Tae Richardson
	Te Ara Whakawaiora / Obesity (national indicator)	Caroline McElnay
TBC	**HB Health Sector Leadership Forum**	
	Date, Theme and Venue to be confirmed	

Meetings 2016	Papers and Topics	Lead(s)
12 Oct	Final – Reducing Alcohol-Related Harm Final – Serious Adverse Events Draft – New Patient Safety and Experience Dashboard ***Monitoring*** HB Nursing Midwifery Leadership Council Update AIM 24/7 Update Final – HB Integrated Palliative Care Urgent Care Alliance Update Radiology Services Committee Infection Prevention Control Committee Qtly.	Caroline McElnay Kate Coley Kate Coley Chris McKenna John Gommans Mary Wills Mark Peterson Chris McKenna
9 Nov	ICU Learings Action Plan update Qtly Final – Developing a Person Whanau Centred Culture Endocsopy / Gastro Project Build Update Travel Plan – verbal Allied Health Professions Forum Tobacco – Annual Update against the Plan (for noting) ** ***Monitoring*** Te Ara Whakawaiora / Smoking (national indicator) ** HB Clinical Research Committee Update Urgent Care Update Laboratory Services Committee Update CAG report update Annual Maori Plan Q1	Kate Coley Kate Coley Sharon Mason Sharon Mason Andy Phillips Caroline McElnay Caroline McElnay John Gommans Liz Stockley Kiri Bird Tae Richardson Tracee TeHuia
24 Nov	**HB Health Awards presentation evening**	
7 Dec	Discussion - HB Workforce Plan Final - Renal Stage 4 ***Monitoring*** Health and Social Care Networks Update Urgent Care Update Clinical Pathways Committee CAG Report	John McKeefry Sharon Mason Liz Stockley Liz Stockley Leigh White Tae Riachardson

6.1

OURHEALTH HAWKE'S BAY Whakawateatia	**Health and Social Care Networks – Purpose and Principles**
	For the attention of: **Māori Relationship Board, Clinical and Consumer Council**
Document Owner: Document Author(s):	Liz Stockley, GM Primary Care Belinda Sleight, Project Manager Strategic Services
Reviewed by:	Executive Management Team
Month:	July 2016
Consideration:	For Decision

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Council:

1. Review and endorse the purpose set out for the development of networks.
2. Review and endorse the principles against which networks will be developed.

OVERVIEW

In February the Health and Social Care Networks Programme was presented to EMT, Clinical Council, Consumer Council, MRB, Priority Populations Committee (HHB) and the HBDHB Board, and in March 2016 to the Health Hawke's Bay Board and Clinical Advisory Group. In general, the vision and direction of the progamme were supported by management and governance, with feedback given, particularly regarding health consumer involvement and the need to improve readability (essentially a request to better communicate the initiative as we roll it out).

This current paper seeks to more clearly articulate the purpose of a network (i.e. what a network is set up to achieve) and the principles by which each network will be designed and implemented.

BACKGROUND

Under the umbrella of Transform and Sustain, the goals within the Primary and Community Strategic Health Care Framework (the framework) drafted in 2014 were set out to enable a primary and community health care sector that is:

- Well positioned to respond to the growth in demand from long term conditions and increasing numbers of older people
- Capable and has capacity to contribute to improving equity in access and outcomes
- Pulling together as a single system, so that people who use services find them seamless and easy to navigate.

The opportunities that are being targeted by the development of networks (why are we doing this) are:

- Collectively making a greater impact on health and well-being outcomes – especially for those most in need
- Redesigning services to be more appropriate and accessible to patients against defined outcomes that matter
- Ensuring services are delivered in the most appropriate setting

- Sustainability of services – ensuring resources are appropriately used, and fit to meet future population demands (such as aging and chronic disease)
- Supporting local clinical and consumer driven decision making
- Collectively raising standards of service to meet quality expectations
- Improving communications and the co-ordination between services
- Allowing us to do more with the resources we have.

NETWORK PURPOSE AND PRINCIPLES

The purpose and design principles of Health and Social Care Networks are presented in the attached two-page document.

PREREQUISITES

In order to successfully establish a series of networks, EMT recognises the need for the following:

- Support to identify what matters to communities
- Improved communication and collaboration between organisations and individuals in the health and social care communities
- Shared electronic care record and access to information at the right time for the care of the patient
- Review of facilities for each network – infrastructure may need to be developed
- Those involved in network development will need support and access to evidence about models of care that work and translate these into local services
- There is a culture of tolerance for not getting things right the first time, provided those mistakes are learned from

RECOMMENDATION

EMT is being asked to do two specific things:

1. Review and endorse the purpose for the development of networks.
2. Review and endorse the principles against which networks will be developed.

Health and Social Care Networks

Vision

Consumers accessing a wide range of coordinated services closer to home.

Purpose

To empower and support people to keep themselves and their whānau well
To ensure services are well co-ordinated and aligned to local need
To eliminate population inequities experienced by groups within our communities
To provide sustainably for today whilst preparing to meet future demands
To enable care as close to home as possible

What does success look like? A phased approach

Phase One 2016-2018	Phase Two 2018-2020	Long Term 2020-
• More health services are community-based within appropriate geographic networks • Communities are engaged • Providers are collaborating • Primary care models of care are developed • Services focused on appropriateness and access • Tools and infrastructure development underway • Individuals and whānau decide care plans	• Health and social care providers work together • Primary care workforce is more sustainable • Scopes of practice have increased in the community • All appropriate services are delivered in community • Individuals more engaged with care • Whole workforce is culturally responsive • Individuals are health literate and can access services as and when they need	• Local governance frameworks are established • Shared funding pools exist across health and social budgets • Co-design is used to redesign services • Voluntary services are included • More community involvement in health and social care • Community drives agenda and priorities • Community ownership of some services • Individuals and whānau drive their whole health journey
What this looks like for consumers (examples)		
Consumers are working with providers to develop and implement a plan to improve community wellness. People with complex conditions have a care plan, developed by them, their whānau, and the professionals that support them. It is easy to book an appointment online or by phone, and appointments are available when needed.	People are able to self-manage because they are supported, can understand health information, and know who to ask for help when they need it. Fewer trips to hospital are required as more services are available close to home. People don't repeatedly explain their symptoms or history because providers can access this information.	Services are linked up so that a person seeking help for a medical issue will also be offered assistance to improve other aspects of their health and wellness, including the socio-economic determinants of health. Health and social care is under the leadership of a community-owned and directed organisation; people can easily have their say and get involved.

Design principles

Network Structure	Focus	Governance and decision making	Service
Networks are geographic-based, however cross-boundary service provision is also allowed where this is existing or makes sense to develop. Led by a Network Leadership Team, consisting of consumer, provider and funder stakeholders, which is the key conduit between the sector, the network and the community. Each network will be supported by a lean management and administration team. Network drivers are determined by consumers, providers, and sector advisors. The population is supported by effective and efficient delivery of services: providers may be internal or external (e.g. visiting services). Provider-partners include, but are not limited to, general practice, Māori providers, NGOs, voluntary, and broader public sector organisations (i.e. inter-sectoral). Network partners will work as an integrated, cohesive whole, within a high-trust environment; not just co-location.	Focusing on prevention, early intervention, and self-management. Strengthening resilience of individuals, whānau, and communities (supported by clinical and organisational expertise). Promoting sustainable practices: resources, funding, and workforce. Promoting health literacy – consumers and providers speaking a shared language. Utilising the skills sets and passion that sits within the network (working on principles of sustainability), seeking out champions to spearhead action (enablement and empowerment). The network will reflect the Treaty principles of partnership, protection and participation. Eliminating health inequity is a central focus of all network operations; this will be reflected in the KPIs developed to report on and monitor impact across the triple aim dimensions. Networks will commit to continuously improving quality, shared learning, and effective change management.	The Network Leadership Team (or Alliance) will be responsible to the community and DHB for agreed outcomes. The Leadership Team will initially recommend approaches and activities to the DHB for implementation. As expertise and experience is built, the Team will gain further operational control and exert greater influence across the health sector. Partners will align with the overall vision, and must be willing to develop their services to contribute to collaborative models (work with the willing). Each network will link directly with the community it serves to define outcomes that matter. Membership will include consumers, clinicians, sector leadership, and community leaders. Input from the health and social care sectors will provide advice to the Network Leadership Team. Leadership will be legitimised by meaningful provider engagement and partnership with consumers.	The network understands the needs of the local community and reflects this through the services it provides (a population health approach). Services must be accessible to the community and be evidence based and outcomes focused. Services will be provided by the most appropriate provider (e.g. clinician, allied health or social care professional, community volunteer), in the most appropriate place and at the right time for the consumer or whānau. Where appropriate, services will be multi-disciplined and integrated vertically and horizontally across health and social care / community sectors. Quality of services will be standardised, delivery will be locally tailored to each network as appropriate. Data will be used to stratify consumers in each practice so that proactive, relevant interactions promote wellness, and prevent illness. Technology will be utilised to augment and expand the services available by more traditional means.

6.2

OURHEALTH HAWKE'S BAY Whakawateatia	**Health and Social Care Networks – Geographic localities proposal**
	For the attention of: **Māori Relationship Board, Clinical and Consumer Council**
Document Owner: Document Author(s):	Liz Stockley Belinda Sleight
Reviewed by:	Executive Management Team
Month:	July 2016
Consideration:	For Decision

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Council:

1. Review and endorse the proposed basis for network localities.

OVERVIEW

The Health and Social Care Networks programme will cluster community-based health and social services that serve a geographically defined location. The purpose of which is to promote and support; collaboration, information sharing and joint initiatives to enable better health outcomes for the population.

Four such networks are proposed across Hawke's Bay; one for each of Wairoa, Napier, Hastings, and Central Hawke's Bay. The geographic boundaries for the networks will be those of the territorial authorities (District and City Councils).

This approach builds upon the existing sense of community that is apparent in Hawke's Bay, a region which recently confirmed the continuing relevance of its four-district structure. We will work with each network locality to determine local priorities, including working with the two larger urban localities to identify areas of interest/need in which to focus specific actions with smaller, more targeted stakeholder sub-groups (e.g. youth health, mental health).

Work to establish networks will be staggered, such that we learn from the early adopters. Wairoa will be the first network to set up, as it is the locality in which the population is most ready and willing to engage. Progress in each locality will also proceed at different rates, again depending on stakeholder readiness. For example, in Central Hawke's Bay, we are proposing to set up a network, but will not establish a leadership structure until some collaborative projects and priority setting activities have built the relationships and trust in that community. For Napier and Hastings, we consider that the network structure will have merits for these larger localities, but we will delay the start of establishment activities until we have crystallised the learnings from the rural –based networks and can see that expected benefits are being achieved.

BACKGROUND

In February, we presented a proposal to establish a series of networks, consisting of services that collaborate (are joined up) to provide care for patients that they have in common. The intent of these

networks is to facilitate the coordinated and collaborative activity that is necessary to achieve our vision. The direction of travel signalled by this proposal was supported by EMT and the various governance groups.

In this paper, we are further defining key aspect of the networks, that is, the geographic area encompassed in each. Governance feedback on the previous paper has been incorporated into this document.

PROPOSAL – FOUR NETWORKS

Wairoa and Central Hawke's Bay (CHB) – for both of these districts, rurality and relative isolation are defining features which set them apart from the urban areas and tend to shape the concerns of community members (e.g. transport issues, lack of locally-available services, population decline). From discussions with stakeholders in each location, it is clear that a sense of community readiness exists in Wairoa, whereas in Central Hawke's Bay a range of shared priorities for change is emerging.

- *Wairoa*: 7,890 population (2013 census); ~7,676 enrolled with general practices located in Wairoa, ~184 enrolled elsewhere.
- *Central Hawke's Bay*: 12,720 population (2013 census; a June 2015 estimate suggests 13,450); ~10,717 enrolled with general practices located in Waipukurau and Waipawa, ~2,241 enrolled elsewhere.

Hastings and Napier – Initial discussions regarding Health and Social Care Networks indicated that these urban areas could be divided up based on general practice locations, much like the clusters developed for the EngAGE initiative currently being rolled out. However, the wider scope of the networks initiative, which is envisioned to incorporate health and wellness providers across a range of organisations and contracts, suggests that a simpler overarching structure would better serve the stakeholders involved. In particular:

- Strategic partnerships: the health and social care networks initiative seeks to build collaboration across health services, Ministry of Social Development (MSD) - funded social services, WINZ, CYFS, some services of the justice and education sectors, related NGOs, and various council initiatives (e.g. community and business development activities). Many of these organisations base their operations on territorial authority boundaries and/or have strong links with their relevant District or City Council. Using the territorial authority model will also facilitate integrated action by the Hawke's Bay Intersectoral Leadership Group, currently consisting of health, MSD and council leaders.
- Secondary services delivered in the community: a number of secondary services are delivered in the community, and we want to preserve the way workloads are currently divided across team members, as this brings consistency for patients and primary care staff who gain assistance or interact with these services. Most services pursue a geographic division of workloads, with the Wairoa/Napier/Hastings/ Central Hawke's Bay groups being most common (see Appendix 1).
- Building collaboration cross general practices is likely to be challenging, as they are private businesses competing for customers (enrolled patients). Therefore, it makes sense to build upon existing relationships where these exist. For example, in Napier, the provision of after-hours services is an example of city-wide coordination/collaboration.
- Splitting each urban area into smaller localities would potentially require assigning to different networks the separate branches of a multi-location practice (e.g. The Doctors Napier and The Doctors Greenmeadows). This is likely to cause difficulties if each network requires of the individual branches different service specifications or funding models in response to the needs of their local population.
- Within the Napier and Hastings networks, we propose to encourage formation of 'communities of interest' that wrap services around particular consumer groups. For example, a 'neighbourhood alliance' of local providers and the community could work together to achieve the specific aspirations of people living in Camberley and Flaxmere. Providers with

specific expertise could work with consumers to develop 'centres of excellence' for a condition or life stage; the multi-disciplinary EngAGE clusters are prototypes of this model focusing on improving outcomes for older people. A number of whānau or hapu could work with community providers to develop a wellness approach that incorporates their kaupapa.

- The larger network geographies could better support professional development via mentoring and secondment activities between providers in the network. Some clinicians had voiced concern for colleagues working in the relative isolation of a few general practices within the smaller network geography model.
- Averaging across the urban practices, around 13% of the enrolled population lives greater than 10km (as the crow flies) from their practice[1]. Defining smaller network geographies makes it more likely that these people will live outside of the area in which services collaborating and sharing information with that practice will be focused.

- *Napier*: 57,240 population (2013 census)
- *Hastings*: 73,245 population (2013 census)

Issues

As with any mechanism for defining network geographies, the four-locality model does not solve all issues, and brings forth others. As we establish the networks, we need to be aware of the following:

- There will still be some people resident in one locality but enrolled at a practice elsewhere; this could potentially lead to a situation in which they gain services from two networks. For example, a person living in Wairoa may habitually visit a general practice that is close to their workplace in Napier however, for other services (e.g. district nursing or a budget advisor meeting with the family as a group) the Wairoa network would be better placed to help. We need to understand how these inter-network interactions would work, including any flow of funding that is needed to support the right service/right place approach for these people.
- The four locality model still requires the splitting of The Doctors Hastings across two networks (Hastings and Central Hawke's Bay).
- Each network may need an 'anchor' location that acts as a focal point and at which a wide range of services and providers may be accessed. Similar to the South Central Foundation's Nuka headquarters at Anchorage, or Counties Manukau's 'super centres', Wairoa has the IFHC, and the Napier and Central Hawke's Bay Health Centres could act as hubs for each of these networks. We need to consider the options for Hastings, particularly now that the "Kauri" initiative is no longer progressing.
- Community of interest activities could potentially add complexity to network management and operations; any such initiatives would need to be written into business plans and budgets of the wider network as part of the annual and forecast planning. A range of network structures could facilitate these initiatives and options need to be considered by the DHB (Ken Foote's expertise).
- Community of interest activities must not result in inequities between networks (we need to ensure the same quality and availability of services to avoid 'poorer' networks).

RECOMMENDATION

That EMT:

1. Review and endorse the proposed basis for network localities.

1. Information supplied by Adrian Rasmussen, Health Intelligence Team, Health Hawke's Bay.

APPENDIX 1

Division of workloads across team members – secondary services delivered in the community

Service	Alignment structure	Notes
Respiratory services, pulmonary rehabilitation, Māori health, cardiac rehabilitation, physiotherapy, occupational therapy, child development services	Four clusters (Wairoa, Napier, Hastings (incl. Havelock North), and Central Hawke's Bay).	Some specialists work across all four clusters. Education-based services may be only offered online to Wairoa and CHB residents.
Dieticians, speech-language therapy (SLT)	Two clusters (Wairoa and Napier / Hastings and Central Hawke's Bay).	SLTs cycle between community and hospital-based work to ensure skills currency. Also practice-based dieticians at Totara Health.
EngAGE	Six clusters, three in each of Hastings and Napier. Central HB and Wairoa not covered currently.	Roll out to Wairoa and Central HB would involve one cluster in each area.
District nursing	Four clusters (Wairoa/Napier/Hastings/CHB), but the urban ones are each split into three sub-clusters, with multiple staff (nurses and assistants) covering each.	Napier cluster split as per EngAGE although Napier Central locality is too big to service; Hastings cluster split Hastings Health Centre; Totara Health plus Havelock North; rest of Hastings.
Ostomy service, continence service, antenatal, neonatal (nurses and social workers)	Small number of staff and FTEs cover all of Hawke's Bay.	
Social work	Mix of general practice employees working in specific practices and DHB employees working broadly across Hawke’s Bay. Wairoa and Central Hawke's Bay have dedicated DHB staff domiciled in those localities.	General practice employees work with practice only (e.g. HHC). Māori Health social worker (DHB employee) works across four practices. Other DHB social workers tend to support specialist areas (e.g. renal, cancer, paediatrics).
Clinical pharmacy	Linked to individual practices, but groupings are likely to follow EngAGE cluster format.	One staff member is currently positioned across two engAGE clusters; likely to be several pharmacists associated with each cluster, especially where these include large practices.
Diabetes service	No clear geographic approach.	Six Diabetes CNS are active across Hawke's Bay.

WHAKAWATEATIA
HAWKE'S BAY
District Health Board

Business Case

Health and Social Care Networks
Phase One

June 2016

Prepared by Belinda Sleight
Project Manager, Strategic Services

Table of Contents

1.0 EXECUTIVE SUMMARY

This business case recommends that a budget of $130,000 p.a. be approved to support establishment of collaborating networks of health and social service care providers. The purpose of these networks is to provide holistic, joined up care focused on patients/consumers and their family/whānau as partners in their health journeys.

Currently, the health system in Hawke's Bay is not well positioned to respond to emerging challenges and, therefore, we need to design new ways of working that will enable care that is person-centered, sustainable, and effective. Particular challenges include providing care for the growing number of frail older people and those people living with complex long term conditions. Further effort is required to deliver equitable outcomes or access to services for Māori and Pacific populations, and those who are unable to afford, access or navigate the health sector.

The concept of Health and Social Care Networks, as a vehicle for addressing these challenges has been discussed in a range of health governance, management and community forums, and there is now support for networks as a change vehicle under the auspices of Transform and Sustain strategic framework. A programme team is now developing overarching principles by which the networks will be designed, and is working with providers and service users in two early-adopter communities to scope projects that will establish networks in their communities.

Key benefits of the programme include:

- Consumers and their families/whānau get the assistance they need from the right person, right time, right setting.
- Closing gaps between services so that people experience joined up care – not having to explain history to each provider, being able to group interventions to single visits, a holistic approach to wellness that addresses health and the social determinants to health.
- Redesigning services so that they suit consumers and are able to be provided sustainably. Also moving services into the community where they are closer to where people live.
- Building upon existing community strengths; not just current services and infrastructure, but also community spirit, individuals with influence and local knowledge.

Sustainable service provision is a key principle of this programme and, therefore, the focus is on lean managerial structures and redesigning services that fit within current budgets despite the growing demand. This funding will support change leadership, stakeholder engagement and input required for a collaborative community-up programme, and seed funding towards the early activities (initial small collaborative projects that will deliver quick wins and buy-in to the collaborative process). The intention is not to build permanent cost increases into the sector, but to work with what we have in more effective and creative ways.

The establishment of Health and Social Care Networks requires a significant programme of activity and of change management. It is also an opportunity to revitalise our sector and increase sustainability through service affordability, infrastructure and workforce. This collaborative environment will be challenging as it will requires us to work differently, listening to diverse points of view, building and delivering a shared vision (future state) and devolving decision making. This will not happen in one step- we will take a staged approach and build capability within the networks so that the DHB, PHO have confidence in their contractual partners.

2.0 PURPOSE

This business case recommends a budget of $130,000 p.a. be approved to support establishment of collaborating networks of health and social service care providers (termed 'Health and Social Care Networks'). The paper is presented to Executive Management and Clinical Council for approval and release of funds.

3.0 BACKGROUND

In December 2013, the Hawke's Bay health sector released *Transform and Sustain*, which set a strategic direction for health service provision over the next five years. In *Key Intention 8 Transforming Primary Care*, the strategy describes a need to redesign primary and community services so that they become fully integrated, provide care closer to the person's home and are able to provider higher quality through more expansive services. Subsequently, a strategic framework *Transforming Primary and Community Health Care in Hawke's Bay* was developed, in which the concept of clustered service provision and collaboration across providers was first presented.

A Steering Group of senior DHB and PHO management and clinicians, has since spent approximately six months developing the network concept and determining how it could be implemented. Related projects and activities have also begun, that have informed the Group's thinking. These include:

- The HBDHB Health Services Directorates considered services that could be provided in the community and the consideration of some models from elsewhere (e.g. Nuka).
- The Hastings Health Centre and Totara Health joint development included a survey of community requirements, and engaged consumers in consideration of the general practice model of care. Whilst the joint development will now not go ahead, learnings will inform the programme regarding consumer requirements and also how to gain consumer viewpoints.
- The key Wairoa providers are now meeting regularly and have agreed to work together to improve population outcomes. A community meeting in March has solidified support for a network, and a leadership group is now being formed.
- Several stakeholder meetings in Central Hawke's Bay have resulted in a collective of provider and consumer representatives that is now meeting regularly to prioritise service development.
- The EngAGE, District Nursing and Pharmacy Facilitator projects are essentially trialling networks of services in Napier and Hastings. Lessons will be learned from these.
- The DHB and PHO are currently considering how primary care infrastructure should be developed. A single shared care record will be a priority and some research has been undertaken for solutions that may work in Hawke's Bay.
- Training courses in co-design and quality improvement, plus ongoing work by QIPS staff, are increasingly focusing on collaborative models and tools for service redesign.

We are now seeking to identify and secure funding to support a coordinated programme of work that will bring together the learnings and facilitate change projects. This budget will consist of new investment, business as usual, and redirection of existing spend, plus cash and in-kind contributions from other organisations as partners with us in the networks.

4.0 SITUATIONAL ANALYSIS

4.1 Current Situation / Problem

The health system in Hawke's Bay, like the rest of New Zealand will experience a significant growth in the population of frail older people and a further growth in the numbers of people living with complex long term conditions. The health system is currently not designed to deliver equitable outcomes or access to services for Māori and Pacific populations and there are

groups of people who are unable to afford, access or navigate the health sector. This problem is not unique to health. There is a lack of co-ordination between health and social care services that can be frustrating for individuals and lead to lack of engagement and wasted resources.

There is a need for primary care to be better positioned to address acknowledged challenges, to be more connected and collaborative, and to deliver services that are accessible and appropriate for the Hawke's Bay population.

We have proposed to establish a number of networks of collaborating health and social care services that are clustered around geographical communities that work closely together to care for patients that they have in common. Implementation of this proposal will lead to a health service in which the right clinician is delivering an appropriate service in the most sensible location, supported by a network of providers who understand and respond to the needs of the patient and their whānau, who in turn are empowered to manage their own health and social wellness.

A programme of work is now underway, using a phased approach that will enable us to learn as we go and work with those communities and stakeholders that are most ready to engage. Initially the networks, with community input, will focus on delivering current services most appropriately in a manner which is responsive to each community and engages community based resources and facilities effectively. This is the focus of Phase One. This vision will grow over time to support devolved decision making over service design and investment in resources and facilities to clinicians, professionals and community leaders. The time frame to achieve this expanded vision may be different for different communities - this is a long term vision.

4.2 Requirements to be met by this project

Key requirements of Phase One are:

- The DHB, Health Hawke's Bay and each community will have a shared view of the outcomes required of networks and how we will achieve them. This will involve an agreed 'standard' approach to network development, and appropriate tailoring to fit population needs.
- A variety of channels will be in place for stakeholder engagement, and stakeholders (providers and consumers) are co-design partners in vision, planning, service redesign and delivery.
- The communities of Wairoa and Central Hawke's Bay are supported to establish the first Health and Social Care Networks. This includes channelling resources into the networks and developing tools to assist establishment and operation.
- A range of organisations providing services that impact health or the social determinants of health (e.g. education, justice) will be partners in the networks. These organisations will increasingly commit resources to the collaborative networks.
- Progress towards a collaborative environment – a model of care that supports self-care, multidisciplinary teams working with people and families with complex needs, sharing of information across providers to facilitate joined-up care.

High-level time line

In Phase One of the programme (2016-2018) we will:

1. Background work – review examples of good practice from other places to avoid reinventing the wheel; align various projects, existing and new initiatives; review services and considering the most appropriate delivery models; review systems and processes to reflect the collaborative working environment; develop a standard pathway, tools and templates to guide establishment of networks throughout Hawke's Bay.
2. Establish a network in Wairoa
3. Motivate collaboration in Central Hawke's Bay

4. Support the identification of sensible network groupings in Napier and Hastings
5. Initiate the development of the technology platform in primary care.

Each of the individual pieces of work will be subject to appropriate project management rigour and business case processes. Some of these initiatives will be concurrent and will inform each other.

What success will look like?
Successful implementation of Phase One means:

- People find it easy to identify and access the help and services they need because they are health-literate, the services have been designed to be easily understood, and there is additional navigation and kaiawhina assistance if required.
- Existing services will be configured in ways that improve the patient experience and respond better to communities.
- Community resources and facilities are evolving to provide a broad range of services.
- Multi-disciplinary, multi-provider case-management is the established approach for working with people and/or whānau with complex health and social needs.
- General practice clinicians have the time to work with patients who need it. Patients at risk are proactively identified and supported.
- Primary care clinicians have opportunities to increase scopes of practice and develop additional expertise.
- Technology and information is increasingly used for joined up service delivery and to support self-management.
- Networks are supported by nimble, responsive management, using existing resources where possible. Organisations are working collaboratively to get the best value from all publicly funded resources.

4.3 Stakeholders Requirements

Stakeholders grouped as:
Health Consumers / community: This project must deliver better access to a comprehensive range of health services that are joined up, so that health and socio-economic determinants of health are approached holistically. The work must focus on health equity across our population, as significant groups (particularly Maori) are over-represented in our poor health statistics. Tackling these issues must include working with the people (individuals, family/whānau, communities) to design and deliver services that work for them and address the things that matter to them.

Providers of health and social care (primary and secondary health care, community social care): This project must enable providers of health and social care to innovate, so that they are able to better provide for the current needs of our population and anticipate and respond to expected future requirements. We must work with providers to effect sustainable change.

Funders: This stakeholder group requires ways of meeting increasing demand for health care within an environment of constrained budgets. This means that networks must be robust vehicles for change that will deliver the required outcomes in a sustainable manner. To this end, we have designed a staged approach, in which responsibility (devolved decision making) will be stepped up as networks gain experience in managing and commissioning services.

First-mover networks: These communities each have a core group of people (providers and consumers) who recognise that change is needed and who are willing to engage in the change process, albeit to varying extents. These communities (individuals, groups) require support such as managerial expertise, seed funding, tools and systems for collaboration.

4.4 Strategic Alignment

The programme has been established under the auspices of Transform and Sustain, particularly contributing to *Key Intention 8: Transforming primary health care*, and *Key Intention 7 Transforming through integration of rural services*. It has been designed to implement the *Transforming Primary and Community Health Care in Hawke's Bay Strategy*.
To deliver outcomes across the three health triple aim dimensions, the programme will:

- Use a population health approach to identify the needs and aspirations of each community, then design and deliver services that are tailored to meet those requirements.
- Work with health consumers to ensure that services are co-designed to meet their needs, both in terms of the type of care available (the services offered), and also the approach to care (e.g. the model of care).
- Develop and enable smarter working within available funding levels.

The programme is broadly aligns with initiatives and strategic directions nationally. Aspects will be informed by activities achieved by other DHBs – for example, the locality-based grouping of services from Counties Manukau, progressive general practice models of care led by Midlands, and the focus on data and information sharing from Canterbury. The programme's focus on joining up health and social care anticipated the recently refreshed Health Strategy's call for better alignment and collaboration for services working across health and the social determinants of health.

5.0 OPTIONS ANALYSIS

5.1 *Funding an Existing Initiative*

This business case has been developed to support a funding allocation for an existing initiative.

Options for funding the initiative include using business as usual funds, redirecting existing spend, and identifying other sources of funding (particularly cash and in-kind support from potential or actual network partners). We will use each of these sources for various parts of the work programme. However, as there is considerable project-based work to be done, we are requesting investment to support the early-stage innovation and community engagement aspects.

6.0 PROPOSAL RELATED TO IMPLEMENTING THE RECOMMENDED OPTION

6.1 Objectives

The objective of this programme is to support services to work collaboratively across the health and social care spectrum to cluster existing services around geographical communities and to reshape services so that:

- Services are appropriate to prevent ill health, enable people to keep themselves well and independent for as long as possible
- Support the development of quality services that are provided in the community
- Ensure services provided by a wide range of health and social care professionals in the community are better co-ordinated and respond to local need
- Improve communication and information sharing between different health, social care and voluntary sector professionals and community groups
- Facilitate closer working between community based and hospital services, ensuring that patients receive a smooth and safe transition from hospital services to community based services and vice versa.

6.2 Benefits

Benefit	Value or Measure
Delivering more health services in the community	Consumer satisfaction from improved access Multi-disciplinary teams are in place to work with people with complex needs
Services are working collaboratively with other organisations across health and social care	Providers find it easy to refer clients to other relevant services across health and social determinants of health
People find it easy to identify and access the help they need	There are improvements in health outcomes and equity of health outcomes because assistance is holistic and there are less gaps to fall through
Improved sustainability of the primary care workforce	Better staff satisfaction Greater variety of 'generalist' roles that help people navigate services Clinicians have more time available to work with those people who need it most
Technology and information is used effectively to support new ways of working	Greater use of technology for accessing expertise (e.g. teleconference FSAs) Individuals and families/whānau are risk stratified and offered help proactively
Sector-wide improvement in which providers and communities are pulling in the same direction towards improved wellness and equitable health outcomes	Communities are actively engaged in prioritising, planning and delivering wellness initiatives Providers are sharing information that enables holistic, timely intervention and assistance across health and social determinants of health

6.3 Assumptions

1. This is the first phase in a series of activities which will result in establishment of health and social care networks in Hawke's Bay. This is a long term (5+ years) programme of work.
2. The DHB and PHO are philosophically willing to change and are willing to embrace a process of co-design to effect that change.
3. This programme will affect a number of existing projects, initiatives and business-as-usual; these will need to align with the change direction established by this programme.
4. We will work with stakeholders to confirm requirements and relevant models for Hawke's Bay Health and Social Care Networks that empower each community; whilst there will be a 'minimum standard' of requirements (e.g. services offered, reporting requirements) to meet sector and national expectations, tailoring to fit the needs of the locality is a key principle of this initiative.

6.4 Business Impact

Successful implementation of the programme as a whole will have wide-ranging effects across the DHB as a business unit and the health and social care sectors. It will also impact other sectors that provide services that contribute to health and wellness (e.g. education, justice).

Business Management: review of a range of business processes to ensure that they are aligned with collaborative actions. Examples could be those processes used for contracting, human resources planning and recruitment, and budget allocation

People and human resources: movement of service delivery into the community setting, seven-day services, working at top of scope, recruitment of more 'generalists' and enabling roles (case managers, social workers, behaviourists, navigators, primary care assistants). Many of these would be associated with general practice rather than within the hospital/DHB remit, but interacting with the broader range of 'health care professionals' will become normal.

Infrastructure and operation support: A focus on community service delivery/care closer to home and information sharing will create the need for investment in infrastructure, particularly IT tools for collaboration.

Consequential: it is possible that the proposed proactive identification of people at risk may increase demand for services in the short-to-medium term. The programme's premise is that earlier intervention will decrease demand for higher-acuity services, however it may take some time to achieve this state.

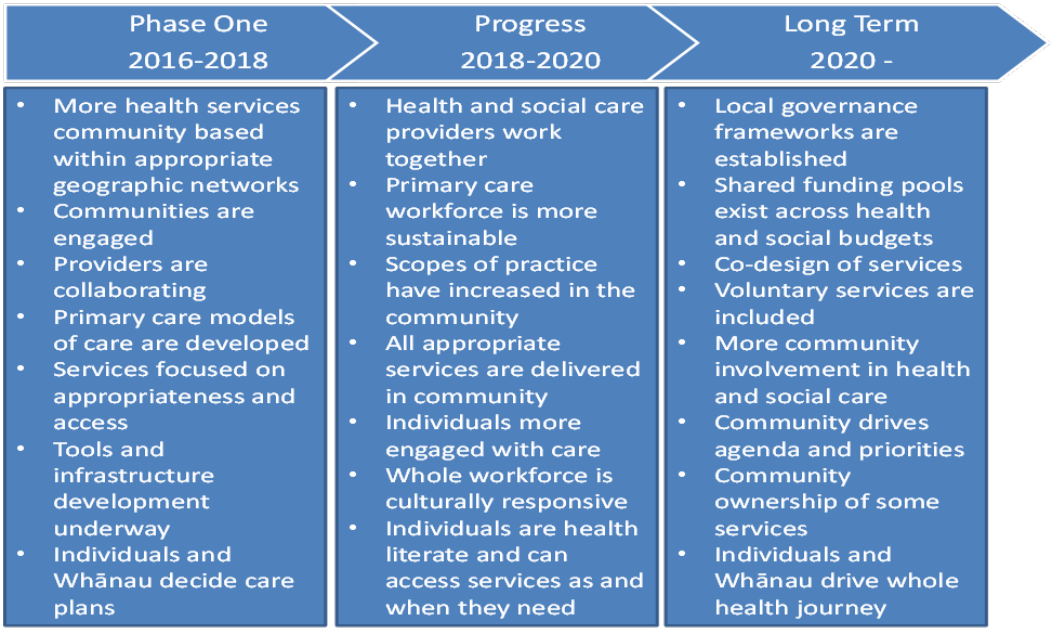
6.5 Approach

This is a programme of work involving a number of projects, namely the high-level design of a standard network configuration (the "Core Network Expertise' project) plus network establishment projects in each of the localities (four in total). Additional work will centre on better aligning primary care IT (patient management systems) with collaborative activity.

The overall programme is summarised in the diagram below; this business case relates to Phase One activities, broken into two stages aligned to the planning calendar as follows:

1. Stage One: Jan 2016 – June 2017 (18 months)
2. Stage Two: July 2017 – June 2018 (one year)

The focus of Phase One will be to cluster existing services around geographical communities and use the design of these services as a lever to engage providers, other public services, Iwi, NGOs and voluntary organisations in the concept of community networks. We will begin with health services and social care providers that are ready to act, and will invite other community partners to also review their services through an aligned approach.



6.6 Estimated Timeline (Stage One, Phase One)

High Level Milestone	Finish Date
1. Programme Start up and planning • Project Manager appointment / TOR signed off/ Steering Group established • Stakeholder analysis and Comms Plan/ Website completed • Project Planning documentation created: Risk Plan, Benefits Plan; Quality Plan; Project Budget • Project Plan acceptance	March – April 2016
2. Core Network Expertise Project: Project Management • Agree TOR – Establish project groups – communication plan etc. • Engagement and communication with Stakeholders • Complete work required and confirm acceptability of deliverables / Monitor and demonstrate benefits • Project closure including Project Completion Evaluation	Mar – Sep 2016
3. Establishing a network project in Wairoa	Jul – Dec 2016
4. Motivating collaboration in Central Hawke's Bay	March – Dec 2016
5. Supporting the identification of sensible network groupings in Napier and Hastings	Aug – Dec 2016
6. Initiating the development of the technology platform in primary care.	March – Dec 2016
7. Review work to date and develop plan for Jan – Dec 2017.	Nov 16 – Jan 17
8. Complete Work as outlined in plan for Jan – Dec 2017.	Jan – Dec 2017
9. Phase Close - Next Phase Plan Review work to date and develop / approve next steps action plan e.g. programme completion evaluation or refreshed TOR	Oct – Dec 2017

6.7 Interrelated Projects

Project Name	Interdependency description
Patient Experience	Will inform this project by providing patient insight to service requirements and information on patient profiling by geographic practice area
EngAGE; DN GP Alignment; Clinical Pharmacy Facilitators	Information on existing models of service delivery and potential geographical networks
Urgent Care	Some of these services, co-designed with primary care stakeholders, may become part of one or more networks. This may motivate collaboration
Customer Focused Booking	Influenced by, and influences, models of care that could be adopted by practices within a network
Health Literacy	Health literacy will be a key component of models of care implemented by general practices within networks
Model of Care support in Primary Care	PHO project to develop a centre of knowledge regarding general practice models of care. Will inform and assist general practices

6.8 Risk Analysis

Risk	Risk Mitigation Approach
Lack of primary care engagement	Early and clear communication to sell benefits, address concerns; gain their involvement in co-design through workshops, feedback opportunities.
Lack of engagement with secondary care	Senior clinicians to act as champions for the initiative; keep them fully informed of/involved in the project's work programme. Regular communications and opportunities to contribute in the co-design process.
Project doesn't adequately address consumer priorities	Ensure there are ways to gather the consumer voice in each locality. Ensure that there is good consumer representation on the Stakeholder Group; this group must be representative of our population and/or have strong networks into our population.
Project, programme and change fatigue	Communicate the vision and engage stakeholders at an early stage so that they own the solutions.
Scale of what we're trying to achieve	Low impact for this current project stage, but recognised as considerably higher likelihood and impact for network implementation. Stage implementation projects, concentrating on those groups most able to move forward as early adopters, so that we can learn from mistakes. Recognise the need to learn from experience.
Too busy keeping the current state afloat	Adequately resource the project (staff time, cash) to ensure that there is enough 'space' to effect change.
New ways of working/new relationships (as equal partners) that parties are not used to (working in partnership with consumers	Conduct activities to address gaps in knowledge/skills/experience. Be clear that this is change behaviour and all parties need to take responsibility for engagement and the resulting outputs.
Governance of networks; how do we account for them?	Build robust processes based on best practice.
Duplication of efforts across other T&S projects (e.g. patient experience, urgent care, AIM 24/7, etc)	Project Manager to get a good understanding of results from other projects, and synthesise the lessons.

6.9 Financing the Project

The requested funding allocation of $130,000 will be used to support (a) across-programme enablers and (b) specific activities within the network establishment projects. An indicative budget of Phase One (covering two years) is presented below.

	2016/17	2017/18
Programme enablers		
Consumer engagement tools	$ 15,000	$ 15,000
Communications, meeting costs, travel	$ 15,000	$ 15,000
Wairoa establishment		
Backfill / project lead	$ 50,000	$ 50,000
Meeting costs (e.g. koha, facilitation, catering)	$ 5,000	$ 5,000
Initial projects/ quick wins	$ 20,000	$ 20,000
Central Hawke's Bay establishment		
Meeting costs (e.g. koha, facilitation, catering)	$ 5,000	$ 5,000
Initial projects/ quick wins	$ 20,000	$ 20,000
Napier establishment		
Meeting costs (e.g. koha, facilitation, catering)		$ 5,000
Initial projects/ quick wins		$ 20,000
Hastings establishment		
Meeting costs (e.g. koha, facilitation, catering)		$ 5,000
Initial projects/ quick wins		$ 20,000
	$ 130,000	$ 180,000

Assumptions/notes:

- All other costs associated with this programme will be met by redirection of existing spend (including staff) into the networks.
- We propose to second 0.5 FTE to act as Wairoa change leader for the establishment phase. This commitment is proposed 2 years (24 months), beginning as soon as possible. A position description for the Change Leader role is attached (Appendix 1); responsibility for the backfill position resides with the Acting Service Director Rural Oral & Community.
- Direct employment costs of staff involved in the programme will be covered from existing budgets and redirection of resources.
- In year 2, we will cover the additional spend either through further redirection of resources or a further investment bid.

6.10 Next Steps

The next steps for implementation include:

- Recruiting back-fill for the Wairoa Integrated Family Health Centre Manager, so that resource is available for leading Network establishment activities.
- Establishing Network Leadership teams in each of Central Hawke's Bay and Wairoa, to lead the early-stage activities (e.g. identifying priorities, analysing data (needs/gaps and strengths/assets), community engagement, shared locality-based vision and values).
- Establishing various stakeholder groups as required by the community (this may be a provider group, a consumer liaison group, special interest groups (e.g. youth health collective); these groups will inform priorities for action, will be key channels for communication with stakeholders, and will be partners in co-design activities.

APPENDICES

Appendix 1: Position Profile – Wairoa Network Establishment Change Leader

Hawke's Bay
District Health Board
Position Profile / Terms & Conditions

Position holder (title)	Wairoa Network Establishment Change Leader 0.5 FTE for 2 years
Reports to (title)	Head of Strategic Services Work plan accountability to Wairoa Network Leadership Team
Department / Service	Strategic Services; Planning, Informatics and Finance
Purpose of the position	▪ To use relationship, motivation and negotiation skills to build trust between stakeholders and drive change within the health and social care sectors that serve the Wairoa community. ▪ To lead and project manage transformational change projects, including the planning, delegating, monitoring, and motivating functions, to achieve the required outcomes and benefits within the expected targets for time, cost, and quality. ▪ To lead the development of the leadership model and programme plan that will set up and implement a Health and Social Care Network for Wairoa. ▪ To recognise and support the Transform and Sustain Strategy by delivering real change in service delivery in Wairoa, through innovative leadership, business model development, and models of care that will improve health and wellness outcomes for the population. This work in Wairoa will directly inform the design and implementation of similar models across Hawke's Bay. ▪ To embed across Wairoa's health sector providers a culture of person and whānau centred care as per the agreed model of care and business model. ▪ To build and maintain relationships across the stakeholder community, including consumers, providers and funders, ensuring that stakeholder partnership is central to all redesign efforts, identification of priorities, and decision making. ▪ To work intersectorally, being recognised as a leader of positive transformation across a range of sectors and organisations that impact health and wellness; examples are social care, education, and justice sectors, iwi groups, and community groups (NGOs, churches, etc).

Working Relationships

Internal	External
▪ Chief Executive Officer ▪ Chief Operating Officer ▪ Company Secretary ▪ HBDHB and Health Hawke's Bay leadership teams as sponsoring groups for the project. ▪ Health and Social Care Programme Manager ▪ Project sponsors, steering committees and stakeholders ▪ HBDHB Programme Management Office Manager ▪ Project Support service staff including: Finance, Quality and Patient Safety, Communications, Information Services, Business Intelligence; Facilities, Procurement, Planning, Strategic Services, Consumer groups, Human Resources ▪ Māori Health ▪ Committees, teams and groups involved in the governance of the health sector & related Project Managers (DN GP Alignment; Urgent Care; engAGE; Clinical Pharmacy Facilitators; Patient Experience) ▪ Wairoa Health Centre	▪ Wairoa Network Leadership Group ▪ Wairoa project team members and support resources ▪ Stakeholders of the development of Health and Social Care Networks, specifically general practice teams, Māori and other community providers, rangatahi advisory group, whānau and the community. ▪ Taiwhenua o te Wairoa

Dimensions

Expenditure & budget / forecast for which accountable	None currently. However, the Change Leader will be expected to competently manage any resources allocated to the projects during their lifecycle. This will include effective processes associated with project budget management including development of funding applications for resource outside any allocated project budget.
Challenges & Problem solving	Challenges for the role include: ▪ To work autonomously with minimum supervision but within a clear project process (maintained by the Project Management Office), and a strategic framework and direction (the "Transform & Sustain" strategy). ▪ To be a dynamic change agent, getting things done with a sound application of change management methodologies. ▪ To deal with complexity and diversity across the varying stakeholder views. ▪ To have excellent interpersonal skills as the approach involves achieving things through the coordination and alignment of staff both internal and external to the organisation, without direct line management authority. ▪ To have sufficient gravitas, and authority to gain the respect of senior managers and clinicians who will be involved in, or affected by, project delivery. To be able to communicate clearly and effectively in writing (including business case development) and in presentation to audiences. ▪ To be methodical, systematic, and persistent in working through problems issues, and obstacles to achieve progress. ▪ To have the intellectual capacity and flexibility to move between, and lead or facilitate complex change and projects covering a diverse range of issues and services. ▪ To be able to work to deadlines in delivering project milestones, progress reports, and evaluations.
Number of staff reports	No Direct Reports but requires coordination of many staff both internal and external to the organisation and the wider community through the project process.
Delegations & Decision	▪ Delegated authority may be transferred to this role. ▪ Must be confident to make decisions or recommendations relating to the project as per agreed delegated authority. ▪ Discretion is required to be exercised in releasing confidential information to the appropriate parties.
Other Indicators	Works with formal, informal and virtual teams in a collaborative structure. With stakeholders, establish a workplan for Wairoa network that includes outcome measures to assess results end of year one and end of year two.


Our vision
HEALTHY
HAWKE'S BAY
TE HAUORA O
TE MATAU-Ā-MĀUI
Excellent health services working in partnership to improve the health and wellbeing 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

Key Accountabilities

CORE ROLE	
Tasks (how it is achieved)	**How it will be measured (KPI):**
Relationships and Leadership: ▪ Build and maintain relationships across the varied stakeholder groups. ▪ Use relationship and negotiation skills to gain buy-in and partnership across diverse stakeholder groups. ▪ Is available to engage with stakeholders at all levels to gain alignment, progress projects and initiatives, and champion a collaborative working environment. ▪ Resolve issues proactively and sensitively. ▪ Act as the first point of contact for the Network Establishment work programme.	Is recognised as the leader of the programme of work that will establish a Health and Socail Care Network in Wairoa. Maintains a positive working environment in which stakeholder partnership is recognisable in all processes, outputs and outcomes. Effective relationships and risk management processes ensure that the project remains on track despite the complexity of the changes envisaged by the work plan. Effective escalation processes are followed when required. Programme stakeholders understand and buy into the programme plan. Successful delivery of the programme is accomplished Programme benefits are demonstrated in the organisation and communicated across the sector.
Lead change: • Work with service providers, consumers and funders to develop an implementation and change management strategy based on population health and asset mapping approaches. • Work with stakeholders to foster participation in the project to ensure their on-going ownership of the change. This will include championing co-design and appreciative inquiry methodologies as key tools for change. • Use influence appropriately to champion and progress positive change. • Communication strategies demonstrate effective engagement of all key stakeholders in an appropriate way including: effective meetings / minutes, formal communications and adhoc communications. • Timely and smooth transition from the old systems to the new.	Robust stakeholder analysis and implementation of a communication plan has resulted in a community of varying viewpoints actively engaged in the project, and contributing to the work plan. Stakeholders requirements for effective service and service delivery change are identified, documented and signed off. Positive feedback from stakeholders on participation opportunities. A commitment to person and whānau-centred care is perceptible in all project processes and outputs. Use of change impact analysis is evident during project planning, such that impacts are known and can be mitigated to facilitate smooth transition.
Deliver project implementation: • Manage project resources effectively including engagement, delegation, and performance management. • Ensure delivery of the expected project deliverables on time, within budget and meeting the requirements that have been agreed. • Effective communication with project sponsor, steering group and all project stakeholders through coordinated implementation of the agreed communication plan. • Managers the day to day work delivery and provides timely reporting of progress as per HBDHB project management standards.	Demonstrates application of evidence based approaches in preparing project implementation plans. Project resources work effectively or performance management is in place. Reporting requirements are met. Expected benefits accruing throughout the project and after its completion are identified in the project planning process, and realisation of these benefits is achieved according to the timeframes envisaged by the benefit realisation plan. Implementation timelines are met.

	Establishes measures to monitor and demonstrate success of the project throughout its duration.

OCCUPATIONAL HEALTH & SAFETY	
Tasks (how it is achieved): Displays commitment through actively supporting all health and safety initiatives. Ensures all staff/colleagues maintain adequate safety standards on the job through consultation, training and supervision. Ensures own and others safety at all times. Complies with policies, procedures and safe systems of work. Reports all incidents/accidents, including near misses in a timely fashion. Is involved in health and safety through participation and consultation.	**How it will be measured (KPI):** Evidence of participation in health and safety activities. Demonstrates support of staff/colleagues to maintain safe systems of work. Evidence of compliance with relevant health and safety policies, procedures and event reporting.

Key Competencies

DRIVE FOR RESULTS	
Tasks (how it is achieved): Demonstrates the ability to drive self and others to deliver results e.g. MOH targets, KPI's, service plans Consistently and constantly fosters joint problem solving and decision making across the team and wider Manages the balance between meeting both organisational wide targets and budget requirements Demonstrates the following: ▪ Strong prioritisation skills ▪ Communication skills (both verbal and written) and ▪ The running of effective meetings	**How it will be measured (KPI):** Organisation meets the defined targets within budget Team meetings held on a monthly basis are effective and results focused Monthly reports and business case's presented professionally, with effective decision making

BUILDING EFFECTIVE TEAMS	
Tasks (how it is achieved): Staff performance development plans are aligned with the approved service/continuum plan. Creates strong morale and spirit in his/her team to foster a feeling of belonging. Demonstrates the ability to blend people into teams when needed to work autonomously e.g. leading project teams, participation in projects, forums. Fosters open dialogues and joint problem solving and decision making. Defines success in terms of the whole team and shares wins and successes. Demonstrates the ability to effectively lead and participate in organisational wide project teams as required.	**How it will be measured (KPI):** 90% of performance appraisals are completed on time with objectives and plans incorporated. Team meetings are run on a monthly basis. Successes are recognised and celebrated on both an individual and team level. Projects are implemented effectively within the parameters of the terms of reference.

CUSTOMER SERVICE	
Tasks (how it is achieved): Open and responsive to customer needs. Demonstrate an understanding of continuous quality improvement.	**How it will be measured (KPI):** Demonstrates a commitment to customer service and continuous quality improvement, through interaction with patient/clients and other customers. Identifies customer needs and offers ideas for quality improvement. Effective management of customers/situations.

HONOURING TREATY OF WAITANGI OBLIGATIONS	
Tasks (how it is achieved): Demonstrates understanding of the principles of the Treaty of Waitangi. Ensure the principles of partnership, protection and participation are applied to day to day work. Ensures procedures do not discriminate against Māori.	**How it will be measured (KPI):** Evidence of the principles applied in work practice.

Essential and Desirable Criteria: Qualifications / Skills / Experience

Essential	
Treaty of Waitangi Responsiveness (cultural safety)	Demonstrates the ability to engage with people in manner that the person(s) determines to be culturally safe. Demonstrates ability to apply the Treaty of Waitangi within the Service.
Qualifications (e.g. tertiary, professional)	▪ Tertiary level qualification (minimum BA level) ▪ Formal training or qualification in Project Management (prefer PMI PMP, PRINCE2 Practitioner, MSP)
Business / Technical Skills (e.g., computing, negotiating, leadership, project management)	▪ Ability to write coherent meaningful project briefs, project implementation documents; business cases and other relevant documents. ▪ Good Facilitation Skills (Vision development etc.). ▪ Competent User of Microsoft Office applications especially: Word; Excel; Outlook ▪ Evidence of applied skills and successful outcomes in negotiating, and leadership roles. ▪ Evidence of strong written and presentational skills. ▪ Evidence of managing complex programmes to time and budget to deliver required outcomes. ▪ Evidence of self-awareness, and emotional and political intelligence. ▪ Good level of numeracy and evidence of working with financial and informatics analysis. ▪ Evidences awareness of project lifecycles for construction, IT and service improvement or redesign projects.
Experience (technical and behavioural)	Shows commitment to, and demonstrates the behaviours of the health sector: ▪ 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) A track record of leading and delivering projects and change in a complex environment. Familiarity with project management software.

Desirable	
	▪ Formal Training or qualification in Change management ▪ Experience of working with other agencies on the wider determinants of health Previous experience in leading and delivering projects and change in a health environment ▪ Experience of working with other agencies on the wider determinants of health.

Recruitment Details

Position Title	Change Leader
Hours of Work	40 hours per fortnight. Fixed term 2 years (24 months)
Salary & Employment Agreement Coverage	Secondment.
Date	June 2016

PRIMARY CARE – SMOKE FREE UPDATE

Liz Stockley and Victoria Speers

HAWKE'S BAY District Health Board Whakawāteatia	**Implementation of the Hawkes Bay Clinical Governance Committee Structures**
	For the attention of: **HB Clinical Council**
Document Owner: Document Author(s):	Kate Coley Kate Coley
Reviewed by:	Chris McKenna , Ken Foote
Month:	July 2016
Consideration:	For Discussion, Information and Approval

8

RECOMMENDATION

That Clinical Council:

- **Endorse** the proposed Clinical Committee structure, including purpose, meeting and reporting requirements
- **Endorse** the proposed Advisory Groups meeting and reporting requirements
- **Note** the actions and implementation timeframe on page 6

Purpose

Purpose of this paper is to outline the high level implementation plan for the Clinical Governance Committee structure which was endorsed by Clinical Council in April 2016.

Background

The Clinical Council was established in September 2010. The purpose of this was to provide clinically led decision making and advice to the Hawkes Bay health system on resource allocation and key service changes. The Council also provides clinical leadership and oversight for clinical quality and patient safety across the sector. Over time a number of sub committees have been established, which have a formal reporting and accountability line to the Clinical Council.

There are a number of other committees that are not formal Clinical Council sub committees, however they provide informational reports to Clinical Council due to their chairs being members of Clinical Council – these include the Health Services Patient Safety Advisory Group (PSAG), and the Nursing & Midwifery Leadership Council. In addition to the above formal and informal committees of Clinical Council, there are a number of committees within Hawkes Bay DHB Health services ensuring that we meet both legislative and Health & Disability Standards including Policy, Credentialing, Restraint and Pharmacy & Therapeutics. In Primary care, the Clinical Advisory Committee (CAG) is the advisory committee set up to provide the Health HB Board with clinical advice and information. The clinical lead of that committee is also a member of Clinical Council and provides feedback and updates following their monthly meetings.

This clinical governance structure was put in place in late 2011, and feedback was sought in 2015 as to how we should refine and refresh this clinical governance structure to meet the needs of the wider health sector with the implementation of the Working in Partnership for Quality Framework.

In April 2016, Clinical Council received a presentation outlining the proposed overarching clinical governance committee structure, which was endorsed. The paper outlines more detail around the committees and advisory groups and the proposed implementation that will need to be undertaken to ensure that this governance structure provides assurance to Clinical Council around patient safety ad clinical quality matters.

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.

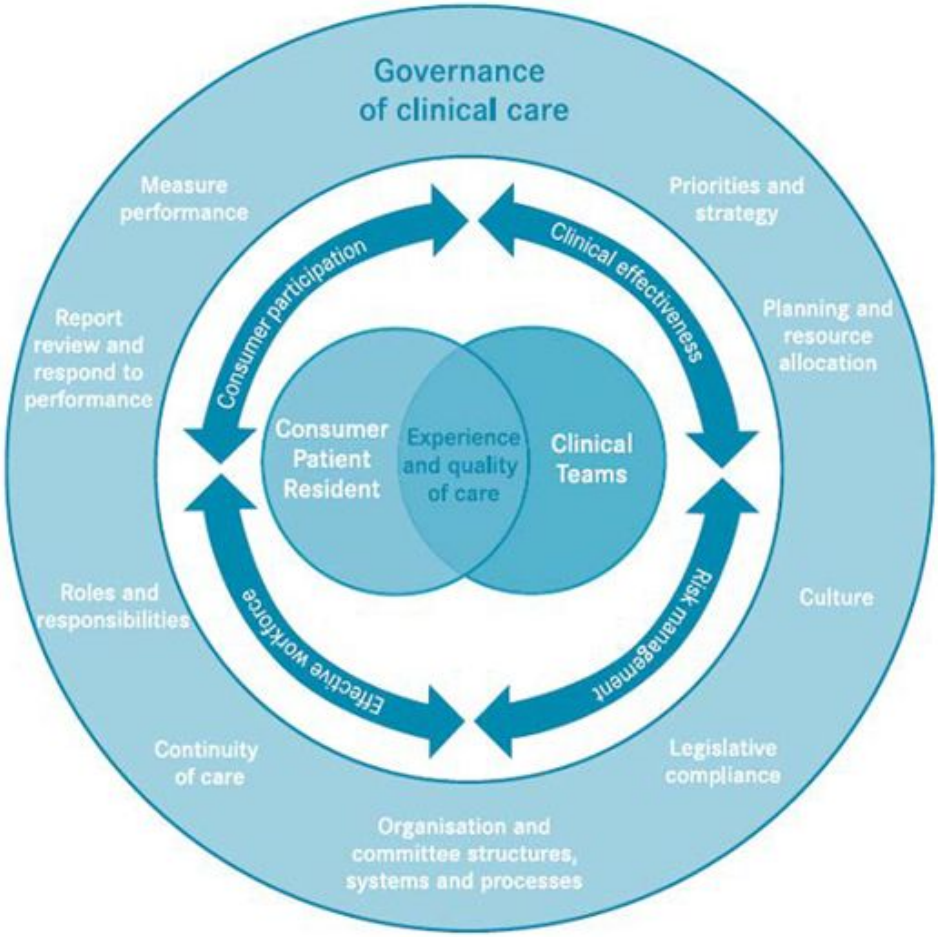
Clinical Governance

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]

Principles:

- Strong clinical leadership & ownership
- 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

[1] Victorian Clinical Governance Policy Framework, 2009

Implementation of the HB Health Sector Clinical Governance Committee Structure

In April 2016 Clinical Council endorsed the proposed new clinical governance structure for the Hawkes Bay health sector. The proposed structure is detailed in Appendix 1

Having endorsed the structure, the key is to ensure effective implementation so that it meets the requirements of the sector and aligns to the principles of effective clinical governance. This will take a period of time to implement across the sector due to the various levels of maturity around information gathering and reporting mechanisms.

The following outlines the key implementation steps.

1. Clinical Council

The overarching purpose of the Clinical Council to provide clinical leadership and oversight for clinical quality and patient safety across the sector will remain unchanged. As the HB clinical governance group the council needs to provide assurance to the Board that the services provided are safe, effective, appropriate, consumer focussed, accessible and efficient. These drivers align to the recognised six dimensions of quality.

The Clinical Council will continue to maintain the current structure and representation from across the HB Health sector. With the change of governance structure reporting through to the council, it is proposed that the Terms of Reference be refreshed to reflect these changes. In addition with the appointment of a new Medical Director, QIPS it is also recommended that at the AGM this position is appointed to sit on Clinical Council.

2. Clinical Council Committees

There will be five clinical council committees each chaired by a Clinical Council Clinician or Executive member, supported by a deputy chair.

It is proposed that these committees 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.

These reports will also be shared across other advisory groups and operational clinical teams to ensure effective information flow. The Chair and Deputy will be responsible for drawing together the report and providing this to Clinical Council as required.

The below provides an overarching purpose for each of the Clinical Council committees:

- ***Research, Education & Training Committee*** – provide oversight for best practice, innovation and development of all health professional groups to ensure competent practice which enables better patient outcomes.

- ***Clinical Effectiveness & Audit Committee*** – ensure an effective overarching clinical pathways and audit programme of systems and processes is in place, to meet both legislative and health & disability standards. This committee will also provide advice to Clinical Council on meeting stakeholder requirements for standards of prescribing, radiology and laboratory services across the HB community.

- ***Patient Safety & Risk Management*** – ensure that across the sector all risks are identified, mitigated and managed effectively, with necessary escalation processes implemented. Provide assurance to Clinical Council that all patient safety matters, incidence and issues are

effectively investigated, recommendations implemented and learnings shared across the sector.

- ***Patient Experience –*** ensure that through all mechanisms consumer and whanau feedback on their experiences utilising the services in Hawkes Bay is shared, learnings identified and improvements are continually made to all services.

- ***Information Management*** – provide oversight to ensure all documentation, policy and records meet the legislative and health and disability standards as required. Ensure that the quality and integrity of patient information is well managed, of high quality and maintain privacy standards. Review and manages all OIA requests identifying themes, issues and areas for potential improvement.

It is expected that these committees will be made up of representatives from the advisory groups sitting underneath their committee (potentially the chair), with further representation from Clinical Council, operational teams from across the sector and consumer representation.

The Terms of Reference and potential representation for these Clinical Council Committees will be developed by a working group of the Clinical Council and endorsed by Clinical Council in September.

3. Advisory Groups

There are a number of existing and new advisory group proposed in the new structure which will sit underneath the clinical council committees. It is proposed that these advisory groups establish / review their terms of reference and representation to again ensure that there is cross sector representation. The new advisory groups e.g. Audit, Patient at Risk will be drawn together in the first instance by the Chair and Deputy of the relevant Clinical Council Committee.

It is envisaged that these advisory groups will meet on a monthly basis and the chairs will represent their advisory group with the relevant Clinical Council Committee on a bi-monthly basis. A full written report will be provided at the bi-monthly meeting.

Information to and from these advisory groups will be both up to the Clinical Council Committee and to the operational clinical leadership teams.

4. Operational Clinical Governance

As part of the overarching clinical governance structure it is imperative that the operational teams become more accountable for the ownership of patient safety and clinical quality matters. It is proposed that each operational team will include clinical governance matters within their standard monthly meetings, covering key aspects of the clinical governance framework, including risk, events, falls, privacy, patient experience, audits etc.

It would be the expectation that any events, breaches, issues from within operational teams will be fully investigated by the teams and reports provided to the relevant advisory group as required. These groups would also be responsible for implementing any improvements, and recommendations and again feeding back progress back to the advisory group.

5. General

There are a number of other matters to be endorsed and implemented to ensure these structures are effective. These are as follows:

- The development of Terms of Reference and proposed representation for the Clinical Council Committees will be undertaken by a Clinical Council working Group and presented to Clinical Council for endorsement. A similar process will be undertaken with the development of the Terms of reference and representation on Advisory Groups thereafter.

- Chairs and Deputy Chairs for Clinical Council Committees will be recommended from across the Clinical Council membership and endorsed as part of the development of their terms of reference.

- Representation for both the Clinical Council Committees and Advisory Groups will be sought from across the sector, ensuring that there is clinical council representation, consumer representation, and operational and clinical representation.

- With the number of clinical council committees and advisory groups it is key that we establish and detail an annual meeting and reporting schedule. This will be developed over the coming quarter so that it is visible across the sector.

- It is proposed that administration support for the Clinical Committees will be provided by the QIPS team. For advisory Groups the administration arrangements will be managed by the Chair of the Advisory Group.

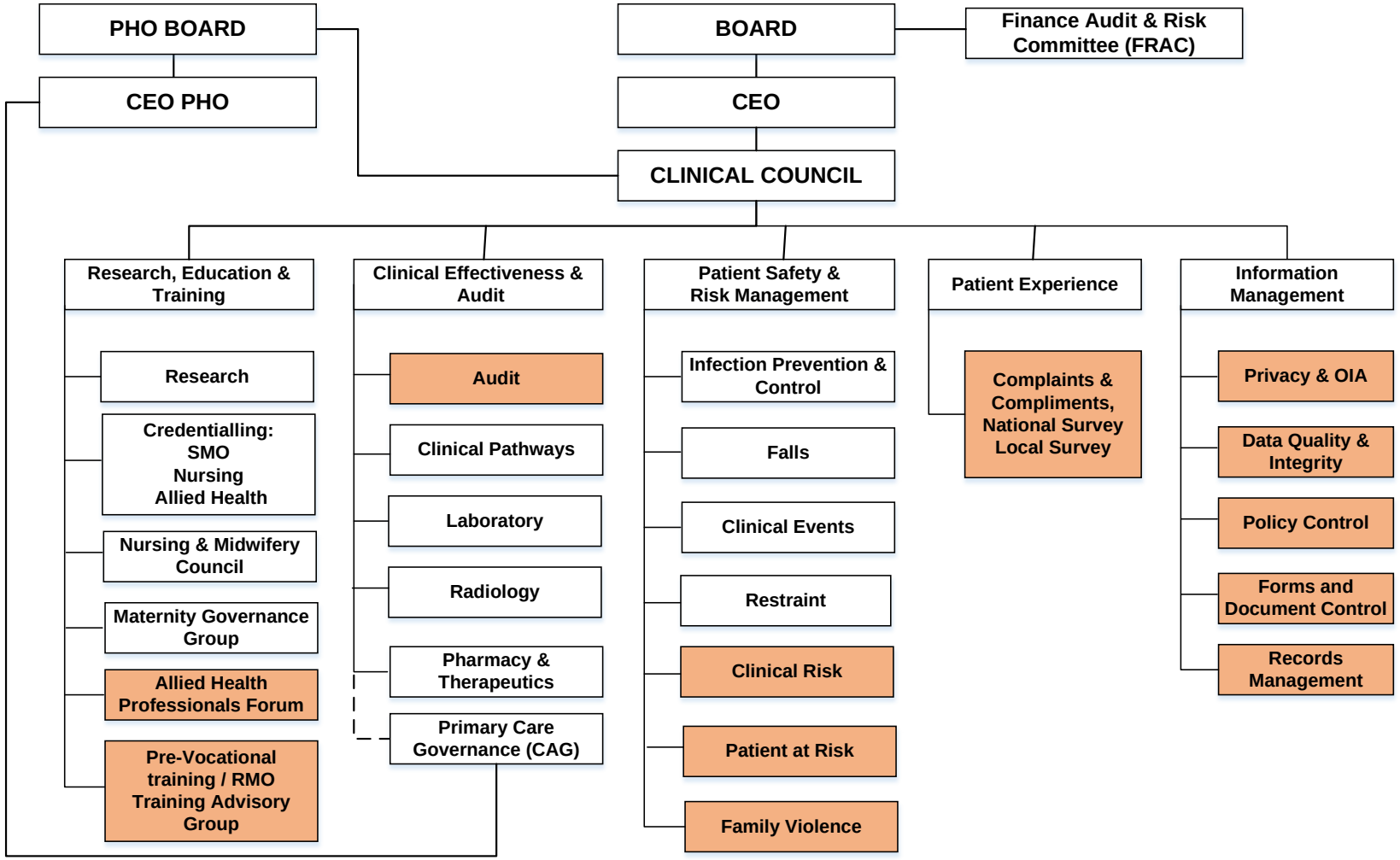
- To support great visibility of information a new Quality performance monitoring dashboard will be developed and reported to Clinical Council and FRAC on a quarterly basis. This will detail indicators on patient safety, effectiveness and experience from across the sector.

- It is clear that the structure will take time to evolve and to support this implementation it is important that there is a mechanism for gathering information around complaints, risks, events incidence etc from across the whole of the system. At present there is a well-established hospital based event management system, however there are multiple approaches across the primary sector. A further paper will be presented to Clinical Council in August detailing the proposed new system. It is envisaged that following endorsement it will take between 6-12 months to fully implement this across the sector.

Next Steps

Activity	Responsibility	Timeframe
Set up briefing meeting with chairs of current committees around the new structure	Clinical Council co-chairs	July
Draft Terms of References & identify representatives for Clinical Committees	Clinical Council working group	September
Develop meeting schedule to meet Clinical Council reporting requirements	Kate Coley / Ken Foote	September
Refresh Terms of Reference for existing advisory groups. Consider refresh of representatives	Clinical Council working group with current chairs	October
Establish new Terms of Reference and representation for new Advisory Groups	Clinical Council working group with current chairs	October
Operational meetings refreshed to include standard agenda items relating to clinical governance	QIPS Team with operational teams	August
Development of Quality Dashboard	Kate Coley	October
Implementation of new Event management system	Kate Coley	February 2017

Appendix 1 – Clinical Governance Committee Structure



HAWKE'S BAY District Health Board Whakawāteatia	**Renal Project – Stage 4** **Facility development update**
	For the attention of: **HB Clinical Council**
Document Owner: Document Author(s):	Paula Jones Megan Knowles
Reviewed by:	Health Services Leadership Group and Executive Management Team
Capital Project Number	CP10432.200
Month:	July 2016
Consideration:	For Information

RECOMMENDATION

That HB Clinical Council:

Note the progress update and future key milestones.

OVERVIEW

Key phases of activity since approval of the Business Case in September 2015 have been:

Planning Stage

The planning stage has gone smoothly and been well supported by users, consultants and consumer representatives.
The preliminary design was completed and signed off by the User Group in Jan 2016.
The only notable changes from the concept plan included in the Business Case were the capacity of the waiting area and the sluice facilities for PD training. These issues were resolved without significant increase to the floor area, refer to Appendix 1 for the proposed floor plan.
The subsequent design phases have gone smoothly and the project was submitted for Building Consent approval at the end of May 2016.

Procurement Planning

Work is currently underway forming procurement plans for several strategic projects in the 2016/2017 capital year. Initial indications in late 2015 signalled an alignment of the Endoscopy project and the Renal service project in October 2016. This has now shifted with the Renal project being ready for tender in July 2016. After talks with three of the tier one construction companies in Hawke's Bay, it is has been established that there would be little cost or quality advantages in combining these tenders. However consideration will be given to tendering the smaller North Wing project with the Renal project tender.
Indications from the construction teams show an increased level of activity in late 2016 through to the 2017 calendar year. Several tier one companies are working close to capacity and discussions relating to tender dates have been completed. At this stage three local firms have indicated that they will participate in a competitive tender. Considerations to other companies will be given on completion of the initial registration of interest.

PROJECT BUDGET

The project has an approved budget of $2.140M and the spend to date is $196,134.
The Cost Estimate Report produced by RLB at the end of the Preliminary Design stage (Feb 2016) was in line with the Concept Design costings included in the Business Case. The QS has reviewed the final design documentation and confirmed there have been no significant changes that would affect the estimate figures.

The breakdown of costs is as follows;

Main Build*	$1,355,000
Siteworks and Landscaping	$20,000
Decanting & Temporary Accommodation	$60,000
FF&E	$140,000
IT/IS	$55,000
Signage	$20,000
Consents & Legal Fees	$10,000
Professional Fees	$280,000
Contingency	$200,000
TOTAL	**$2,140,000**

- This figure has a degree of accuracy of +/- 10%

Project Risks

Plans to temporarily relocate renal dialysis home training services during the construction phase into the in-centre dialysis unit were included in the business case. Due to demand in the in-centre it is unlikely this will be able to be facilitated within current operational budget, and may require additional resourced shifts to accommodate.

Mitigating strategies include the project team currently exploring alternative options and locations to facilitate renal dialysis home training temporarily without the need to request additional funding. Also, the construction methodology and programme will be designed in order to minimise this risk by reducing the period for which renal dialysis home training needs to be temporarily relocated.

PROJECT PROGRAMME

The project is currently running ahead of schedule as a result of the design phase progressing better than expected, this was due to several factors;

- There have been no major scope changes from the concept plan
- The seismic review of Old Ballantyne House was more favourable than first indicated during preparation of the Business Case
- Less structural detailing was required from the Engineer
- Less work required around Biomed workshop means this team does not need to be relocated as initially planned, therefore the relocation planning has been simplified
- The Architect on the project is particularly competent and professional in the delivery of project documentation

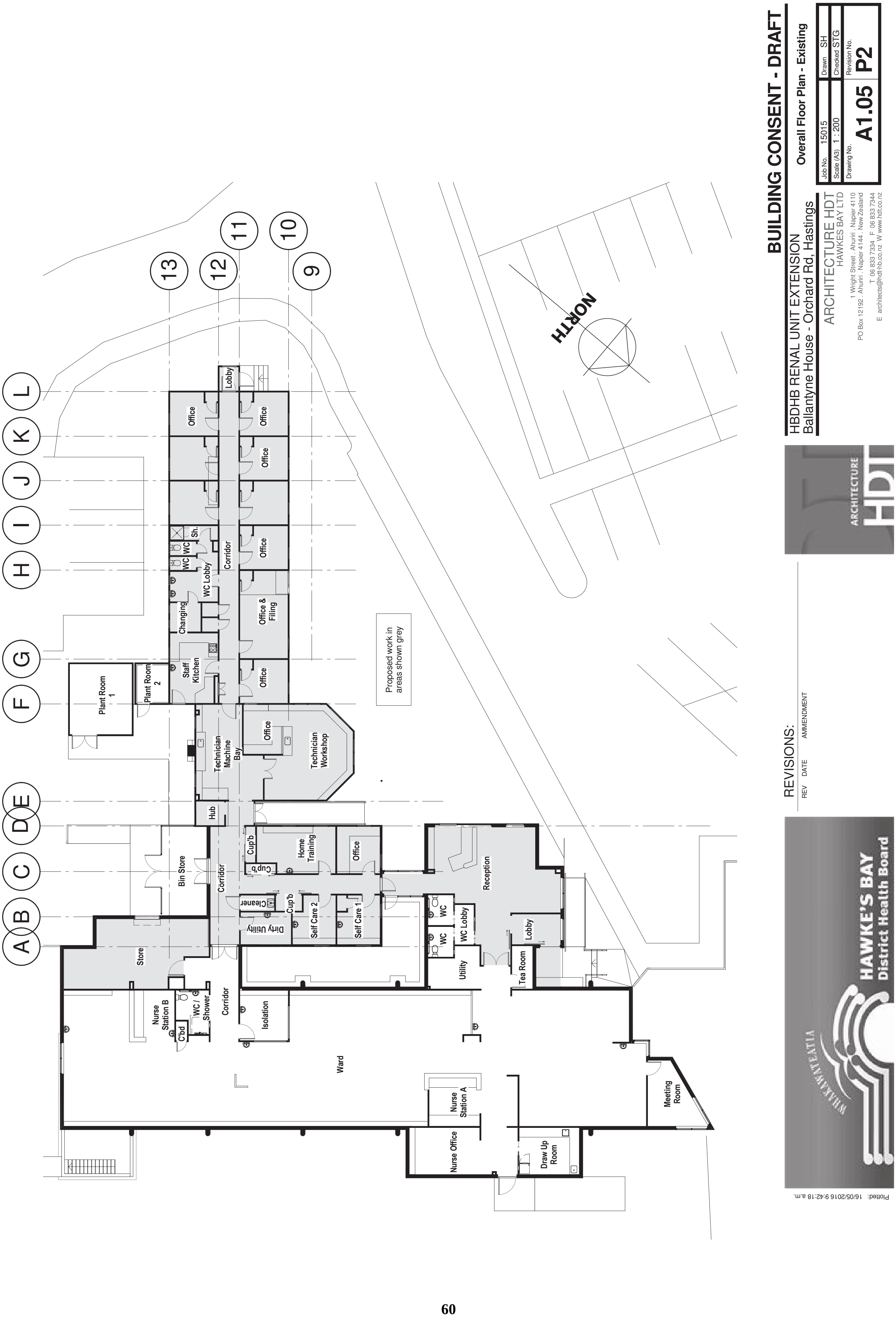
Given the current high levels of activity in the local construction market it is desirable to secure a Contractor as soon as possible. It is therefore recommended to continue progressing to tender in July and through to board approval in October 2016. The original versus proposed timeline is attached in Appendix 1.

Key milestones for 2016

Building consent lodged	May 2016
Out to tender	July 2016
Tenders close	August 2016
Tender evaluation	September 2016
Board approval	October 2016
Start on site	November 2016

APPENDICES

Appendix 1	Proposed Floor Plan (AHDT)
Appendix 2	Project Timeline (PM HBDHB)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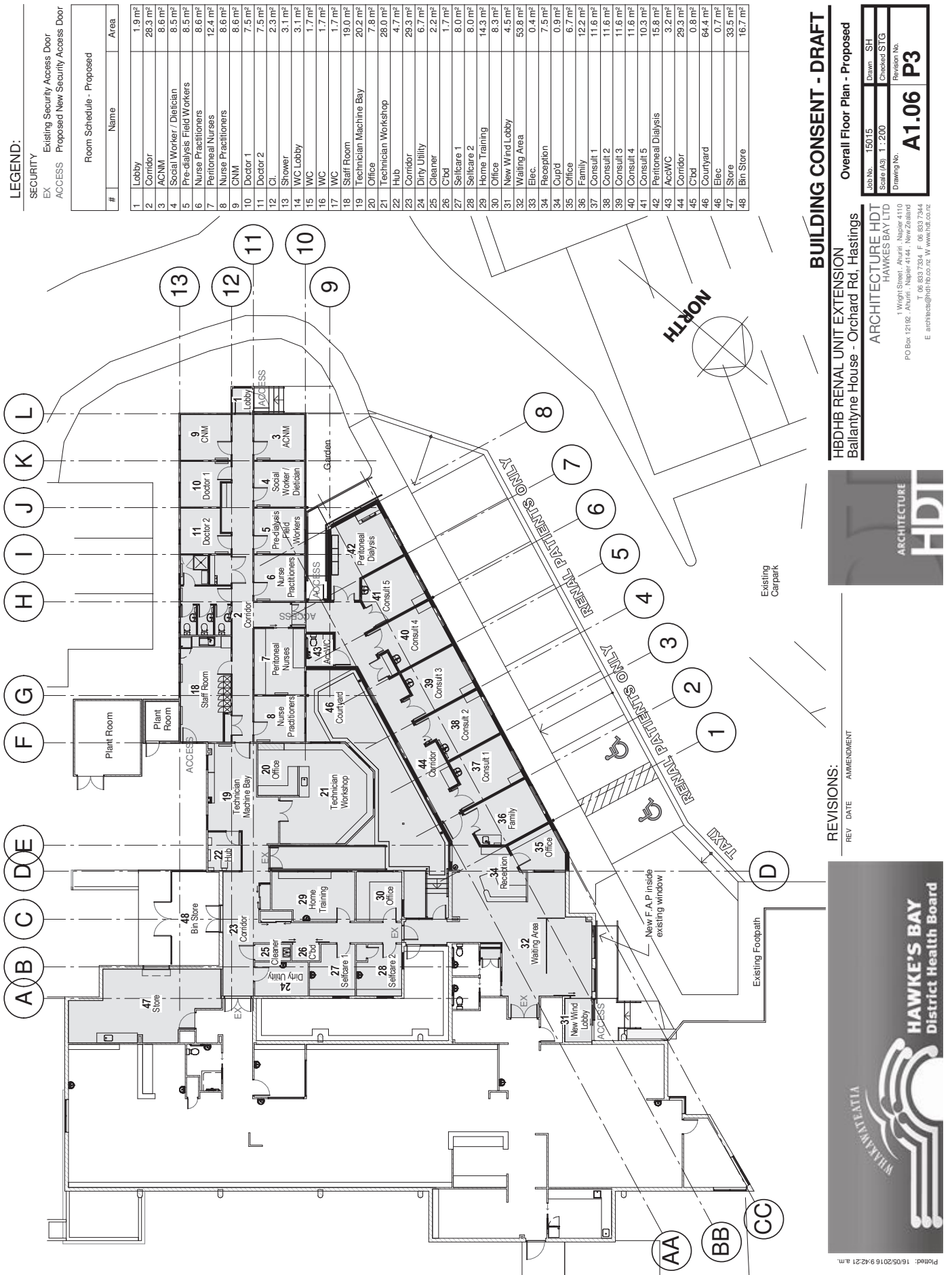
Overall Floor Plan - Existing
Job No. 15015
Drawn SH
Scale (A3) 1 : 200
Checked STG
Drawing No.
A1.05
Revision No.
P2
HBDHB RENAL UNIT EXTENSION
Ballantyne House - Orchard Rd, Hastings
ARCHITECTURE HDT
HAWKES BAY LTD
1 Wright Street . Ahuriri . Napier 4110
PO Box 12192 . Ahuriri . Napier 4144 . New Zealand
T 06 833 7334 F 06 833 7344
E architects@hdt-hb.co.nz W www.hdt.co.nz
ARCHITECTURE HDT
REVISIONS:
REV DATE AMMENDMENT
HAWKE'S BAY
District Health Board
WHAKAWATEATIA
Plotted: 16/05/2016 9:42:18 a.m.
NORTH
Proposed work in areas shown grey
A
B
C
D
E
F
G
H
I
J
K
L
9
10
11
12
13
Lobby
Office
Office
Office
Office
Sh.
WC
WC
WC Lobby
Corridor
Changing
Office & Filing
Staff Kitchen
Office
Plant Room 2
Plant Room 1
Technician Machine Bay
Office
Technician Workshop
Hub
Cup'b
Home Training
Office
Bin Store
Corridor
Cup'b
Cleaner
Cup'b
Self Care 2
Self Care 1
Dirty Utility
Reception
WC
WC Lobby
WC
Lobby
Store
Utility
Tea Room
Nurse Station B
WC / Shower
C'bd
Corridor
Isolation
Ward
Nurse Station A
Meeting Room
Nurse Office
Draw Up Room


LEGEND:
SECURITY
EX Existing Security Access Door
ACCESS Proposed New Security Access Door
Room Schedule - Proposed
Name Area
1 Lobby 1.9 m²
2 Corridor 28.3 m²
3 ACNM 8.6 m²
4 Social Worker / Dietician 8.5 m²
5 Pre-dialysis Field Workers 8.5 m²
6 Nurse Practitioners 8.6 m²
7 Peritoneal Nurses 12.4 m²
8 Nurse Practitioners 8.6 m²
9 CNM 8.6 m²
10 Doctor 1 7.5 m²
11 Doctor 2 7.5 m²
12 Cl. 2.3 m²
13 Shower 3.1 m²
14 WC Lobby 3.1 m²
15 WC 1.7 m²
16 WC 1.7 m²
17 WC 1.7 m²
18 Staff Room 19.0 m²
19 Technician Machine Bay 20.2 m²
20 Office 7.8 m²
21 Technician Workshop 28.0 m²
22 Hub 4.7 m²
23 Corridor 29.3 m²
24 Dirty Utility 6.7 m²
25 Cleaner 2.2 m²
26 Cbd 1.7 m²
27 Selfcare 1 8.0 m²
28 Selfcare 2 8.0 m²
29 Home Training 14.3 m²
30 Office 8.3 m²
31 New Wind Lobby 4.5 m²
32 Waiting Area 53.8 m²
33 Elec. 0.4 m²
34 Reception 7.5 m²
34 Cup'd 0.9 m²
35 Office 6.7 m²
36 Family 12.2 m²
37 Consult 1 11.6 m²
38 Consult 2 11.6 m²
39 Consult 3 11.6 m²
40 Consult 4 11.6 m²
41 Consult 5 10.3 m²
42 Peritoneal Dialysis 15.8 m²
43 AccWC 3.2 m²
44 Corridor 29.3 m²
45 Cbd 0.8 m²
46 Courtyard 64.4 m²
46 Elec 0.7 m²
47 Store 33.5 m²
48 Bin Store 16.7 m²
NORTH
RENAL PATIENTS ONLY
TAXI
Existing Carpark
Existing Footpath
New F.A.P inside existing window
Garden
Courtyard
Plant Room
ACCESS
EX
BUILDING CONSENT - DRAFT
HBDHB RENAL UNIT EXTENSION
Ballantyne House - Orchard Rd, Hastings
Overall Floor Plan - Proposed
ARCHITECTURE HDT
HAWKES BAY LTD
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PO Box 12192 . Ahuriri . Napier 4144 . New Zealand
T 06 833 7334 F 06 833 7344
E architects@hdt-hb.co.nz W www.hdt.co.nz
Job No. 15015
Scale (A3) 1 : 200
Drawing No. A1.06
Drawn SH
Checked STG
Revision No. P3
REVISIONS:
REV DATE AMMENDMENT
ARCHITECTURE HDT
HAWKE'S BAY District Health Board
WHAKAMATAUTIA
Plotted: 16/05/2016 9:42:21 a.m.

Renal Project Stage 4

Facilities Project Programme

Milestone	Original Completion Date	Proposed Completion Date
Business Case Signed Off	Oct-15	Oct-15
Concept Design Complete	Jan-16	Jan-16
Preliminary Design Complete	Apr-16	Jan-16
Developed Design Complete	Jul-16	Mar-16
Detailed Design Complete	Oct-16	May-16
Building Consent Complete	Nov-16	Jun-16
Go to Tender		Jul-16
Tenders Close	Dec-16	Aug-16
Tender Contract Analysis Complete	Jan-17	Sep-16
Project Sign Off - Proceed	Feb-17	Oct-16
Relocate Staff (to old MHU)	Mar-17	Nov-16
Construction Start	Apr-17	Nov-16
Construction Completion	Mar-18	Oct-17
Fit-out / Equipment / Relocation / Transition	Apr-18	Dec-17
Handover / Go Live	May-18	Jan/Feb-18

The Design Stage has progressed better than expected due to several factors;

- There have been no scope changes from the concept plan which has meant design is progressing more quickly.
- The seismic review of Old Ballantyne House was more favourable than first indicated during preparation of the Business Case
- Less structural detailing required from the Engineer
- Less work required around Biomed workshop means this team does not need to be relocated as initially planned, therefore the relocation planning has been significantly simplified
- The Architect we engaged is very competent and professional in the delivery of project documentation
-

Facilities Project Timeline 05-05-16

HAWKE'S BAY District Health Board Whakawāteatia	**Discussion paper on Reducing Alcohol-Related Harm**
	For the attention of: **HB Clinical Council, HB Health Consumer Council and the Māori Relationship Board**
Document Owner: Document Author(s):	Dr Caroline McElnay, Director Population Health Dr Rachel Eyre, Medical Officer of Health
Reviewed by:	Executive Management Team
Month:	July 2016
Consideration:	For Discussion and Endorsement

10

RECOMMENDATION

That HB Clinical Council, HB Health Consumer Council and the Māori Relationship Board:

1. **Note** the contents of this report.
2. **Feedback** on the questions.
3. **Endorse** the proposed approach of developing a HBDHB Position Statement.

OVERVIEW

The purpose of this paper is to facilitate discussion amongst HBDHB committees on alcohol-related harm. Alcohol-related harm is a critical issue for our DHB, creating a significant burden of harm to individuals, to communities and to our health system.

Following a first round of discussions among the committees, it is proposed that a Position Statement on alcohol-related harms be drafted for the second round. The Position Statement would outline the DHB's priorities to reduce alcohol-related health harms in the next three to five (3-5) years (this timeframe being consistent with the National Drug Policy). This would be the DHB's opportunity to develop a common agenda on alcohol harms and to outline actions to address them. A final Position Statement would be put forward to be endorsed by the HBDHB Board.

An example of a Position Statement from the combined Wellington region of three district health boards is attached.

A short film has been produced and will be presented to the committees with this discussion paper.

BACKGROUND

Why we need to take alcohol-related harm seriously

- There are a high number of hazardous drinkers[1] in New Zealand and Hawke's Bay is no exception
- Every year around 1000 New Zealanders die from alcohol-related causes
- Alcohol-related harm in New Zealand is estimated to cost an overall $6.5 billion per year
- Alcohol is a toxin, an intoxicant, a carcinogen and an addictive psychotropic drug
- Hazardous drinking patterns can create both acute and chronic health problems
- Alcohol not only affects the individual but also those around them. It has detrimental effects e.g. lifelong brain damage to young people and to the foetus when a woman drinks whilst being pregnant
- Lack of systematically collected data on 'alcohol-related harm' including 'harm to others' limits our ability to estimate the true cost to communities and prevents adequate resources and effective strategies being assigned

What alcohol-related harm looks like in Hawke's Bay (based on current health data[2])

Alcohol related harm in our DHB region is demonstrated by:

- Rates of hazardous drinking in Hawke's Bay are higher than the national average (by 60%)
- Increasing rates of hazardous drinking over time (by almost 10% from 2006/07 to 2011/14)
- Highest rates of hazardous drinking among young people (41% in the 15-24 year age group)
- Higher rates of hazardous drinking and increased hospitalisations among Māori
- Increased hospitalisation rates for alcohol-related conditions among women
- Slight increase in women exceeding the alcohol and other substance legal limits while driving
- Hawke's Bay has slightly higher rates than New Zealand for alcohol related crashes resulting in non-fatal injuries but the percentage of alcohol-related crashes resulting in fatal injuries have dropped below national average

In 2015, a Hawke's Bay community survey[3] showed wide-spread recognition of alcohol harm and some pointers for change in the alcohol environment, as follows:

- Two-thirds feel the drinking of alcohol has a negative impact in their community
- Nearly 90% of people agree that alcohol affects family violence in the community and over 80% agree it affects community safety
- The majority of respondents want fewer bottle stores. Bottle stores and supermarkets selling alcohol are the most commonly identified as having the greatest impact on alcohol harm in communities
- Almost 80% want more alcohol-free entertainment options

What works to reduce alcohol related harm (based on the evidence) and what opportunities do we have:

Policy:

- The strongest measures to reduce alcohol-related harm are at the policy level and involve increasing price, reducing availability and reduced advertising. The Sale and Supply of Alcohol Act (2012) requires Medical Officer of Health input and enables more community say to reduce alcohol availability at a local level e.g. via the Local Alcohol Policy (LAP) process and licensing decisions.

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1 Hazardous drinkers are defined as adults who obtained an Alcohol Use Disorders Identification Test (a validated tool) score of 8 or more representing an established pattern of drinking that carries a high risk of future damage to physical or mental health.

2 Includes latest NZ Health Survey (Ministry of Health) results, HBDHB hospitalisation data and Massey data (Environmental Health Indicators NZ programme).

3 This 2015 HBDHB led survey involved 1000 adult respondents from across Hawke's Bay.

Community:

- The next most effective and cost-effective measures at a DHB level include a range of community-level interventions that aim to delay drinking in young people, reduce harm to Māori, pregnant women, and Pasifika, encourage moderation in older adults and seek to reduce availability (limiting both demand and supply)
- Interventions need to be whānau and community focussed and not just focussed on individual choice
- A focus on settings where target groups are found allows for integrated approaches
- Community-level interventions need to be community-led but communities often lack resources to do this and to focus on alcohol harm
- It is critical to find ways to delay drinking as long as possible, especially under 18s, to prevent alcohol's harmful effects on growing brains (up to the age of 25 years old)
- The message that there is no safe amount of alcohol which can be drunk in pregnancy needs to be widely understood - including by health professionals
- Reducing the exposure of young people to alcohol promotion, marketing and sponsored events particularly associated with sport is important

Screening:

- Screening and brief intervention approaches in hospital (ED), primary care, with pregnant or reproductive age women, and in settings with a wider community reach is a proven cost-effective strategy
- A screening/data collection initiative in ED may be able to gain support from other funders, (such as from the Health Promotion Agency and ACC), to inform a business case for the DHB to undertake the next phase (brief intervention and referral)
- There is scope for improving screening and brief intervention in primary care and wider settings, to include midwives (currently being looked at under Foetal Alcohol Spectrum Disorder), and others (Police, aged care sector, etc.). Achieving the buy-in from primary care around the importance of screening and brief intervention is key

Collaboration:

- There are a range of opportunities to build on and strengthen existing initiatives in the community, for example as led by Safer Communities Networks
- The DHB is a signatory to the Joint Alcohol Strategy (by Napier City Council and Hastings District Council) and is involved in the review
- There is an opportunity to support partnerships with local Iwi to better meet Māori needs. Māori often take more notice of whānau and friends' messages and support than health professionals
- A range of frameworks and plans can help guide our actions. Our DHB's Position Statement can be used as our platform to promote our common agenda with other groups

How can our DHB improve what it does – future actions?

Suggested areas for future investment include:

- Enable screening (initially) and brief intervention in ED (with possible external funding)
- Improve uptake of brief intervention in primary care, encouraging greater buy-in by primary care health professionals (e.g. use of incentives)
- Investigate brief intervention training opportunities in wider community settings, including midwives
- Develop a process for communication/community engagement to facilitate conversation on alcohol health impacts and to inspire and support community action
- Enhance support for Safer Communities projects, ensuring those projects which reduce inequity are prioritised and adequately resourced (which target for example, delayed drinking/reducing social supply for Māori youth)
- Develop more Iwi partnership approaches to reducing alcohol-related harm
- Provide health leadership by being alcohol-free at health sector events such as award ceremonies and other health events
- Collaborate with other agencies, particularly councils, during development of LAPs. The DHB is working alongside Napier City and Hastings District Councils to implement their Joint Alcohol Strategy - an opportunity exists to become a signatory to the revised strategy

- Establish usefulness of a review of current Mental Health and Addiction Services and whether they are accessible, appropriate and sufficient to meet the needs of target groups
- Align alcohol strategies with other work in the area of social needs, as alcohol harm is often connected with poverty and stress e.g. vulnerable children and CYF review
- Establish a dedicated Alcohol Harm Minimisation Coordinator role to: help identify champions to promote key messages and counter resistance; develop a supportive structure including a high level steering group; write and co-ordinate a three to five (3-5) year plan with an associated monitoring framework to report back to Board level.

(Please note that the data, evidence for what works and rationale for improvement suggestions are detailed in a background report (currently in draft) available on request from the author).

QUESTIONS FOR THE COMMITTEES

Your feedback is sought on the following questions to help guide the next steps.

1. Is there an appetite to tackle this issue of alcohol related harms?

2. What are your ideas about how we go about this e.g. the process for getting buy-in and commitment to actions from across our DHB, how we engage intersectorally and how we work with communities to bring about the necessary social change?

ATTACHMENT

Position statement on reducing alcohol related harm from Waiarapa DHB, Hutt Valley DHB, Capital and Coast DHB, Regional Public Health (2012-13) provided as an example.

Position statement on reducing alcohol related harm

The District Health Boards of Wairarapa, Hutt Valley and Capital and Coast and Regional Public Health are committed to reducing the alcohol-related harm. Our efforts to do so will be based on the best available evidence and we will undertake the following actions within our available resources.

1. We support the adoption of the most effective population-based strategies to reduce harmful use of alcohol, as identified by the World Health Organisation, including; reducing the availability of alcohol, increasing the purchase age, reducing the legal blood alcohol concentration for driving, increasing the price, and reducing alcohol advertising and marketing.

2. We support government policy to:
   i) Reduce excessive drinking by adults and young people;
   ii) Reduce the harm caused by alcohol use including crime, disorder, public nuisance and negative public health outcomes;
   iii) Support the safe and responsible sale, supply and consumption of alcohol;
   iv) Improve community input into local alcohol licensing decisions;
   v) Improve the operation of the alcohol licensing system.

3. We will actively work towards reducing alcohol and other drug-related harm inequalities in identified high-risk populations.

4. We will promote harm reduction strategies for alcohol and other drugs through the provision of information to health care professionals and the public.

5. We will work to increase access to treatment options for alcohol and other drugs across the region, particularly for high-risk populations.

6. We will work to increase opportunities for screening and brief interventions in appropriate health settings such as emergency departments and primary care.

7. We will actively work to increase our capacity to monitor the impact of alcohol and drug-related harm on health services.

8. We will link with Primary Health Organisations, Non-Government Organisations, Justice and Education sectors and other parts of the Health sector and communities to ensure that we have a full understanding of the alcohol and other drug issues as experienced by our population and can then determine the best interventions to address any emergent issues.

9. We will support our public health and clinical staff in their work to; plan for, promote, support and deliver alcohol and other drug harm reduction and treatment strategies appropriate for our regions' communities.

10. We will engage with local government and communities to identify alcohol issues and support the implementation of local solutions.

11. We will actively work to increase our capacity to assess the impact of our interventions.

EXAMPLE

Background and rationale

The impact of harmful use of alcohol on health and health services
Hospital services face daily the outcomes of harmful consumption of alcohol across the lifespan. Emergency departments, trauma wards, operating theatres and intensive care units bear the brunt of providing care for injury, violence and acute conditions. Other services carry the burden of care for patients with mental illness or chronic disease and cancer brought about by harmful alcohol consumption over the longer term. Others deal with the developmental problems arising from alcohol use in pregnancy such as foetal alcohol spectrum disorders.

New Zealanders' pattern of drinking is of concern. We live in a society that supports harmful drinking and where consuming alcohol is seen as a normal accompaniment to our everyday activities. While there are many people who drink at low risk levels or do not drink alcohol at all, drinking at harmful levels and getting drunk is accepted. Such behaviour is frequently celebrated and glamorised. Our young people drink the way they do because they see this behaviour as "the norm". What they see and hear from adults and the community promotes this message.

It is vital then, that more people adopt the recommended guidelines for low risk drinking (see appendix 1). Following these guidelines can be difficult due to alcohol consumption being used and accepted as a means of dealing with stress, Further the social pressure to drink, the vast range of alcohol products, the way it is promoted, its availability during most hours of the day and days of the week, and the number of settings for drinking and purchase make it easy to drink large amounts.

The increasing scientific evidence regarding the health outcomes influenced by alcohol indicates the importance of tackling societal attitudes and behaviours towards alcohol. In particular historical liberalisation of policy has been accompanied by increases in the quantity of alcohol consumed[1].

- In 2007 in New Zealand alcohol is estimated to have been responsible for 802 deaths (5.4% of all deaths) and 13,769 years of life lost (YLLs) under 80 years of age. Much of the harm (43%) was due to injury (unintentional, violence and self-harm), but alcohol also contributed to a range of chronic non-communicable diseases, including cancers, liver disease and cardiovascular diseases[2].

- Alcohol related admissions to hospital transition from injury as the primary cause to increasing presentations of chronic conditions such as cancer, cardiovascular disease and digestive disorders[3] as age increases.

- Men have roughly twice the rate of death and hospital admissions attributable to alcohol. Deaths from injury were more common in men, contributing to 73% of all years of life lost from drinking in men and 42% in women[4].

- 82% of New Zealand women report consuming alcohol prior to conception and 34% report drinking during pregnancy[5].

EXAMPLE

[1] Huckle, T., R. Q. You, et al. (2011). "Increases in quantities consumed in drinking occasions in New Zealand 1995â€"2004." *Drug and Alcohol Review* 30(4): 366-371.
[2] Connor J, Kydd R, Shield K, Rehm J. (2012) *Alcohol-attributable burden of disease and injury in New Zealand:* 2004 and 2007. Wellington: Alcohol Advisory Council of New Zealand
[3] Connor, J., Kydd,R.,Rehm, J.,Shield,K. (2013). *Alcohol-attributable burden of disease and injury in New Zealand:* 2004 and 2007. Research report commissioned by the Health Promotion Agency. Wellington, Health Promotion Agency.
[4] Connor, J., Kydd,R.,Rehm, J.,Shield,K. (2013). Alcohol-attributable burden of disease and injury in New Zealand: 2004 and 2007. Research report commissioned by the Health Promotion Agency. Wellington, Health Promotion Agency.
[5] Mallard S, Connor J, Houghton L. 2013 Maternal factors associated with heavy periconceptional alcohol intake and drinking following pregnancy recognition: A post-partum survey of New Zealand women. Drug and Alcohol review vol 32 issue 3

- Hazardous drinking is more common in the most deprived areas of New Zealand[6] and there is a clear association between overall alcohol outlet density and socioeconomic deprivation, with more alcohol outlets situated in deprived areas[7]

- In the Wellington Region 22% of men and 11% of women have a hazardous drinking pattern scoring 8 or more on the 10-question AUDIT test[8].

Legislative and Policy Environment

National Drug Policy
Government policy recognises that no single strategy can address the harms from drug and alcohol use and that multiple strategies are needed. The strategies are captured in a single framework of three core areas[9]:

- Supply control – control or limit the availability of drugs, including alcohol
- Demand reduction – limit the use of drugs and alcohol by individuals, including abstinence
- Problem limitation – reduce the harm from existing drug and alcohol use

The Law Commission
In 2008 The Law Commission was engaged to evaluate the existing laws and policies relating to the sale, supply and consumption of alcohol. The final report released in 2010 - *Alcohol In Our Lives, Curbing the Harm* made 153 recommendations to government for change in law.[10]

Major recommendations included: raising the purchase age to 20, sweeping reform to the self-regulation of advertising and marketing, an immediate increase in the tax on alcohol and the introduction of a minimum pricing regime, and regulations to allow restriction on the supply of alcohol. Of these major recommendations government chose to implement significant change to the supply of alcohol allowing for greater restrictions predominantly through control of hours, density and location. Communities were given some control over licensing matters with councils able to adopt Local Alcohol Policies.

The Sale and Supply of Alcohol Act 2012
In December 2012, the government introduced a new act regulating the supply of alcohol. This act has significant changes from the previous Sale of Liquor Act 1989. Particularly pertinent to health services are:

- A broader definition of alcohol related harm

  "alcohol related harm –
  (a) means the harm caused by the excessive or inappropriate consumption of alcohol; and
  (b) includes –

EXAMPLE

[6] Connor, J. L., K. Kypri, et al. (2010). Alcohol outlet density, levels of drinking and alcohol-related harm in New Zealand: a national study. *Journal of epidemiology and community health* 65(10): 841-846
[7] Connor, J. L., K. Kypri, et al. (2010). Alcohol outlet density, levels of drinking and alcohol-related harm in New Zealand: a national study. *Journal of epidemiology and community health* 65(10): 841-846
[8] Ministry of Health (2013) Regional results from the 2011/12 New Zealand Health Survey http://www.health.govt.nz/publication/regional-results-2011-12-new-zealand-health-survey
[9] Ministry of Health (2007) *National Drug Policy 2007-2012*, Downloaded from http://www.ndp.govt.nz
[10] The NZ Law Commission (2010) NZLC R114 *Alcohol in our lives: Curbing the harm.* Downloaded from http://www.lawcom.govt.nz/project/review-regulatory-framework-sale-and-supply-liquor

(i) any crime, damage, death, disease, disorderly behaviour, illness, or injury, directly or indirectly caused, or directly or indirectly contributed to, by excessive or inappropriate consumption of alcohol: and
(ii) any harm to society generally or the community, directly or indirectly caused, or directly or indirectly contributed to, by crime, damage, death, disease, disorderly behaviour, illness, or injury of a kind described in subparagraph (i)"[11]

- An increased role for the medical officer of health

  (a) The medical officer of health is required to enquire into all licensing applications and report on those of concern
  (b) All territorial authorities must consult with the medical officer of health while drafting their local alcohol policies.

  Local alcohol policies are implemented through local council (they are voluntary, not compulsory) and guide all alcohol licensing applications in the district. They can place restrictions on the availability of alcohol by stipulating controls on the hours of operation, density of premises, the types of premises etc for given locations. The policy is both a tool for harm reduction and enables a community to have a say in licensing matters.

- A requirement to respond to territorial authorities request for alcohol related health information, particularly the health of the districts residents and the nature and severity of the alcohol-related problems arising in the district.

The district health boards of Wairarapa, Hutt Valley and Capital and Coast and Regional Public Health are committed to playing an active role in informing local alcohol policies as part of their efforts to reduce alcohol-related harm.

Evidenced based strategies
Alcohol problems are not restricted to a small proportion of heavy/dependent drinkers or to the young. Therefore action at all levels of society by all means is required to bring a societal change in attitudes to consumption. There is no single factor that contributes to the development of alcohol-related problems and a multi strand evidenced based approach addressing supply control, demand reduction and harm minimisation is required.

As a member state of the World Health Organisation, New Zealand health services are expected to demonstrate commitment to advancing alcohol harm reduction both locally and nationally. This includes advocating for more effective policy and intervention strategies suitable for the New Zealand context.

The most effective strategies for reducing the harmful use of alcohol include population based strategies such as reducing the availability of alcohol, increasing the purchase age, lowering the blood alcohol concentration for driving, increasing the price and reducing alcohol marketing and advertising[12]. At the individual level brief interventions are of assistance[13].

[11] *Sale and Supply of Alcohol Act 2012*. Public Act 2012 No. 120
[12] World Health Organization (2010). Sixty-third world health assembly. Strategies to reduce the harmful use of alcohol: draft global strategy
[13] World Health Organization (2010). Sixty-third world health assembly. Strategies to reduce the harmful use of alcohol: draft global strategy

EXAMPLE

OURHEALTH HAWKE'S BAY Whakawateatia	**Last Days of Life Care Plan and Toolkit**
	For the attention of: **Māori Relationship Board (MRB) and Clinical and Consumer Council**
Document Owner: Document Author:	Mark Peterson Leigh White
Reviewed by:	Paul Malan (Strategic Services Manager Older Health and Mental Health Services) and Mary Wills (Head of Strategic Services), Executive Management Team
Month:	July 2017
Consideration:	For Information

RECOMMENDATION

That the Māori Relationship Board, Clinical Council and Consumer Council:

1. **Review** and Provide Feedback.
2. **Endorse** Ongoing Work

EXECUTIVE SUMMARY

Last days of life care planning is an integral component of aged care services, medical and surgical care, management of chronic and complex illness. It is imperative that all health professionals should be competent to provide care to people who are approaching the end of their life and the tools (attached) are to be used as a guide. Last days of life care planning is a replacement for the phasing out of the Liverpool Care Pathway.

The impact of delayed last days of life planning can lead to a number of adverse outcomes:

- continued aggressive, unwanted and/or unwarranted life-sustaining measures instigated;
- poor experiences for families where distraught family members are called on at a time of grieving to engage in last days of life decisions;
- potentially avoidable conflicts between families and the health care team, or within the health care team; about the best course of treatment and care for the dying person;
- care being delivered in acute settings when better outcomes could be delivered in supported community or home environments;
- stress for health professionals balancing their obligation to act in the best interests of the dying person, sometimes differing views amongst treating clinicians and families.

The purpose of the enclosed document is to provide an update on the progression of work.

SUMMARY UPDATE

- Last Days of Life Care Plan with supporting documents (Toolkit) are in final draft (attached) and signed off by the HBDHB Working Group (Refer to Arttachment 3) to support a trial.
- Trial of documents in Aged Residential Care to be completed.
- Last Days of Life Care Plan with supporting documents (Toolkit) sent to MoH for example of.
- HBDHB LTC Portfolio Manager to participate in the National Advisory Group for implementation of Te Ara Whakapiri - The Principles and Guidance for the Last Days of Life.

CONSULTATION UPDATE

A cross-sector representative group was formed to collectively document updates: Trish Freer & Faye Milner (PHO), Jill Garrett (HBDHB Primary Strategic Service Manager), Janice Byford-Jones, Karen Franklin, Sarah Nichol, Jo Loney (Cranford Hospice) and Anne Gray (Secondary Care Services). The group has developed documents, informed their stakeholders and presented (or will present) to the following committees:

Committee	Date	Feedback
Consumer Council	Consumer input has been received with regard input into the documents (refer enclosed Attachement - Appendix 2)	
PHO I'ND	June 2016	Acknowledged paper
PHO Leadership Team (PHOLT),	June 2016	Presenting Monday 4 July 2016
PHO Clinical Advisory Governance Group		To present July 2016
Palliative care Sector Integration	4 July 2016	To present 4 July 2016
Maori Relationshiop Board	13 July 2016	To present July 2016
Clinical Council	13 July 2016	To present July 2016
Consumer Council	14 July 2016	Included in Documents as Information

EXPECTED ROLE OF HBDHB

The Last Days of Life Care Plan and Toolkit are at the point of a trial and this has been agreed within five Aged Residential care facilities. Trial will commence post consultation – aiming for end of July 2016. Funding for the development of the tools and 500 copies for the trial will be provided by Strategic Services.

EXPECTED ROLE OF HEALTH HB

To endorse the work and support implementation of the HBDHB Last Days of Life Care Plan document and toolkit as a replacement for LCP based on Te Ara Whakapiri: Principles and Guidance. To support the introduction and adoption in primary care. Note: Symptom Management for last days of life Algorithms are currently well embedded into general practice and these will not change.

Note:

- during the trial phase, General practice will be business as usual except for those GPs who are providing oversight for the trial in ARC.
- assumption of expected costs will be evaluated post trial and further consultation will occur with regard to wider implementation. It is expected the cost implication for PHO will be socialisation and education at CME sessions.

EXPECTED ROLE OF SECONDARY SERVICES

Because of internal changes occurring in secondary care, a trial at this point is delayed.

EXPECTED ROLE OF CRANFORD

In consultation with Cranford no trial will need to occur in the community as the forms will not be used in this area of practice at this time. Trial implementation, oversight in ARC and findings may be supported by Cranford (funding and date of commencement to be confirmed). To ensure the workforce is educated and skilled to provide quality care for people in their last days/hours of life. Cranford will ideally undertake workforce development in ARC, secondary care and present to Primary Care in CME sessions.

EXPECTED ROLE OF RESIDENTIAL CARE

A proposed trial of 3 months (dates and timeframes not as yet agreed).

- ARC Facilities: Mary Doyle, Brittany, Masonic and Atawhai/Gracelands
- GP support: Dr M. Peterson, Dr P. Henley, Dr L. Whyte and Dr J. Eames

EXPECTATION OF TRIAL OUTCOMES

Even though the aim of the trial is to trial the documents it is hoped that use will result in:

- improved decision making;
- a positive impact on multi-professional team communication and working;
- increased confidence of nurses about when to approach medical colleagues to discuss treatment plans;
- people being treated with greater dignity and respect;
- greater clarity around preferences and plans about how these can be met.

Will await national approach with regard to audit process – but early thoughts:

- Determine how death audits will be reviewed at a local level, based on predicted, as well as unexpected, hospital deaths.

WHAT WILL SHOW IMPROVEMENT

Health records will better reflect a holistic approach to care in the last days of life. This includes evidence of communication and consideration of the individual needs of the person and family/whanau. It is expected that staff working with the document will show high level of confidence in planning and providing care. Having a consistent approach to the delivery and management of care will allow for effective evaluation and subsequent improvement to services provided through evaluation. This will be inclusive of the family/ whanau experience.

ATTACHMENT(s)

Appendix 1 Heat Tool
Appendix 2: Copy of Consumer Feedback
Appendix 3: Working Group Members
Appendix 4: Care Plan
Appendix 5: Toolkit

Appendix 1

Key Performance Indicators against the Health Equity Assessment Tool (HEAT)

Health Equity Assessment Tool - Questions	Assessment of the proposal using the Health Equity Assessment tool
What health issue is the policy/programme trying to address	That people are aware of the essential components and considerations required to promote quality care at the end of life for all adults in New Zealand. Feedback will be taken into account from a consumer review: (e-mail)- *"I spoke with whanau from a range of cultural backgrounds such as Māori, Samoan, Cook Island, Tongan, mixed European and those that were not raised within their cultural heritage. The key area of concern for all was "trust". Trust in the system, trust in the people and trust in the word (written and verbal)."* The tool is to provide consistency and quality of care taking into consideration the individual person's/whanau choice. It is a tool that is worked through with the person/whanau, vs a process that is "done to" the person(s) receiving care. (see email below) *"Whereby some whanau have felt they have been pushed into making a decision due to the need to free up a bed; lack of staffing support; and implied costs of maintaining life in a hospital setting."*
What inequalities exist in this health area?	The Planning for Last Days of Life Care Plan is for care for adults and excludes children. This is being addressed in another process. Without a standardised tool, the risk of substandard, fragmented care, and or variations in care is a risk. The tool caters to the individual and eliminates the risk of 'stereotypical applications of care to ethnicities- see comment below. *email - "Also acknowledging that the tool is for all cultures* *- Another important aspect is to ensure that health workers do not assume that because of the ethnicity of the whanau that they fit within the expected cultural criteria. For example, not every Māori whanau are connected to their whanau, hapu, marae, iwi or cultural heritage. It must be what is acceptable and applicable to the individual (whanau) rather than their ethnicity alone."*
Who is most advantaged and how?	The Planning for Last Days of Life Care Plan is for care for adults and the advantage is to have a better quality of care experience in their last phases of life. It also empowers the work force to work individually with the person to ensure care and management meets their individual needs
How did the inequality occur? (What are the mechanisms by which this inequality was created is maintained or increased?)	The equity has occurred with the national consensus of the removal of the LCP leaving a gap in standardisation of care services. Removing the LCP without replacement of a suitable alternative that is endorsed centrally would lead to multiple variation, and the absence of agreed standards.
What are the determinants of this inequality?	(Lack of) Participation in decision making by providers Attitudes of Care Planning for last days of Life

How will you address the Treaty of Waitangi in the context of the New Zealand Public Health and Disability Act 2000?	The Last Days of Life Care Plan is underpinned by Te Whare Tapa Whā, an holistic approach to care that addresses a person's physical, family/whānau, mental and spiritual health. It is person centred tool based on a partnership and full participation by the person and whanau in care management. Providing an individualised care plan helps to guide and prompt the care of the person who is dying and support for their families/whanau and other people who are significant to them. The individual nature of the tool allows for culturally appropriate care to be provided. A core purpose of the document is to support consistent care across organisations regardless of the setting. It is predicted that it may become evident that those that die in their own homes may also benefit from the use of the care plan document, this is particularly important when considering the higher percentage of Maori that die in the community. This factor will be considered after the trial??
Where/how will you intervene to tackle this issue?	Adopting the seven overarching principles outlined in Te Ara Whakapiri: Principles and Guidance for the last days of life will truly reflect the needs of a person and their family/whānau at the end of life. In essence, the plan, path or guidance encompasses the fundamentals of Te Whare Tapa Whā, namely the mental, physical, spiritual and social principles of well-being. The Last Days of Life Care Plan provides guidance, instructions and prompts to clinicians and the wider multi-disciplinary team that will assist them with their assessment and decision making regarding a person's deterioration and the possible outcome/s and indicated management. The plan ensures all necessary assessment, planning and monitoring are documented in line with the person's preferences. This provides evidence of appropriate care and communicates individualised care to all involved.
How could this intervention affect health inequalities?	Champions within providers of services. Agreed competencies and standards. Consistency in the implementation of the last days of life management.
Who will benefit most?	Adults and whanau in HB and health care providers supported in their management of care by a reputable and endorsed tool.
What might the unintended consequences be?	Lack of adoption of the tool and default to the previous LCP
What will you do to make sure it does reduce/eliminate inequalities?	Develop a process of monitoring outcomes for diverse population groups represented in the HB demographic. Monitoring uptake and engagement with the tool by providers. Attendance of ongoing CME-CNE.
How will you know if inequalities have been reduced/ eliminated?	Evaluations of outcomes for patients / whanau inclusive of case studies – whanau stories.

Appendix 2

-----Original Message-----
From: [redacted]
Sent: Wednesday, 25 May 2016 12:07 p.m.
To: 'Graeme Norton Hme'
Subject: FW: Last days of Lire documents for comment

Kia ora Graeme

Well I have had some very interesting conversations and feedback, but the email below covers off the feedback from others very well.

I spoke with whanau from a range of cultural backgrounds such as Maori, Samoan, Cook Island, Tongan, mixed European and those that were not raised within their cultural heritage.

The key area of concern for all was “trust”. Trust in the system, trust in the people and trust in the word (written and verbal). The past experiences of our whanau have left some lasting “bad” impressions. However, some advise that there has been some definite improvements over the years. There is some cynicism that in today’s hospital environment, whereby some whanau have felt they have been pushed into making a decision due to the need to free up a bed; lack of staffing support; and implied costs of maintaining life in a hospital setting. Whanau have been told that it is more cost effective for the hospital if they took their whanau member home to look after themselves.

Another important aspect is to ensure that health workers do not assume that because of the ethnicity of the whanau that they fit within the expected cultural criteria. For example, not every Maori whanau are connected to their whanau, hapu, marae, iwi or cultural heritage. It must be what is acceptable and applicable to the whanau rather than their ethnicity alone.

In sharing these examples there were also a number of “happy” examples shared, but of course it is the bad experiences we remember and voice.

I hope this helps with development of the final plan.

Nga mihi,
[redacted]

Appendix 3

Acknowledgement of the HB Integrated Working group:

Dr Carol McCallum *(Palliative Physician*)
Karyn Franklin *(Clinical Services Manager, Cranford Hospice*
Sarah Nichol *(Quality Co-Ordinator Cranford Hospice)*
Sue- Mary Davis *(Palliative care nurse Liaison with Aged Residential Care)*
Anne Gray/Lorna Hulkes *(shared) (Palliative CNS Secondary Care)*
Joan McAsey (*Practice Nurse, Hastings Health Centre*)
Irene O'Connell (*Clinical Manager, Eversley Aged Residential Care*)
Jo Loney (*Education Service Manager, Cranford Hospice*)
Liz Beattie (*Clinical Manager, Masonic Aged Residential Care*)
Trish Freer (*Health Programmes Manager – HHB*)
Faye Milner (*Secretarial Support – PHO*)

Request critique of documents:

Dr Mark Peterson
Graeme Norton (sent to the Consumer Council)
Dr Liz Whyte
Dr Eames
Mrs Jacqui Thomas (*Consumer*)

APPENDIX 4

OURHEALTH HAWKE'S BAY
Whakawāteatia

Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

LAST DAYS OF LIFE CARE PLAN

Identifying the Dying Person

Flowchart

RECOGNITION OF PERSON DETERIORATION

DOES THE PERSON SHOW 2 – 3 OF THE FOLLOWING SIGNS/SYMPTOMS?

- ☐ Profound weakness
- ☐ Reduced intake food/fluids
- ☐ Difficulty swallowing/taking oral medications
- ☐ Drowsy or reduced cognition – semi conscious with lapses into unconsciousness
- ☐ Bed bound after progressive decline over days and weeks
- ☐ Peripherally shut down

Is this deterioration acute or unexpected? YES → **Are there reversible cause(s) of deterioration?** YES → **Is investigation or new intervention appropriate and/ or wanted by the person/ family/whānau/ carer?** YES → **Treat Causes**

YES NO NO

- Family notified (if not already aware of person's condition); family involvement in care and allowances made for them to remain with person.
- Psychological support: plan of care discussed with person(if able) and family/whānau /carer
- Spiritual/religious/cultural beliefs: addressed with person (if able) and family/whānau /carer – facilitate any identified rituals around death. Referral to cultural/spiritual/religious support people if required.
- Medication: non essential medications discontinued, anticipatory PRN medication prescribed - consider route (refer to your organisation's symptom management algorithms)
- Discontinue unnecessary interventions: e.g. IV antibiotics, blood tests, observations/Early Warning Symptoms Score
- Ensure DO NOT RESUSCITATE order is documented.

DOCUMENT ABOVE INFORMATION AND COMMENCE END OF LIFE CARE PLANNING

As with all clinical guidance this document aims to support but does not replace clinical judgement

BrebnerPrint TRIAL 16/06/16

INSTRUCTIONS

OURHEALTH HAWKE'S BAY
Whakawāteatia

Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

INSTRUCTIONS

This plan is an integrated care document that can be used across all settings, including the home, aged residential care, hospital and hospice

The term "last days of life" defines the period of time in which a person has been assessed and diagnosed as dying by a multi-disciplinary team and that death is expected within hours or days.

The goals of care are optimal symptom management and support for the person/family/whanau. The person should be assessed and a individualised care plan developed in line with the person (if able), family/whanau wishes and needs.

CRITERIA FOR THE USE OF THE CARE PLAN

A health practitioner undertakes assessments when recognising a person may be entering their last days of life, planning priorities of care and continually assessing care needs. Any changes in condition act as a prompt to ensure conversations occur with the person and with their family/ whānau.

INSTRUCTIONS FOR USE

This document is organised in three parts and must link with the person's clinical records. It is imperative to clearly communicate all decisions leading to a change in care, and document these conversations.

Preparing for last days of life: *Pages 3 to 5*	Baseline assessment to identify priorities of care
Planning for care: *Pages 6 to 7*	Person centred priorities of care
Ongoing assessment: *Pages 8 to 11*	Regular assessments *(recommend 4 hourly or more often if required)* of the persons condition to ensure that changes are addressed in a timely manner.
Care after death: *Page 12*	Checklist

LEAD HEALTH PRACTITIONER/S

Doctor: ..... Page contacts (HBDHB): .....

If GP - See Page 3 for Contact Details

Nurse Practitioner: .....

Work number: ..... After hours number: .....

Primary Nurse: .....

THIS PLAN SHOULD BE REASSESSED EVERY THREE DAYS

Date of Life Care Plan commencement ..... Signed .....

Reassessment date: ..... Reassessment time: ..... Signed .....

Reassessment date: ..... Reassessment time: ..... Signed .....

Reassessment date: ..... Reassessment time: ..... Signed .....

OURHEALTH HAWKE'S BAY
Whakawāteatia

Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

CONTACTS

FAMILY/ WHĀNAU	
	1st Contact:
If the person's condition changes, who should be contacted first?	Name: ..... Relationship: ..... Telephone Number: ..... Mobile Number: .....
If the person's condition changes, when should they be contacted?	At any time ☐ Not at night time ☐
	2nd Contact:
If the first contact is unavailable, who should be contacted?	Name: ..... Relationship: ..... Telephone Number: ..... Mobile Number: .....
When to contact	At any time ☐ Not at night time ☐
Next of Kin if different from above	Name: ..... Relationship: ..... Telephone Number:
KEY SERVICE PROVIDERS	
	1st Contact:
Name of General Practitioner Notified of change in person's condition ☐ Yes ☐ No	Name: ..... Mobile Number: ..... At any time ☐ Not at night time ☐
In what circumstances do they want to be contacted?	**2nd Contact:**
If unavailable, which GP should be contacted?	Name: ..... Mobile Number: ..... At any time ☐ Not at night time ☐
Community Providers are notified of "Last Days of Life" if applicable	Cranford Hospice ☐ Yes ☐ No ☐ N/A District Nurses ☐ Yes ☐ No ☐ N/A NASC Agency ☐ Yes ☐ No ☐ N/A Home Support Agency ☐ Yes ☐ No ☐ N/A Other ☐ Yes ☐ No ☐ N/A ....

PREPARING FOR LAST DAYS OF LIFE

OURHEALTH HAWKE'S BAY
Whakawāteatia

Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

INITIAL ASSESSMENT PAGE 1 OF 2

RECOGNITION OF DYING: *Goal: Both the person/family/whānau have awareness and understanding of the diagnosis*	
The person is aware they are dying? ***See guidelines on "Identifying the dying person"***	☐ Yes ☐ No ☐ Unconscious Date: ..... Signature: .....
Is the family/whānau aware their family member is dying? ***See guidelines on "Breaking Bad News" and "W.H.A.N.A.U" tool***	☐ Yes ☐ No Date: ..... Signature: ..... **Document clearly in PROGRESS NOTES what was said and by whom.**
Advance Care Plan: *Goal: Both the person/family/whānau are given the opportunity to discuss what is important to them*	
Does the person have an existing Advance Care Plan? ***If Yes – where is it located***	☐ Yes ☐ No Located: ..... Date: ..... Signature: .....
Does the person have an existing Directive/ Do Not Resuscitate Order documenting their wishes at end-of-life? ***If Yes – where is it located***	☐ Yes ☐ No Located: ..... Date: ..... Signature: .....
Does the person have nominated Enduring Power of Attorney (EPOA) for Health?	☐ Yes ☐ No Name: ..... Relationship: ..... Contact No.: .....
Has the EPOA been activated? Copy sighted?	☐ Yes ☐ No ☐ Yes ☐ No **Document clearly in PROGRESS NOTES what was said and by whom.**
Preferred Place of Care: *Goal: person and family/whānau choice if appropriate*	
Person's preferred place of care	☐ Home ☐ Hospital ☐ Hospice ☐ Aged Residential Care
Family/whanau preferred place of care ***If going home or to Aged Residential Care from HBDHB see "Discharge Checklist"***	☐ Home ☐ Hospital ☐ Hospice ☐ Aged Residential Care
Information and Explanation: *Goal: Both the person/family/whānau are given the opportunity to discuss what is important to them.*	
Family/whanau given information of facilities available e.g. visiting times, parking, tea and coffee, quiet area, toilets. ***Information brochure "What to expect when someone is dying" explained and given to family/ whānau if appropriate.*** ***Give "Bereavement Information" brochure and list of Funeral Directors if appropriate time.***	☐ Yes ☐ No ☐ Yes ☐ No Brochure given ☐ Yes ☐ No ☐ Yes ☐ No Brochure given ☐ Yes ☐ No Name of Funeral Director (if known) ..... If for cremation/burial ..... Specific death certificate questions: Previous occupation..... Ethnicity..... Marital Status.....

OURHEALTH HAWKE'S BAY
Whakawāteatia

Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

INITIAL ASSESSMENT PG 2 OF 2

Cultural:

If able, the person is given the opportunity to discuss their cultural needs e.g. needs now, at death and after death. Family/whānau is given the opportunity to discuss their cultural needs at this time e.g. needs now, at death and after death. ***Refer to appropriate cultural support e.g. Maori Health Service, Asian Support, Pacific Island Support. See W.HA.N.A.U: Personalising care at end of life.***	Date and time of conversation: .... Date and time of conversation: .... Names of services involved: ..... **Document clearly in PROGRESS NOTES what was said and by whom.**

Religious and Spiritual:

If able, the person is given the opportunity to express what is important to them at this time eg. wishes, feelings, faith, beliefs, values (needs now, at death and after death)	☐ Yes ☐ No Date and time of conversation: .....
The family/whānau is given the opportunity to express what is important to them at this time eg. wishes, feelings, faith, beliefs, values (needs now, at death and after death) ***Refer to Chaplain Service or contact person's preferred support person if required. See Spiritual care assessment tool based on FICA approach.***	☐ Yes ☐ No Date and time of conversation: ..... Names of services involved: ..... **Document clearly in PROGRESS NOTES what was said and by whom.**

MUST BE COMPLETED BY MEDICAL PRACTITIONER

• Active acute medical treatment is no longer in the person's best interest	☐ Yes	☐ No	Date:	Signature: .....
• Non-essential medications discontinued and current medications reviewed	☐ Yes	☐ No	Date:	Signature: .....
• PRN subcutaneous anticipatory medications charted. ***See Symptom Management Algorithms***	☐ Yes	☐ No	Date:	Signature: .....
• Inappropriate interventions discontinued e.g blood tests, routine observations, blood glucose monitoring, oxygen therapy	☐ Yes	☐ No	Date:	Signature: .....
• The need for artificial hydration/nutrition has been discussed	☐ Yes	☐ No	Date:	Signature: .....
• Not for Resuscitation status recorded	☐ Yes	☐ No	Date:	Signature: .....
• Implantable Cardioverter Defibrillator (ICD) is deactivated	☐ Yes	☐ No	Date:	Signature: .....
• Organ donation considered and information given to person/family ***See Tissue Donation brochure***	☐ Yes	☐ No	Date:	Signature: .....

Individual/Specific Requests

.....

.....

.....

PLANNING CARE

OURHEALTH HAWKE'S BAY
Whakawāteatia

Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

ALL PERSONNEL COMPLETING THE LAST DAY OF LIFE - *CARE PLAN* - PLEASE SIGN BELOW

You should also have an understood the 'Health Care Professional' leaflet

Name (print)	Full Signature	Initials	Professional Title	Date

OURHEALTH HAWKE'S BAY
Whakawāteatia

Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

CARE PLAN PAGE 1 OF 2

Plan of care developed using information from initial assessment; any known ACP documentation; input from person/ family/whānau.

Person PROBLEM / FOCUS	GOAL	ACTIONS
Te Taha Tinana		
PAIN	Person is pain free • Verbalised by person if conscious • Pain free on movement • Appears peaceful	e.g. Consider need for positional change ☐ ....
AGITATION	Person is not agitated • Person does not display signs of delirium, terminal anguish, restlessness (thrashing, plucking, twitching)	e.g. Exclude retention of urine as cause ☐ e.g. Consider need for positional change ☐ ....
RESPIRATORY TRACT SECRETIONS	Excessive secretions are not a problem	e.g. Medication to be given as soon as symptoms arise ☐ e.g. Consider need for positional change ☐ e.g. Symptom discussed with family/other ☐ ....
NAUSEA AND VOMITING	Person does not feel nauseous or vomits • Person verbalises if conscious	....
DYSPNOEA	Breathlessness is not distressing for person ☐ Person verbalises if conscious	e.g. Consider need for positional change ☐ ....
OTHER SYMPTOMS (E.G. OEDEMA, ITCH)	.....	....
MOUTH CARE	Mouth is moist and clean • See mouth care guidelines	e.g. Ensure mouth is kept moist ☐ e.g. Family/whānau/other involved in care given ☐ ....
MICTURITION DIFFICULTIES	Person is comfortable	e.g. Urinary catheter if in retention ☐ e.g. Urinary catheter or pads, if general weakness creates incontinence ☐ ....
MEDICATION	All medication is given safely and accurately	e.g. If syringe driver in progress check rate and site ☐ .....

Plan of care continued onto next page

PLANNING CARE

OURHEALTH HAWKE'S BAY
Whakawāteatia

Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

CARE PLAN PAGE 2 OF 2

Plan of care developed using information from initial assessment; any known ACP documentation; input from person/ family/whānau.

Person PROBLEM / FOCUS	GOAL	ACTIONS
MOBILITY / PRESSURE AREA CARE	Person is comfortable and in a safe environment	Mattress: ..... Position changes: ..... Personal Hygiene needs: .....
BOWEL CARE	Person is not agitated or distressed due to constipation or diarrhoea	.....
Taha hinengaro		
PSYCHOLOGICAL SUPPORT	Person becomes aware of the situation as appropriate	e.g. Person is informed of procedures ☐ e.g. Touch, verbal communication is continued ☐
	Family/whānau / other are prepared for the person's imminent death with the aim of achieving peace of mind and acceptance	e.g. Check understanding of nominated family/whānau/ others/younger adults / children ☐ e.g. Check understanding of family/whānau/others not present at initial assessment ☐ e.g. Ensure recognition that the person is dying and of the measures to ensure comfort ☐
Te Taha Wairua		
RELIGIOUS/ SPIRITUAL SUPPORT	Appropriate religious / spiritual support has been given	e.g. Support from Chaplaincy team may be helpful ☐ e.g. Consider cultural needs ☐
Te Taha Whānau		
CARE OF THE FAMILY/ WHANAU/ OTHER	The needs of those attending the person are accommodated	e.g. Consider health needs and support ☐
CULTURAL SUPPORT	Consider the cultural needs of the person/ family/whānau	.....
OTHER E.G. COMMUNICATION		.....

Health Professional Name: .....

Signature: ..... **Date:** .....

Please turn over for on-going assessment / outcome monitoring chart

OURHEALTH HAWKE'S BAY
Whakawāteatia

Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

ONGOING ASSESSMENT - OUTCOMES

The goals and action plan must be monitored a minimum of 4 hourly and more often if necessary. Each entry in this monitoring chart indicates the previous 4 hour.

Use the following code to indicate if in the past 4 hours the goals were achieved: Codes (please enter in columns(not a signature))
A= Achieved – The Goal was achieved and no additional interventions were required in the previous 4 hours
C = Change – Use this if the goal was not achieved and / or if additional actions were required to maintain the goal
If code C is used – details MUST be provided in the persons progress notes – including (PIE) Problem, Intervention and Evaluation

GOALS FROM CARE PLAN	Date:			Day:			Date:			Day:			Date:			Day:		
TIME																		
PAIN *Person is pain free* • Verbalised by person if conscious • Pain free on movement																		
AGITATION *Person is not agitated* • Person does not display signs of delirium, terminal anguish, restless (thrashing, plucking, twitching)																		
RESPIRATORY TRACT SECRETIONS *Excessive secretions are not a problem*																		
NAUSEA AND VOMITING *Person does not feel nauseous or vomits* • Person verbalises if conscious																		
DYSPNOEA *Breathlessness is not distressing for the person* • Verbalised by person if conscious																		
OTHER SYMPTOMS (E.G. OEDEMA, ITCH)																		
MOUTH CARE *Mouth is moist and clean*																		
MICTURITION DIFFICULTIES *Person is comfortable*																		
MEDICATION *All medication is given safely and accurately*																		
MOBILITY / PRESSURE AREA CARE *Person is comfortable and in a safe environment*																		
BOWEL CARE *Person is not agitated or distressed due to constipation or diarrhoea*																		
PSYCHOLOGICAL SUPPORT *Person becomes aware of the situation as appropriate*																		
Family/whanau/other are prepared for the person's imminent death with the aim of achieving peace of mind and acceptance																		
RELIGIOUS / SPIRITUAL SUPPORT *Appropriate religious / spiritual support has been given*																		
CARE OF THE FAMILY /WHANAU/OTHER *The needs of those attending the person are accommodated*																		
CULTURAL SUPPORT *Consider the cultural needs of the person/ family/whānau*																		
OTHER E.G. COMMUNICATION																		
HEALTH PROFESSIONAL INITIAL																		
DESIGNATION																		

ONGOING ASSESSMENT

OURHEALTH HAWKE'S BAY
Whakawāteatia

Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

ONGOING ASSESSMENT - OUTCOMES

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If code C is used – details MUST be provided in the persons progress notes – including (PIE) Problem, Intervention and Evaluation

GOALS FROM CARE PLAN	Date:			Day:			Date:			Day:			Date:			Day:		
TIME																		
PAIN *Person is pain free* • Verbalised by person if conscious • Pain free on movement																		
AGITATION *Person is not agitated* • Person does not display signs of delirium, terminal anguish, restless (thrashing, plucking, twitching)																		
RESPIRATORY TRACT SECRETIONS *Excessive secretions are not a problem*																		
NAUSEA AND VOMITING *Person does not feel nauseous or vomits* • Person verbalises if conscious																		
DYSPNOEA *Breathlessness is not distressing for the person* • Verbalised by person if conscious																		
OTHER SYMPTOMS (E.G. OEDEMA, ITCH)																		
MOUTH CARE *Mouth is moist and clean*																		
MICTURITION DIFFICULTIES *Person is comfortable*																		
MEDICATION *All medication is given safely and accurately*																		
MOBILITY / PRESSURE AREA CARE *Person is comfortable and in a safe environment*																		
BOWEL CARE *Person is not agitated or distressed due to constipation or diarrhoea*																		
PSYCHOLOGICAL SUPPORT *Person becomes aware of the situation as appropriate*																		
Family/whanau/other are prepared for the person's imminent death with the aim of achieving peace of mind and acceptance																		
RELIGIOUS / SPIRITUAL SUPPORT *Appropriate religious / spiritual support has been given*																		
CARE OF THE FAMILY /WHANAU/OTHER *The needs of those attending the person are accommodated*																		
CULTURAL SUPPORT *Consider the cultural needs of the person/ family/whānau*																		
OTHER E.G. COMMUNICATION																		
HEALTH PROFESSIONAL INITIAL																		
DESIGNATION																		

OURHEALTH HAWKE'S BAY
Whakawāteatia

Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

PROGRESS NOTES

If code C is used IN THE ON-GOING ASSESSMENTSECTION – details MUST be provided in the persons progress notes – including (PIE) Problem, Intervention and Evaluation

DATE	PROGRESS NOTES	SIGNATURE AND DESIGNATION

PROGRESS NOTES

OURHEALTH HAWKE'S BAY
Whakawāteatia

Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

PROGRESS NOTES

If code C is used IN THE ON-GOING ASSESSMENTSECTION – details MUST be provided in the persons progress notes – including (PIE) Problem, Intervention and Evaluation

DATE	PROGRESS NOTES	SIGNATURE AND DESIGNATION

12 of 13

OURHEALTH HAWKE'S BAY
Whakawāteatia

Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

CARE AFTER DEATH

NOTE: This section is to be used if advised by your organisation. It may be more appropriate to use your services Care of the Deceased Checklist or Forms

TIME OF DEATH	
Person has died	Date/ Time/ Signature: .....
People in attendance at time of death	.....
Person has been verified dead	Date/ Time/ Signature: .....
Person certified (Medical)	Date/ Time/ Signature: .....
AFTER DEATH CARE	
Discussed as appropriate with family/whānau procedures following death, e.g. funeral arrangement, viewing of the body/tūpāpaku	☐ Yes ☐ No
Bereavement support has been discussed ***See Organisation Policy on Care at death and after death***	☐ Yes ☐ No
ACTIONS COMPLETED	
Notify Next of Kin	☐ Yes ☐ No
Notify Attending Doctor	☐ Yes ☐ No
Clinical records complete	☐ Yes ☐ No
Ensure body correctly identifiable	☐ Yes ☐ No
Sign off Release of Body form (if applicable)	☐ Yes ☐ No ☐ N/A
WINZ notified/form printed (if applicable)	☐ Yes ☐ No ☐ N/A
Ministry of Health (MoH) notification/form printed (Death only)	☐ Yes ☐ No ☐ N/A
Options HB notified (if applicable)	☐ Yes ☐ No ☐ N/A
Community Providers are notified of Death (if applicable)	Cranford Hospice ☐ Yes ☐ No ☐ N/A District Nurses ☐ Yes ☐ No ☐ N/A NASC Agency ☐ Yes ☐ No ☐ N/A Home Support Agency ☐ Yes ☐ No ☐ N/A Other ☐ Yes ☐ No ☐ N/A ....

APPENDIX 5

OURHEALTH
HAWKE'S BAY
Whakawāteatia

TOOLS AND RESOURCES TO GUIDE THE CARE OF PEOPLE IN THEIR LAST DAYS OF LIFE

OURHEALTH HAWKE'S BAY Whakawāteatia

ADDITIONAL TOOLS

to assist with decision making and providing information to ensure the physical (tinana), psychological (hinengaro), spiritual (wairua) and family (wairua) wellbeing for all people is upheld.

TOOL	WHERE TO ACCESS
1. Identifying the dying person - Flowchart	Information Pack In hospital: Via Nettie Map of medicine
2. Symptom Management Algorithms Hawkes Bay Algorithms	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine
3. Hospital Discharge checklist	In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine
4. W.H.Ā.N.A.U: personalising care	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine
5. Spiritual care assessment tool (FICA)	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine
6. Breaking bad news flow chart (SPIKES)	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine
7. List of cultural support	Access organisations own resources

BROCHURES AVAILABLE	WHERE TO ACCESS
What to expect when someone is dying - information for family/whanau	For supplies of brochure contact : ?? Cranford Hospice Telephone 06 8787047
Tissue Donation - information for persons and family/ whānau	For supplies of brochure contact: Donor Co-Ordinator Organ Donation of New Zealand Ph 09 630 0935
What to do after death, grief and bereavement support - practical information for family/ whānau	For supplies of brochure contact: Funeral Directors Association of NZ (Inc) P O Box 10888 Wellington 6143 Email: info@fdanz.org.nz Website: www.funeralsnewzealand co.nz

OURHEALTH HAWKE'S BAY
Whakawāteatia

BREAKING BAD NEWS FLOWCHART

PREPARATION

Check the person's notes to assess what has already been discussed *(don't assume prior discussions have been remembered or understood)*
Check who should be present e.g. family, other health professionals
Set time aside with no distractions e.g. pager, mobile phone
Set the scene and ensure privacy

WHAT DOES THE PERSON KNOW?

It would help me to know what you understand about your illness, how did it all start, what is happening now?
(this is about gaining the person's level of understanding and engagement, ACP and EPOA)

IS MORE INFORMATION WANTED?

"Would you like me to give you more details about your illness?"

GIVE AN ALERT!.... AND…….PAUSE!

"I am afraid that it looks more serious than we hoped"

ALLOW PERSON TO REFUSE INFORMATION AT THIS TIME

"It must be difficult to accept this?" *(Determine how much they want to know at this time)*

GIVE EXPLANATION (IF REQUESTED)

A narrative of events may be helpful

ELICIT AND LISTEN TO ANY CONCERNS

"What are the main things that you are worried about?" *(Reassure that support is paramount)*

SUMMARISE AND PLAN

"Your main concerns at the moment seem to be…."

OFFER AVAILABILITY AND SUPPORT

Offer follow up discussion, e.g. social work referral, church minister, chaplain, cultural support services

COMMUNICATE WITH MULTIDISCIPLINARY TEAM AND DOCUMENT

Clearly document conversation in clinical notes and who was present at this discussion

BREAKING BAD NEWS FLOWCHART

OURHEALTH HAWKE'S BAY Whakawāteatia

ADAPTATION OF SPIKES*

S	**SETTING** up the discussion	• read notes/test results • check who should be present ; involve significant others; is a translator needed? • arrange privacy; think of tissues/water • set time aside with no distractions e.g.pager • mentally prepare self how news will be shared and how to respond to reaction • sit down and make a connection with person/family/whanau
P	Assessing the **PERCEPTION** of condition/ seriousness	• use open ended questions to gather how person perceives the situation e.g. What have you been told so far? • listen to their level of comprehension, accept denial but do not confront at this stage; this can correct any misinformation and tailor breaking news to what they already understand
I	**INVITATION** from person to give information	• how much do they want to know "Are you the sort of person who likes to know everything?" • accept the person's rights not to know -"Would you like me to give you all the information or sketch out what has happened and spend more time discussing the treatment plan?"
K	**KNOWLEDGE:** giving facts and information to person	• warning the person that bad news is coming lessens the shock and can facilitate information processing "I'm sorry to tell you that…" "The results are not as good as we hoped" • use language intelligible to person; use diagrams if helpful • consider their emotional state • give information in small chunks; avoid jargon and acronyms • Avoid excessive bluntness and avoid "There is nothing more we can do" as this maybe inconsistent with their own goals such as good pain relief and control
E	**EXPLORE** emotions and empathize	• observe and identify emotions expressed by person "You appear sad" "I can see how upsetting this is for you" • what strategies/mechanisms have they used in the past to deal with bad news? • do they have a particular outlook on life/cultural/spirituality that helps • who are the important people in their life
S	**STRATEGY & SUMMARY**	• draw up plan with person "Your appointment to see Mrs Brown the oncologist is on…" "You are going to contact the funeral director…" • consider immediate plans – what are you doing next; who will you tell/ how will you tell them; how will they cope? • have person repeat key points to ensure that they have understanding • does anything need to be clarified or any other questions? • by understanding person's goals, hope can be fostered to help them accomplish their goals • offer other professional support e.g. Chaplain, cultural support, social work referral, funeral director • document/communicate discussion/plan with other professionals that need to know • close the meeting

- Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES-A six-step protocol for delivering bad news: application to the person with cancer. Oncologist 2000;5(4):302-311.
- Kayleigh Steel, Michael Kennedy, Sean Prendergast, Christina Newton, Andrew MacGillivray and Aileen D'Arcy
- www.physio-pedia.com/File:SPIKES_Table.jpg

OURHEALTH HAWKE'S BAY
Whakawāteatia

Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

DISCHARGE CHECKLIST FOR A PERSON IN THEIR LAST DAYS OF LIFE

CHECKLIST	YES	NO	N/A	SIGNED	DATE	COMMENT
Does the person have a preferred place of care						
Person/family are aware of prognosis						
Person's main nominated contact supports decision for discharge						
Not for Resuscitation complete						
Ambulance booked – aware of Not for Resuscitation						
GP or nominated other aware of discharge and arrangements made for GP to visit.						
Hospice is aware of discharge						
District Nurse updated of care needs and discharge date and time (inclusive of Rural/CHB and Wairoa)						
Aged Residential Care updated of care needs and discharge date and time						
Assessment completed by Needs Assessment Co-Ordination Agency (Options HB) and individual care package in place						
Other MDT members aware e.g. social worker, OT, physio						
Current medication assessed and non essential medication discontinued						
Discharge medication/s ordered: Appropriate subcutaneous AND anticipatory medication prescribed and faxed to pharmacy.						
If person is being discharged with a continuous infusion pump. Complete appropriate Discharge Checklist.						
Person/family understand the discharge medication						
Equipment delivered/planned e.g. electric bed, mattress,						
Oxygen arranged if applicable.						
Circle of Support has been completed and documented who is the first point of contact.						

DISCHARGE CHECKLIST FOR A PERSON IN THEIR LAST DAYS OF LIFE

11.2

OURHEALTH HAWKE'S BAY
Whakawāteatia

W.H.A.N.A.U: PERSONALISING CARE AT END-OF-LIFE

This has been designed as a prompt card providing potential conversation starter questions to guide conversations about end of life. The background image of Te Whare Tapa Whā (Durie 1985) reminds of the need for a holistic approach to care and W.H.A.N.A.U. guides conversations to ensure that care for people can be personalised.

'W.H.Ā.N.A.U' - PERSONALISING CARE AT END-OF-LIFE

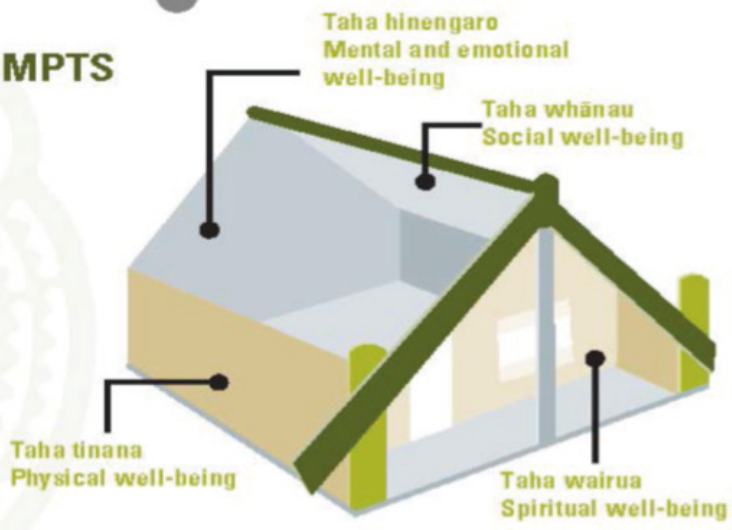
- ✓ **WHO TO ASK?** It may be better to talk with a whānau spokesperson, or with the whānau or family all together
- ✓ **HAVE** *time* and *space* to talk and *offer* thinking time
- ✓ **ASK** - don't assume what's important to you is the same for others
- ✓ **NEED** others to join these conversations? – friends, whānau
- ✓ **AGAIN** - people's needs change, so ask again
- ✓ **UNCOMFORTABLE** asking or responding to these questions? Ask for help – colleagues, chaplains, cultural advisors

SOME USEFUL PROMPTS

What can we do now to help you and those people important to you to feel safe and comfortable?

Do you have beliefs and family traditions that are especially important to you?

What are the important things about you and your whānau that we need to know right now?



Source: Batten et al (2014)

OURHEALTH HAWKE'S BAY
Whakawāteatia

SPIRITUAL CARE ASSESSMENT TOOL BASED ON FICA APPROACH

SPIRITUAL CARE ASSESSMENT TOOL BASED ON FICA APPROACH

BACKGROUND

The FICA Spiritual History Tool was developed by Dr Puchalski and a group of primary care physicians to help physicians and other healthcare professionals address spiritual issues with persons. Spiritual histories are taken as part of the regular history during an annual exam or new person visit, but can also be taken as part of follow-up visits, as appropriate. The FICA tool serves as a guide for conversations in the clinical setting.

SUGGESTED QUESTIONS

These should be adapted to suit each person and revisited as person circumstances change.

Faith	What things do you believe in that give meaning/value to your life? **and/or:** Do you consider yourself spiritual or religious? **and/or:** **and/or:** What is your faith or belief?
Importance	In what ways are they important to your life? **and/or:** What influences do they have on how you take care of yourself?
Influence	**and/or:** How are your beliefs/values influencing your behaviour during your illness? **and/or:** In what ways do your beliefs/values help you in regaining your health/ wellbeing?
Community	Is there a person or group of people who you love or who are very important to you? **and/or:** How is this supportive to you? **and/or:** Do you belong to a religious/cultural community?
Address	Is there anything we can do to help you while you are with us? **and/or:** Would it help to talk to someone about these issues?

An example of a spiritual assessment in a non-religious person

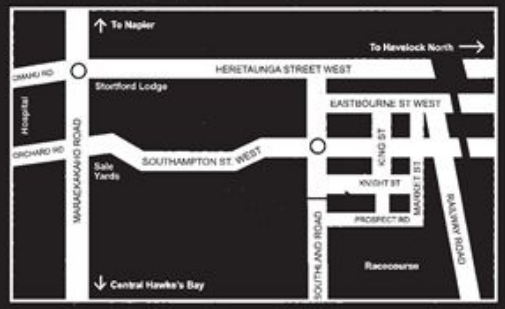
F	Naturalist
I	Feels at one with nature. Each morning she sits on her patio looking out over the trees in the woods and feels 'centered and with purpose"
C	Close friends who share her values
A	After discussion about belief, she will try to meditate, focusing on nature, on a daily basis to increase her peacefulness

You can refer to the faith leader or Chaplaincy Department at any time, but some specific situations may include:

- When one's own belief system prohibits involvement in the spiritual/religious/cultural care of the person
- When spiritual or religious/cultural issues seem particularly significant in the person's suffering
- When spiritual or religious/cultural beliefs or values seem to be particularly helpful or supportive for the person
- When spiritual or religious/cultural beliefs or values seem to be particularly unhelpful for the person
- When addressing the spiritual or religious/cultural needs of a person exceeds your comfort level
- When specific community spiritual or religious/cultural resources are needed
- When you suspect spiritual or religious/cultural issues which the person denies
- When the person or family have specific religious needs e.g. Confession, Holy Communion, Sacrament of the Sick, needs a prayer mat or private space to pray, sacred texts, etc
- When the person's family seem to be experiencing spiritual/emotional pain or trauma
- When members of staff seem to be in need of support.

Source: Puchalski and Larson (1998)

"You may want a friend, someone from your family or whānau or a minister to be with you now."



WHAT TO EXPECT WHEN SOMEONE IS DYING

What to do when your loved one dies

You don't have to do anything straight away. There's no need to call the police or an ambulance. You will need to call the hospice nurse or your GP at some stage to tell them your loved one has died. A doctor will need to prepare a death certificate. If death occurs at night and you are comfortable being at home with your loved one, make these calls in the morning – usually after 7am.

Your loved one's body can stay at home for several hours for relatives and friends to visit and pay their respects. Phone the hospice nurse if you need help at this time. If not, you'll need to lie your loved one on their back. Cover them only with a light sheet. Make sure electric blankets and heaters are off and the room is cool. You may want a friend, someone from your family or whānau or a minister to be with you now.

Cranford Hospice 24 hour contact number 06 878 7047

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Cranford hospice hawke's bay

A Service of: Presbyterian Support East Coast

This brochure describes some of the typical features of the process of dying. It may help to reduce anxiety about the unknown.

The dying process is unique to each person, but in most cases there are common characteristics or changes that help to indicate that a person is imminently dying.

Death usually comes gradually and peacefully, and there are many changes that signal life is coming to an end. Most that occur at this time are normal and don't need any special treatment, hospitalisation, or professional help.

If you are unsure about anything, please call Cranford Hospice or the health professional supporting you at this time.

Here are some of the changes that may occur when someone is dying:

Not eating or drinking

As people get closer to dying, the body does not need fluid to function. Your loved one is likely to lose interest in food and drink to the point that they're not eating or drinking anything at all. They may have lost the ability to swallow, so don't try to give them drinks at this stage because liquid will only pool at the back of their throat. Moistening the mouth with ice chips or a wet cloth may be all that is needed.

Increased confusion and restlessness

It is common for dying people to be quite restless or agitated in the last 24 to 48 hours before they die. Try to reassure them by talking calmly and telling them who you are. Don't make sudden noises or startle them. Constant touching or stroking may be disturbing, try gently holding their hand. Playing their favourite music may help to calm them.

Breathing

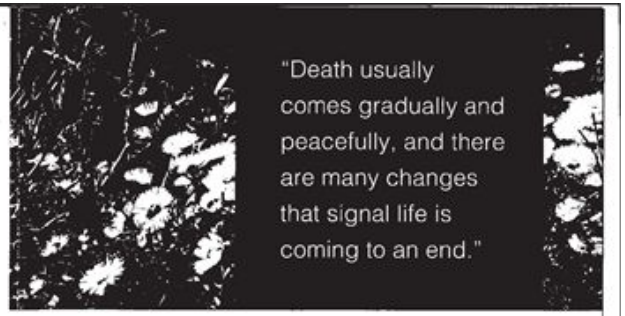
As your loved one finds it harder to swallow, saliva and secretions may collect at the back of their throat and make a noise when they breathe – it's sometimes called the 'death rattle'. This isn't distressing for them, but it might be to you. Raising the head of the bed with pillows may help.

As death approaches, you'll notice your loved one's breathing pattern changes. There may be gaps of seconds or minutes between breaths. When the gaps between breaths get longer and longer, it's a sign that death is close.

Sometimes when a person is taking their last breaths, they may seem to grimace. This isn't because they're uncomfortable, it's just the muscles in the upper part of their body and face contracting and relaxing.

Changing colour

As blood circulates more slowly, your loved one's arms and legs will start to feel cool and may look patchy/mottled and dark. Their face may be pale and pinched, their nose may feel cold and the beds of their fingernails and toenails may turn blue. You may notice their skin is clammy and marks easily where they're touched. There's no need to put on



"Death usually comes gradually and peacefully, and there are many changes that signal life is coming to an end."

a lot of extra bedding or an electric blanket – this might just make them restless. Depending on the weather, a sheet and a few warm blankets should be enough.

Incontinence

Sometimes there is a loss of control of bowels or bladder. It will be important to discuss this with your nurse in order to get appropriate supplies.

How to tell if your loved one has died:

- Their breathing stops
- Their chest stops moving up and down
- They will have no heartbeat or pulse
- They don't respond when you shake them or talk loudly
- Their eyes are fixed and their pupils are dilated – sometimes their eyelids stay open
- Their jaw relaxes – sometimes their mouth stays open
- They may have lost control of bladder or bowels

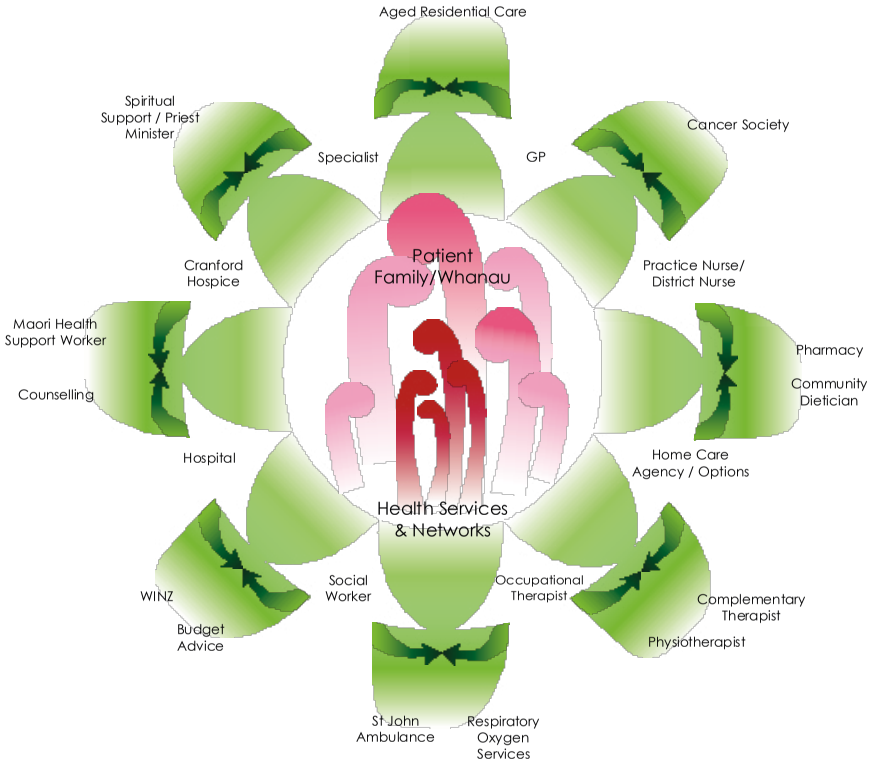
Appointments

Notes

‘Palliative care is a sacred encounter for any culture’

Palliative Circle of Support

For Hawkes Bay



Referral into

Partnership of Care Services

Acknowledgement: This resource was produced in Wairoa by Gae Redshaw RN- Hawkes Bay District Health Board

Important Contact People:	Phone Numbers:
GP Practice	
Doctor	
Practice Nurse	
Hospital / Acute Ward	
District Nurse	
Pharmacy	
Cranford Hospice	
Nurse / Kaitakawaenga	
Social Worker	
Maori Health Provider	
Cancer Society Support Care	
Spiritual Support	
Occupational Therapist	
Home Care Agency	
Care Person	
Physiotherapist	
Ambulance *(Are you a member of St Johns Ambulance?)*	
Other	

(Keep this information inside your diary)

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OURHEALTH
HAWKE'S BAY
Whakawateatia

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TRANSFORM & SUSTAIN REFRESH

Presentation – Tim Evans

AIM 24/7 VERBAL UPDATE

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Dr John Gommans

LABORATORY SERVICES COMMITTEE

Dr Kiri Bird, Chair

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Title: **Draft Laboratory Testing Guidelines**		Effective date: **December 2015**
Document Owners *Dr John Gommans, CMO Hospital* *Dr Mark Petersen, CMO Primary Care*	Authorised by ***Head of Laboratories***	Version: **01** Document expiry date: **October 2018**

Introduction

The main aim of these guidelines for laboratory testing is to ensure appropriate and effective use of laboratory tests in Hawkes Bay DHB. They have been developed primarily to reduce requests for tests that are clinically inappropriate and/or unlikely to be of benefit to management of the patient.

Unnecessary tests are a waste of resources and also can cause harm:

- A study of 1900 patients undergoing cardiac surgery published in the Annals of Thoracic Surgery found the average patient had 115 tests and 454 mL of blood drawn!
- Another study showed the finding of bacteriuria from doing MSUs in asymptomatic elderly patients led to inappropriate antibiotic prescribing exposing patients to side effects. Chasing incidental findings on unnecessary tests can cause harm to patients.

These guidelines are also intended to ensure we make the most appropriate use of our resources, including low cost high volume and low volume expensive tests.

Having agreed guidelines helps protect patients by ensuring only appropriate tests are done and protect clinicians as the DHB accepts liability for the risk of complaint or poor outcome as a result of not requesting a test based on these guidelines..

These guidelines have been endorsed by the Hawkes Bay DHB Laboratory Committee, Executive Management Team and Clinical Council.

In the future these guidelines will be used to develop rules for electronic ordering.

The guidelines focus on tests that are:

- commonly requested but may have limited clinical utility,
- commonly repeated unnecessarily,
- expensive and so will require appropriate level of authorisation.

The guidelines have been organised into:

The National Radiology Access Criteria state that: ***"a useful investigation is one in which the result – positive or negative – may alter management and improve the outcome for the patient"***.

The same reasoning applies to laboratory testing. Clinicians are encouraged to consider whether the requested investigation meets these criteria as currently a significant number of laboratory investigations do not fulfil these aims.

Clinicians should avoid repeating tests that have recently been performed without a clear resaon. Clinicians should check which tests have been done and ideally this should include reviewing all Laboratory results. There should be consideration of whether the test actually needs to be repeated and if the results will influence patient management.

Screening for some conditions in sick patients in hospitals is inappropriate as tests can be falsely positive or give misleading results. Laboratory testing should be done after regard to your patient's clinical symptoms.

Laboratory reference ranges cover 95% of a 'normal' population, therefore a clinician should expect 5% of their requested results to be abnormal on their "normal" patient. To further investigate such results without matching to the clinical condition is effectively "medicalising" a healthy patient. Routine screening is best left to GPs.

Guideline Development

The **Best Practice Advocacy Centre** (BPAC) has an excellent summary of the general principles of laboratory investigations in primary care. These also apply to hospital practice. The BPAC emphasize **"Testing, testing: one, two, three"**

1. **Think twice before you test**
2. **Select the right test, at the right time, for the right patient**
3. **Ask yourself: can I improve my testing?**

A **Laboratory Test Schedule** was developed by DHB Shared Services in 2013. Guidance is provided on the ordering of laboratory tests. In the schedule, tests have been categorised as 'Tier One' and 'Tier Two' tests. A 'Tier One' test is able to be ordered by any medical practitioner; a 'Tier Two' test requires the clinician to have appropriate vocational registration or credentialing to be able to order the test.

See the **www.DHBSHAREDSERVICES.HEALTH.NZ** for further details.

Source of Recommendations.

Laboratory Test Referral Guidelines have been developed by DHB Shared Services, which provide an overview of the indications for testing, referral criteria and recommendations on frequency of testing for some of the tests on the schedule.

It is noted that these guidelines do not override established local care-pathways or guidelines which represent local consensus but should be used to inform and supplement them.

These Hawke's Bay guidelines are based on a combination of the Shared Services recommendations and the **Choosing Wisely** recommendations (see next page).

Where no guideline exists consensus has been sought from senior clinicians working in Hawkes Bay DHB.

Recommendations based on the DHB Shared Services **Laboratory Test Referral Guidelines** s are in **green**, those from Choosing Wisely are in **red** and **Hawkes Bay** recommendations are in bold **black** font.

Genetic Testing: The Laboratory Test Schedule also includes comprehensive guidelines on genetic testing and emphasize that clinicians seek advice before requesting such tests. The **BPAC site** also has a very useful document summarising the available genetic tests and their role in primary care.

Electronic Ordering: In the future electronic ordering will include forcing functions to minimise inappropriate testing or too frequent repeating of tests without clinical justification. Until then we are reliant on limited laboratory rules and the education of clinical staff to change practice and clinical audit.

The DHB Shared Services' Working Group supports the need for an electronic platform, integrated into Practice Management Software. The Ministry of Health is currently undertaking work to code the tests for this purpose. The Ministry note that until we get electronic ordering of laboratory tests, the schedule and guidelines will be used as

a point of reference.

Choosing Wisely

The American Boards in Internal Medicine have started an initiative to rationalise management.

The ABIM note:

"W*aste and overuse are widespread in US medicine, affecting both the quality of care (up to 30,000 deaths annually from overuse) and costs to the health care system."*

Similar initiatives are being undertaken in Australasia as 'Choosing Wisely Australia' including the Royal Australian College of Physicians which has established the 'Evolve' program.

We have included the relevant 'Choosing Wisely' recommendations in these guidelines

The general recommendations are listed here:

General Recommendations from Choosing Wisely

Do not order repeated laboratory tests for patients transferred into the ED who have laboratory results within reference range available from outside of the hospital (GPs).

Do not order screening laboratories (e.g., CBC, chemistry studies) for patients with uncomplicated gastroenteritis or viral syndromes.

Don't do regular testing but test in response to clinical questions.

Don't do repeat CBC and biochemistry if clinically stable.

Don't obtain baseline laboratory studies in patients without significant systemic disease undergoing low-risk surgery; specifically complete CBC, basic or a metabolic panel, or coagulation studies when blood loss (or fluid shifts) is/are expected to be minimal.

See the following links for further information:

America's Epidemic of Unnecessary Care - The New Yorker

Choosing Wisely American Boards in Internal Medicine

Choosing Wisely Website (with search engine)

Choosing Wisely Recommendations Australia ACEM 2015

US ACEM Top-Five List JAMA 2014

Choosing Wisely in the UK BMJ 2015

Triage Bloods in the Emergency Department

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The following tests will be requested (if clinically indicated) by the triage nurses for patients referred to inpatient teams:

General Medicine
- CBC, Creatinine, Urea, Na, K, Glucose, *(*but **not** lipids*)*.
- LFTs, Calcium and Phosphate will also be requested if indicated or the diagnosis is unclear.

Overdose
- CBC, Creatinine, Urea, Na, K, LFTs, Glucose, Paracetamol level, Ethanol level (if intoxication suspected), bHCG (if pregnancy possible).

Cardiology
- CBC, Creatinine, Urea, Na, K, Trop I, Glucose.

Abdominal pain
- CBC, Creatinine, Urea, Na, K, LFTs, Amylase

Trauma
- As for abdominal pain plus Ethanol level if suspected.

PV bleed
- CBC, Glucose, bHCG, Group and Hold.

Specific additional tests (listed alphabetically) that may be ordered in ED include:

bHCG in all women of child bearing age where pregnancy is possible **and** it is clinically relevant to quantify with a serum bHCG

Blood Gases and **Blood Cultures** if indicated (see page 7 and 17 for details).

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CK only if rhabdomyolysis is suspected.

Coagulation studies (INR & APTT) will only be done for specific indications such as patients on anticoagulants, significant liver disease and if a suspected coagulopathy in unwell patient.

CRP will **only** be done for assessment of occult infective and inflammatory conditions. The CRP is not a de facto measurement of "unwellness" and will not be done on routine conditions or infections. See the costs and indications on page 9 for more details.

D-dimer will only be done in patients with suspected VTE when clinical assessment indicates low to intermediate probability VTE (DVT/PE).

Ethanol levels will be checked if suspected intoxication or in undifferentiated overdose, abnormal behaviour or decreased LOC.

Troponin I will only be done if cardiac ischaemia suspected.

Urate if gout is suspected and cannot be diagnosed by joint aspirate, remembering that if the urate is not elevated it does not rule out gout and if elevated this does not rule it in.

Urinanalysis perform a dip stick first and only send onto the laboratory if there is just cause for requesting microscopy, culture, and sensitivities.

Common Tests and Repeat Testing

We have grouped the tests under departments (Haematology, Biochemistry, Immunology and Microbiology) and in each section we have listed the tests in alphabetical order.

Haematology

Blood count (Cost approximately $9)

A CBC is the single most costly test performed in Hawkes Bay due to volumes requested. Nearly 126,000 tests costing almost $1.1 million are done every year. Many CBC tests are repeated unnecessarily.

The Choosing Wisely recommendations include the following relevant general recommendations which will apply to CBCs:

Don't do regular tests but test in response to clinical questions.

Don't do repeat tests if clinically stable; repeat only when clinically indicated.

Do not repeat laboratory tests for patients transferred into the ED who have laboratory results within reference ranges available from outside hospital.

Don't do screening tests in low risk patients undergoing low risk surgery.

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Coagulation screen – INR & APTT ($10)

The Choosing Wisely recommendations include the following:

Avoid coagulation studies unless there is a clearly defined specific clinical indication, such as for monitoring of anticoagulants, in patients with suspected severe liver disease or coagulopathy.

D-dimer ($28)

D-dimer has limited specificity, rises with age and is raised in most inflammatory conditions and therefore.will be positive in many hospitalised patients without VTE. Testing should be restricted to those patients with a high enough clinical suspicion of VTE to merit further investigation, not to rule out the remote possibility of VTE:

Do a D-dimer only in patients with low to intermediate probability VTE (DVT/PE) where there is a high enough suspicion to justify further investigation for VTE by imaging if the result is positive.

Do not do a D-dimer in post-operative patients.

ESR ($8)

The Choosing Wisely recommendations include the following:

Don't order an ESR to look for inflammation in patients with undiagnosed conditions. The laboratory will only perform an ESR for the following clinical conditions when indicated on the laboratory request form:

Adult clinical indications	Paediatric clinical indications
Temporal Arteritis	Kawasaki
Rheumatoid Arthritis	Rheumatic fever
Polymyalgia Rheumatica	Ulcerative colitis
Rheumatic fever	Chrohn's disease
Vasculitis	SLE
Connective tissue disease	? Junior Idiopathic Arthritis (JIA)
Hodgkin lymphoma	
Post op joint replacements ? infected	

Haemochromatosis studies ($100)

Many tests are not indicated.

The commonest cause of hereditary haemochromatosis is mutations in the HFE genes.

Most patients (90%) with hyperferritinaemia will not have hereditary haemochromatosis.

14.1

Testing is appropriate for investigation of hyperferritinaemia but **only** if there is one or more of:

- persistent hyperferritinaemia that is not explained by the more common causes such as alcohol intake, fatty liver, liver pathology or inflammation, or
- severe hyperferritinaemia (persistently >1000 without severe inflammation), or
- hyperferritinaemia with fasting iron saturation >0.50.

Testing is also indicated in screening of relatives a patient with confirmed haemachromatosis.

Do not do HFE genotype testing for hyperferritinaemia without these indications and first checking that this test has not already been done. Genetic testing should only be performed once in a patient's life time!

JAK2 V617F Mutation ($190)

Testing should always be discussed with a haematologist. JAK2 mutations are associated with the myeloproliferative disorders polycythaemia vera (PV), essential thrombocythaemia (ET) and myelofibrosis.

Testing is usually indicated in the presence of sustained erythrocytosis (Hb > upper normal limit) and/or thrombocytosis (platelets >600) and if this is not clearly explained by other causes (for example chronic hypoxia and inflammation, respectively). Venous thrombosis (particularly mesenteric) is occasionally associated with these conditions.

Thrombophilia testing (the costs of a typical screen are over $200, LAC alone is $97)

The Choosing Wisely recommendations include the following:

Don't test for thrombophilia in adult patients with venous thromboembolism (VTE) occurring in the setting of major transient risk factors (surgery, trauma or prolonged immobility).

Don't do an inherited thrombophilia evaluation for women with histories of pregnancy loss, intrauterine growth restriction (IUGR), preeclampsia and abruption. (Specific testing for antiphospholipid antibodies, when clinically indicated, should be limited to lupus anticoagulant, anticardiolipin antibodies and beta 2 glycoprotein antibodies).

When thrombophilia screening *is* indicated:

· Early age of onset < 45 years
· Familial history of venous thromboembolism (VTE) with more than two other symptomatic 1st degree family members
· Thrombosis after trivial provocation, age < 45 years with symptomatic 1st degree family member

· Intrauterine death at > 20 weeks gestation
· Stillbirth at > 20 weeks
· Neonatal purpura fulminans **(Protein C and S only)**
· Warfarin-induced skin necrosis **(Protein C and S only – patient cannot be on warfarin)**
· Association of thrombosis and fetal losses (**Lupus anticoagulant only)**
· Arterial thrombosis (**Lupus anticoagulant only)**

When thrombophilia screening *is not* indicated:

· Commencement of oral contraceptive/hormone replacement therapy.
· general obstetrics – those clinically at risk should receive thromboprophylaxis regardless of thrombophilia screening
· cancer patient screening
· Recurrent idiopathic thrombosis - by definition this is an indication for prolonged secondary prophylaxis
· Age of onset >45 years

Note:
The existence of underlying conditions, drugs and treatment need to be considered as these may be the causative agents of clot formation.
Always check if this test has already been done - the genetic thrombophilia tests should only be performed once in a patient' life time.

Transfusion Medicine

Cross- match ($54 + $284 per unit of red cells; $823 per bag of platelets; $212 per bag of FFP)

Blood is a precious and expensive product. Many patients who have a cross-match never get transfused so blood is wasted. Unnecessary blood transfusions are common. We recommend:
Do not do a cross match unless the patient is going to be given blood for active bleeding and/or is very likely to require an urgent blood transfusion. Do not 'order two if one will do'.

Group and Save ($44 and an additional $80 if an antibody is found)

Many patients who have a 'Group and Save' never get transfused. We recommend:

Do not do a 'Group and Save' unless the patient is likely to require an urgent blood transfusion (major surgery or actively bleeding).

Do not do a 'Group and Save' in stable patients with a chronic anaemia or 'just in case'.

Biochemistry

Blood gases ($17)

Blood gases are "the" possibly most inappropriately over-requested blood test in Hawke's Bay costing $400,000 a year. There has been a 51% increase in requesting since 2011-12

We recommend:

Do not do blood gases "to get a quick set of electrolytes".

Do not do arterial gases if venous gases will give the answer.

Blood gas analysis is time-consuming and relatively more expensive (than usual creatinine/electrolytes) taking laboratory staff away from other duties and so affects timeliness of other work.

In most cases (including suspected metabolic conditions like DKA, lactic acidosis or bowel ischaemia) a venous blood gas (**VGB**) guides management as well as an arterial blood gas.

Arterial blood gas (**ABG)** should only be done in selected patients with severe respiratory illness if the result of the arterial pC02 or A-a gradient will aid decision making, and in intubated patients.

Taking an arterial specimen is much more painful, so don't do an ABG if a VBG will suffice.

B12 and Folate ($5) – available only during weekdays

These are commonly requested and repeated without good clinical indications. We recommend: Do not do B12 and folate unless there is a suspicion of deficiency or malabsorption, for example peripheral neuropathy or macrocytic anaemia, or in unexplained dementia. Do not do a B12 and folate until you have checked it has not been done within the past month.

BNP ($38)

BNP testing is restricted within Hawke's Bay Hospital. Many BNP tests add little to patient management. The DHB Shared Services **Laboratory Test Referral Guidelines** note:

The natriuretic peptides are extremely useful for evaluation patients with non-specific symptoms of early chronic heart failure. In particular, the strong negative predictive value of a normal result is very useful and enables evaluation and treatment to be directed elsewhere.

A clearly high result supports heart failure, although in most acute cases this is clinically obvious through other means and measurement adds little to management or prognosis.

The value is much less well established for guiding ongoing anti-failure treatment, and at present they have a secondary role only. NICE guidelines (UK) recommend their use for this purpose be restricted to difficult patients under specialist management. Current NHF/NZGG guidelines do not specifically restrict their use in this setting but have not encouraged it.

We recommend:

The BNP should only be used in patients with suspected but undiagnosed heart failure.

Do not do a BNP if the result will not change management.

Do not use the BNP routinely to monitor therapy in heart failure.

The laboratory will not process repeated BNP requests within 48 hours. Clinicians have the opportunity after review of the patient to confirm the need of the test by contacting the laboratory.

Calcium, Magnesium and Phosphate ($2.5)

We recommend these should be requested selectively (for example in malignancy or CKD): **Do not do Calcium, Magnesium and Phosphate unless clinically indicated.**

Cholesterol and Lipids ($5.5)

The Choosing Wisely recommendations include the following:

Do not routinely test for hyperlipidaemia in those with a limited life expectancy.

We also recommend:

Do not do 'screening' lipids during an acute hospital admission.
Do not request lipid studies within three months after of previous testing.
Do not request lipid studies after an acute myocardial event as the cholesterol drops by greater than 10% within 24 hours of the event.

Creatinine, Urea and Electrolytes ($2.5)

Routine testing is not indicated in all admissions. Many tests are repeated unnecessarily. As noted under the general recommendations from Choosing Wisely:

Don't do regular tests but test in response to clinical questions.

Don't do repeat tests if clinically stable; repeat only when clinically indicated.

Do not repeat laboratory tests for patients transferred into the ED who have laboratory results within reference ranges available from outside hospital.

Don't do screening tests in low risk patients undergoing low risk surgery.

We also recommend:

Do not repeat the creatinine and electrolytes if they were normal unless there are clinical indications to suggest a likely change (eg hypotension, reduced urine output).

CRP ($10.38)

CRP testing costs about $650,000 a year and many tests add little to patient management.

We recommend:

Do not request CRP unless it is clinically indicated.

Do not repeat the CRP without a good reason.

The CRP is not a de facto measurement of "unwellness".

If clear indications exist, a CRP can be used to detect occult inflammation.

A CRP does not help in the ongoing management of an obvious infection such as cellulitis and the clinical progress of a patient is a much better guide to management of most patients. There is never any justification for daily CRPs!

Ferrritin and Iron (Ferritin $7, Iron and TIBC $4)

Iron studies rarely provide additional information to a ferritin in cases of iron deficency.

We recommend:

Do a ferritin in the initial investigation of patients with suspected iron deficiency.

Do iron saturation in the investigation of suspected haemachromatosis.

HBA1C ($12)

HBA1C testing costs just under $400,000 a year. More tests are being done as HBA1C is used for diagnosis as well as monitoring but many tests are repeated too frequently. We recommend:

Do not repeat the HBA1C within 3 months of previous testing in Type 2 Diabetes.

Repeat testing (within 3 months) may be helpful in selected patients with very poorly controlled Type 1 diabetes and in pregnancy but the laboratory will not repeat the HBA1C within 28 days.

LFTs

We recommend:

Do not request routine LFTs in all admissions. Do LFTs only if clinically indicated.

Do not repeat LFTs without a good clinical reason.

Do not repeat LFTs too frequently (and virtually never within 24 hours).

With very mildly abnormal LFTs in sick patients a full screen of tests for all possible causes of liver disease is not indicated. It is often best to ask the GP to repeat the LFTs after an interval.

If chronic viral hepatitis is a possibility consider requesting HBsAg and Anti-HCV antibody.

Thyroid Function Tests ('TFTs') (TSH $7, Thyroxine $7) The Choosing Wisely recommendations include the following:

Don't order multiple tests in the initial evaluation of a patient with suspected non-neoplastic thyroid disease. Order thyroid-stimulating hormone (TSH), and if abnormal, follow up with additional evaluation or treatment depending on the findings.

Don't order T3 levels when assessing levothyroxine (T4) dose in hypothyroid patients. The DHB Shared Services **Laboratory Test Referral Guidelines** note:

Free T3 measurement is useful only in specific clinical settings:

- Evaluation of possible or established hyperthyroidism. It can identify the severity and also patients with low TSH but normal FT4 (either 'T3 toxicosis' or early recurrence) ☐ Monitoring of patients on thyroid replacement in two specific circumstances:
  - patients with hypopituitarism, sometimes as an adjunct to measurement of free T4, because the TSH is typically unreliable in such patients.
  - sometimes in monitoring of patients on suppressive treatment for thyroid cancer
- Rare clinical settings of TSH secreting pituitary tumours or defects in thyroid hormone metabolism or action (e.g. congenital deiodinase deficiency, hormone resistance)

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We also recommend:

Do not do TFTs as a screening test in hospital admissions.

Do not do TFTs unless there is a clinical indication (for example new AF).

Do not repeat TFTs without a good reason – i.e. Within four weeks.

Do not repeat TFTs within 4 weeks of starting or changing treatment of thyroid disease except in patients with severe thyrotoxicosis (who should be under Endocrinology). Our laboratory adds the FT4 if the TSH is elevated and both FT4 and FT3 if the TSH is low.

Troponin ($9)

Troponin elevation is common and has limited specificity in very sick patients.A recent study stressed the importance of assessing the change in troponin as the most specific test for ACS – in this study a change of 40% over a 2-h time interval improved the positive predictive value of the test by more than 95%.
We recommend: **Do not do a Troponin unless an acute coronary syndrome is strongly suspected or needs to be excluded.**

Tumour markers (CEA $15, CA 125 $18, CA19-9 $18, PSA $10)

The Choosing Wisely recommendations include the following:

Do not perform serum tumour marker tests except for the monitoring of a cancer known to produce these markers.

Do not perform PSA testing for prostate cancer screening in men with no symptoms and whose life expectancy is less than 7 years.

The DHB Shared Services **Laboratory Test Referral Guidelines** have recommendations for a number of specific tumour markers. They note tumour markers are **not** indicated for

- screening of an asymptomatic low risk population,
- investigation of non-specific symptoms, when the probability of malignancy is low, ☐ investigation of other suspected malignancies.

CEA testing costs $15, and, with over 6,000 tests a year costs us more than $100,000/year.

The DHB Shared Services **Laboratory Test Referral Guidelines** note:

CEA is elevated in patients with a wide range of malignancies including colorectal, gastric, pancreatic, lung, breast, and medullary thyroid cancer. It is also elevated in non-malignant disorders; ulcerative colitis, pancreatitis, cirrhosis, pleural inflammation, chronic renal failure and in

smokers. It is most widely used in monitoring colorectal cancer (CRC) but is not sufficiently sensitive to be used in screening and not selective enough to be used in diagnosis.

It is indicated in/for:

- Patients with symptoms or signs associated with high suspicion of CRC
- At diagnosis of CRC (to provide prognostic information)
- After treatment of CRC (to monitor response and detect relapse)
- In some cases of breast cancer to monitor response after treatment and detect relapse

CA125 testing costs $18, and, with 3,000 tests a year, costs us more than $50,000/year.

The DHB Shared Services **Laboratory Test Referral Guidelines** note:

CA 125 is elevated in patients with a wide range of malignancies including ovarian, pancreatic, lung, breast, endometrial, non-Hodgkin's Lymphoma and hepatocellular. It is also elevated in non- malignant disorders such as acute and chronic liver diseases, acute and chronic pancreatitis, rheumatoid arthritis, ulcerative colitis, endometriosis, menstruation, non-malignant ascites and pleural effusions, and SLE. It is most widely used in monitoring serous epithelial ovarian cancer and it may provide prognostic information. Its role in screening is still under evaluation but it may be useful in diagnosis in patients with high probability of ovarian cancer It is indicated in/for:

- Patients with features associated with high suspicion of ovarian cancer: persistent continuous or worsening unexplained abdominal or urinary symptoms and pelvic mass. □ Case detection in patients at high risk of familial ovarian cancer.
- At diagnosis of ovarian cancer to provide prognostic information
- After treatment to monitor response and detect relapse

CA 19-9 testing costs $18, and, with over 2,000 tests a year costs us $40,000/year.

The DHB Shared Services **Laboratory Test Referral Guidelines** note:

CA 19-9 is elevated in patients with a wide range of malignancies including pancreatic, gastric, colorectal, hepatic and ovarian. It is also elevated in non- malignant disorders such as acute and chronic liver disease, acute and chronic pancreatitis, biliary diseases, diabetes and irritable bowel syndrome. It is most widely used in monitoring pancreatic cancer but is not sufficiently sensitive to be used in screening and not selective enough to be used in diagnosis. It may provide prognostic information at time of diagnosis. It is indicated for:

- Patients with symptoms or signs associated with high suspicion of pancreatic cancer: progressive obstructive jaundice with weight loss and/or pain in the abdomen or mid back
- At diagnosis of pancreatic cancer to provide prognostic information
- After treatment of pancreatic cancer to monitor response and detect relapse

CA 15-3 testing costs $18, and, with over 1,000 tests a year costs us $20,000/year.

The DHB Shared Services **Laboratory Test Referral Guidelines** note:

CA 15-3 is elevated in patients with a wide range of malignancies including breast, pancreatic, colorectal, lung, endometrial, liver and ovarian. It is also elevated in non-malignant disorders such as cirrhosis, benign breast disease and gynaecological disorders and pregnancy. It is most widely used in monitoring breast cancer patients after treatment although evidence this improves outcomes is weak. It does not have the required sensitivity or specificity to be used as a screening or diagnostic test. At diagnosis of breast cancer the level of CA 15-3 can provide information about the likelihood of metastases.

It is indicated:

- At diagnosis of breast cancer to provide prognostic information
- After treatment to monitor response and detect relapse

Vitamin D levels ($26)

Vitamin D testing is no longer routinely performed unless it meets the following criteria

1. Testing has been ordered by an endocrinologist; or
2. Testing has been ordered for a patient at high risk of bone disease; or
3. Testing has been ordered for a patient with suspected metabolic bone disease; or
4. Testing has been ordered after discussion with and approval by a Chemical Pathologist.

Testing has been ordered by a Paediatrician*The relevant clinical information must be provided on the request form in order for testing to be done*

14.1

Immunology

ANA ($25) ENA Screen ($30)

The Choosing Wisely recommendations include the following:

Don't test for ANA sub-serologies unless ANA +ve and clinical suspicion or evidence of rheumatic disease.

Don't repeat ANA if established JIA or SLE.

We recommend:

Do not request ANA unless there are features suggestive of a connective tissue disease. Do not repeat ANA within 12 months of previous tests unless the result does not fit the clinical picture or there has been evolution in the clinical picture.

Do not repeat ENA testing unless there has been a change in the clinical picture.

ANA testing has limited specificity and, if performed unselectively, gives many false positives.

ENA results do not usually change significantly with treatment and repeat testing is therefore not useful unless there has been a change in the clinical picture suggesting evolving disease. The laboratory will not process repeat specimens without being contacted or repeat ANA or ENA tests within 12 months without SMO discussion.

ANCA ($24)

The DHB Shared Services **Laboratory Test Referral Guidelines** recommend the following are indications for an ANCA:

1. Glomerulonephritis (especially RPGN),
2. Pulmonary haemorrhage (especially pulmonary renal syndrome),
3. Cutaneous vasculitis with systemic features, multiple lung nodules,
4. Chronic destructive disease of the upper airways,
5. Longstanding sinusitis or otitis,
6. Subglottic tracheal stenosis,
7. Mononeuritis multiplex or other peripheral neuropathy,
8. Retro-orbital masses,
9. Monitoring response to treatment (more controversial).

We recommend:

Do not do an ANCA unless a patient has one of these indications.

Coeliac Abs ($33)

Gliadin or deaminated gliadin peptide (DGP) is the preferred test for coeliac disease.

Testing costs the DHB over $60,000 a year. We recommend the following:

Do not test for coeliac disease unless there are good clinical reasons (for example unexplained iron deficiency or symptoms of malabsorption).

Faecal Calprotectin ($105)

Calprotectin tests cost over $300,000 a year. We have now restricted testing to SMO requests.

The laboratory will not repeat calprotectin testing within 28 days.

The DHB Shared Services **Laboratory Test Referral Guidelines** have the following:

Faecal calprotectin is a marker of intestinal mucosal inflammation that can be useful in differentiating between irritable bowel syndrome (IBS) and inflammatory bowel disease (IBD) in symptomatic patients. In IBD, levels correlate with disease activity and a concentration <50 µg/g is considered to be a good negative predictor (published negative predictive values 70-90%) and to help triage patients for colonoscopy. Levels >50 µg/g are associated with a risk of relapse.

The guidelines note the following indications and referral criteria:

- In patients presenting with diarrhoea, first line tests to exclude pathology may include CBC, CRP, ferritin, TFTs, stool culture and ova and parasites if travel history.
- Faecal calprotectin is a second line investigation if there is a concern about possible IBD, although may be a first line investigation if there is a family history of IBD. It may be particularly helpful in paediatric IBD when other investigations may be normal.
- In the presence of “red flags” (e.g. unexplained iron deficiency anaemia, rectal bleeding, weight loss or family history of colon cancer), faecal calprotectin testing may incur unnecessary delay in referral to a gastroenterologist and especially where there is likely consideration for colonoscopy.

Free light chains ($52)

Free light chain testing has increased over 79% in the last four years. The test measures the total amount of immunoglobulin light chain in the serum that is unbound (“free”) to immunoglobulin heavy chains. An imbalance of kappa v lambda isotypes is suggestive of monoclonal plasma cell dyscrasia.

The test can be used instead of urinary Bence Jones Protein in screening and diagnosis.

The DHB Shared Services **Laboratory Test Referral Guidelines** have the following:

The International Myeloma Working Group guidelines suggest that Serum Free Light Chains are used for prognostic purposes in patients with monoclonal gammopathy of unknown significance (MGUS) and also smouldering multiple myeloma, active multiple myeloma and amyloidosis. The test is indicated if the patient:

- has known or suspected myeloma or MGUS
- has known or suspected amyloidosis
- has unexplained renal impairment or proteinuria
- has unexplained peripheral neuropathy

Should only be performed with a maximal frequency of once every 4 weeks. It is anticipated testing is needed no more frequently than every 3 months unless on active chemotherapy.

Our multiple myeloma guidelines suggest the acronym CRAB is a helpful guide to investigation for myeloma. Test for free light chains if any of the following are unexplained:

Calcium elevation
Renal impairment (acute or chronic)
Anaemia (normochromic, normocytic < 100g/L or > 20g/L below normal)
Bone (lytic lesion, crush fractures, osteopenia)

IgE ($41)

The test should be done selectively. The Choosing Wisely recommendations include the following:

Don't perform unproven diagnostic tests, such as immunoglobulin G (IgG) testing or an indiscriminate battery of immunoglobulin E (IgE) tests, in the evaluation of allergy.

Food specific IgE testing should not be performed without a clinical history suggestive of IgE mediated food allergy.

IgE testing in hospital is a SMO only test. To reduce inappropriate tests we limit testing to the most likely allergens. The requestor must specify the most likely allergen rather than just "food".

14.1

IgG, IgA and IgM ($8 each)

Immunoglobulin levels cost $20,000 a year. These tests should be done selectively.

The main indication is to quantify immunoglobulin levels in multiple myeloma and monoclonal gammopathy. Another accepted indication is individuals with recurrent infections suspected of immune deficiency.

Quantiferon Gold ($54)

Quantiferon Gold or Interferon Gamma Release Assay (IGRA) testing costs are significant. The test has a very limited role in the diagnosis of TB and should not be performed except at the request of an SMO when screening for latent TB infection in patients going onto biologic therapy or screening TB contacts. The DHB Shared Services **Laboratory Test Referral Guidelines** has the following on screening for latent TB (LTBI):

Contact screening for LTBI
Contacts aged 7 years and under: use a Mantoux test.
Contacts > 7 years: use a Mantoux test or IGRA or a Mantoux followed by IGRA (if Mantoux +ve)

Healthcare worker screening for LTBI
Use IGRA to screen health care workers for LTBI

Refugee screening for LTBI
Refugee children aged 7 years and under: use a Mantoux test
Refugee children aged 8- 15 years: Mantoux test or IGRA or a Mantoux followed by IGRA (if +ve)
Refugees aged 16 and older: use either a Mantoux Test or IGRA

Screening for LTBI in immune-compromised people
Use IGRA
In some situations a clinician may elect to use both a Mantoux test and IGRA An
IGRA is particularly recommended in the following:

- BCG vaccinated people
- Immune-compromised people
- When it is considered a high risk the person will not return for the reading of their Mantoux
- When it is impractical for the person to make repeat visits for sequential testing

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Microbiology

Blood Culture ($33)

Blood cultures are a significant costly test at $114,000/yr. Currently 10% of the cultures become positive

Choosing Wisely states the following:

Do not do blood cultures in patients who are not systemically septic or who have a clear source of infection and in whom a direct specimen for culture (urine, aspirate or sputum) is possible.

Do not order blood cultures for patients with a skin infection (cellulitis, abscess) without sepsis.

Do not order blood cultures for patients with a urinary source of infection without sepsis.

We also recommend:

If endocarditis is a possibility do repeated cultures (x3) before starting antibiotics and only start antibiotic treatment after discussing with a SMO.

If endocarditis is not suspected do 2 sets (4 bottles) of blood cultures simultaneously.

Except in patients with staphylococcal bacteraemia do not repeat cultures after starting antibiotics just because the fever continues. If 2 sets have been done that is adequate.

As a general rule (except in suspected endocarditis) do blood cultures only if patients with sepsis do not have a clear cause of their infection and are sick enough to require IV antibiotics. **Sepsis** = confirmed or suspected infection **and** 2 or more SIRS criteria:

T >38C or <36C, HR>90, RR>20 or PaCO2<32mmHg, WBC>12,000 or <4000 or "left shift" **Severe sepsis** = sepsis **+** new organ dysfunction **+/or** hypoperfusion **+/or** hypotension

MSU/CSU ($18)

Many urine test requests are not clinically indicated.

Choosing Wisely states the following:

Do not order urine cultures for healthy patients with uncomplicated urinary tract infection.

Do not perform surveillance urine cultures (or treat bacteriuria) in elderly patients in the absence of symptoms or signs of infection.

Avoid surveillance cultures for screening and treatment of asymptomatic bacteriuria in children.

We also recommend:

Do not do a MSU unless there are symptoms of urosepsis or sepsis of uncertain cause.

Do not request a routine MSU in a confused or unwell elderly patient who has another clear cause or causes of their delirium or un-wellness.

Do not repeat the MSU if it was contaminated and antibiotics have already been given.

Do not do a CSU unless a catheterised patient has features of sepsis.

Do not do urine culture in suspected kidney disease without sepsis (do microscopy alone)

Note in older patients asymptomatic bacteriuria is common (up to 30%) and should not be treated.

Catheter colonisation is the norm; treatment is only indicated if a patient has features of sepsis.

Patients with undiagnosed kidney disease (new AKI or CKD and a raised creatinine, haematuria or proteinuria) will require urine examination for casts, cells and protein but do not require culture.

If clinically suspecting a UTI, first perform a urine dipstick testing in your clinical area and only send MSU to the laboratory if the results are abnormal. Write on the request form the abnormal results. If there are no dipstick results on the request form, the urine may be discarded unless the request form clinical information clearly identifies need for MSU.

Sputum Culture

We recommend:

Do not do routine sputum cultures in every patient with a cough (be selective).

Results of most sputum cultures rarely change management. Sputum cultures should be done selectively (for example in patients with bronchiectasis or COPD but not in asthma or bronchitis).

Stool specimens ($55 and C difficile $39)

Choosing Wisely only have one recommendation:

Do not repeat stool examination for C difficile to confirm "cure" if symptoms have resolved.

The DHB Shared Services **Laboratory Test Referral Guidelines** have this summary:

Specific investigations are not routinely required in the majority of patients with acute diarrhoea of up to 14 days duration. Enteric pathogens may not be amenable to treatment; however in some situations they pose a public health risk.

A laboratory diagnosis is useful for people who:

- may have an infection that could benefit from specific therapy;
- are at risk of severe complications e.g. intestinal failure and short bowel syndrome;
- are at risk of spreading infection; or
- are involved in an outbreak and may have a common source of infection.

14.1

Stool culture also has a role in selected patients with suspected Inflammatory Bowel Disease to exclude infectious causes.

We recommend:

Do not send stool for culture in every admission with, or who develops, diarrhoea.

Do not send stool for culture unless there are good clinical indications.

Stool cultures have a low rate of pick up for identifying the likely pathogenic organism.

The laboratory have established the following of rules for stool testing:

- Only one faecal specimen a day per patient will be processed.
- If diarrhoea develops after 3 days in hospital the laboratory will only test for C. difficile.
- Repeat testing of a patient who is positive for C.difficile toxin is not indicated within a 28 day period. A negative C.difficile toxin test may be repeated (once) if symptoms persist. Further testing is not indicated during the same episode of diarrhoea.
- FOB testing will not be performed on inpatients. Inpatients with symptoms or signs of gastrointestinal bleeding require more definitive investigations.
- Parasite examination has been limited to Giardia/Cryptosporidium. Full parasite work-up will only be performed when clinical details indicate the patient has:
    - o recently travelled to countries with poor food or water services,
    - o recently immigrated,
    - o eosinophilia with diarrhoea lasting more than 15 days ,
    - o immunocompromised status.

Swabs and other cultures ($34)

We recommend:

Send material (fluid or tissue) if available for culture, not swabs.

Do not do send swabs for culture unless part of an accepted protocol (eg neutropaenic sepsis or throat infection) or if antibiotic therapy has failed.

Many swab results add little to patient management, especially swabs of skin lesions or wounds as decisions to treat or not, with antibiotics and with what antibiotic are usually made before swab cultures are available.

If available, material like pus or tissue (put in a urine container, without formalin!) rather than a swab should be sent for culture.

Nasal swabs are not informative for sinusitis and will not be cultured.

MRSA screen ($32)

MRSA screening costs over $200,000 a year. Please ensure it is indicated for infection control.

TB testing ($50 per specimen)

TB testing costs $15,000 a year. It is important never to miss TB but tests should only be requested in patients where TB is realistically a possible diagnosis or in the screening of risk patients.

Virology

Viral studies can be very expensive:

- HIV nucleic acid is $460
- Hepatitis B nucleic acid is $180
- A respiratory viral screen is $143
- HIV viral load is $362

Choosing Wisely only have this one specific recommendation on virological testing:

Don't repeat the viral load in HCV unless on therapy.

The DHB Shared Services **Laboratory Test Referral Guidelines** have this on **hepatitis** testing:

- Clinicians should try to identify patients with raised LFTs due to chronic viral hepatitis,
- All HBsAg-positive pregnant women should have their HBV viral load measured,
- There is somewhat of a hiatus in treating HCV infection, pending the availability of newer agents, but all HCV PCR-positive patients should be referred to a specialist,
- Many HBsAg-positive patients are not being properly followed up or referred, and stand the risk of developing preventable liver disease.

The guidelines note regarding serological diagnosis:

Hepatitis A and E

These are the simplest to diagnose:
The **IgM** is almost always positive at the time the transaminases are raised.
The **IgG** is used to determine immunity, or show seroconversion if IgM results are inconclusive.

Hepatitis B

HBsAg is present in almost all actively infected persons with HBV and is the first test that should be requested if HBV infection is suspected.

HBV surface antibody is a test that should really only be ordered for adults in occupational health settings, preferably within a few months of the final dose of vaccine: those who develop a clear response will be protected for life.

HBV e antigen predicts high titres of virus, but its absence does not exclude high viral loads, especially in adults who were infected in childhood.

HBV DNA measurement is an essential part of assessment and management

Note that we screen with HBsAg, anti-HBs and anti-HBc to reduce the need for repeat testing.

Hepatitis C

Anti-HCV antibody is present in almost all those infected with HCV, but depending on the age and sex at acquisition, only 70-80% will have active viral replication.

A viral load test is needed to identify actively infected patients.

Like HIV, the antibodies are non-neutralising, ie do not control infection.

The emphasis in Hepatitis C management is to identify and refer patients with raised ALT who are keen to engage in treatment.

Expensive Tests Requiring SMO Approval

The Routine Laboratory Tests that can be requested by Junior medical and nursing staff

Biochemistry Tests	Biochem Tests Cont.	Microbiology Tests
Amylase	Lithium	ANA
AFP	Magnesium	Aspirates/Pleural/CAPD
B12 & Folate	Osmolarity (Pl & Urine)	Blood Cultures
Bicarbonate	Paracetamol	CSF
Blood Gases	Phenytoin	Equipment Sterility testing
CA125	Phosphate	Giardia & Cryptosporidium
Calcium	Procalcitonin	HBV, HCV, HIV, Syphilis
Carbamazepine	PSA	Mycology
CEA	Rheumatoid Factor	Routine culture of -
CK	Salicyclate	Urines, Faeces, Swabs, Sputum
Cortisol	TAC	RSV
CRP	Theophylline	
CSF Protein & glucose	Thyroid Function	**Haematology Tests**
Digoxin	Tobramycin	FBC and/or ESR
Ethanol	Troponin I	Factor VIII (haemophiliacs)
Gentamicin	UEC	INR, APTT, Fib, DDimer
Glucose	Urate	Kleihauer
HbA1c	Urine Albumin	Malaria
HCG	Urine Protein	Monospot
Immunoglobulins	Valproate	
Iron, Transferrin, Ferritin	Vancomycin	**Histology**
Ketones		Routine (excl. frozen section)
Lactate	**Transfusion Medicine**	
LD	Antenatal Screen	
LFT	DAT (Direct Antiglobulin Test)	
Lipids	Neonatal Blood Group & DAT	

Note:

- All other testing is required to be written on a Specialist Request Form – with the full knowledge of the Senior Medical Officer responsible for the patient.
- Testing not on this list are almost invariably sent to other reference laboratories for testing. Requests for such tests cannot be accepted after-hours. The pre-analytical processing will divert the restricted staff working those shifts from performing the urgent testing that can be resulted after-hours. Arrange for the appropriate sample collection on the next routine weekday shift.
- If the testing requires to be sent out of New Zealand, then please discuss with the Laboratory Manager at extension 2634.

Requesting Tests

While in an ideal world we would never have to wait for tests, we do not live in an ideal world.

Routine tests should not be requested after 1630hrs or at weekends as laboratory staffing is reduced and resources should be focussed on truly urgent work.

Only request tests ‘out of hours’ if these are needed to make urgent management decisions.

Where truly urgent results are required the relevant laboratory department must be contacted.

Special care must be taken when requesting blood tests for transfusion. A doctor must sign the request form and get consent for the patient to receive blood products.

If a patient requires a test to determine if they can go home please indicate this to the nursing staff so it can be done first thing in the morning.

All tests ordered must have the name of the responsible team or consultant.
Every test ordered by any clinician is the responsibility of that clinician or their delegated supervising team/consultant including to electronically acknowledge they have seen (and if necessary acted on) the result.

Note that “add on” testing is time consuming for the laboratory and it is better to try and get it right first time.

The correct collection of samples is critical. See nettie
. Please refer to the Laboratory Handbook in nettie – link = for:

- Contact names and numbers
- Departmental hours of service
- Collection and labelling of specimens
- Accessing results through the ADT computer system
- Directory of tests, indications, normal ranges

DRAFT

OURHEALTH HAWKE'S BAY Whakawateatia	**Radiology Services Committee**
	For the attention of: **HB Clinical Council**
Document Owner:	Dr Mark Peterson, Chair
Reviewed by:	n/a
Month:	July 2016
Consideration:	For Information and Endorsement

RECOMMENDATION

That HB Clinical Council:

1. **Note** the contents of this paper
2. **Endorse** the National Criteria for Access to Community Radiology.

The Radiology Services Committee met on Tuesday 5 July 2016 with various items discussed summarised as follows:

Staff update:

Dr Iain Morle has retired and Dr Andrew West has been appointed as Acting HOD. Advertising is about to commence to recruit a replacement for Iain. At the same time Dr West has been seconded to TRG Radiology one day a week in an exchange with Dr Matt Turei who is working in the Radiology Department.

HBDHB Radiology Services review:

An external review of the Department has been requested to ascertain that service and quality issues are of an appropriate standard. A TOR has been developed for this review and the College of Radiologists has been approached to recommend a reviewer. This review is in advance of the IAANZ four yearly Technical Review which is likely to occur in October.

The National Criteria for Access to Community Radiology:

Find attached, this was discussed again and approved to go to Clinical Council for endorsement prior to formal adoption by HBDHB.

Radiological investigation is a basic component of primary health care. Improving primary health care practitioners' ability to diagnose and manage conditions and to make more appropriate referrals to secondary health care should lead to better patient outcomes.

The Ministry of Health originally developed the *National Radiology Referral Guidelines* in 2001. As a result of feedback from the sector, the Ministry has replaced the *National Radiology Referral Guidelines* with this set of criteria. The move from guidelines to criteria is carefully considered. Guidelines by definition identify the best practice management of a given condition, but do not take into consideration resource limitations and (in the case of radiology) the need to manage demand for diagnostic imaging or the access of primary care providers to specific types of imaging.

These criteria were developed by a panel of clinicians comprising primary care, radiology, nursing and occupational health representatives.

The process to develop these criteria included:
- a stocktake of current access criteria across all DHBs
- a review of DHBs' existing access criteria
- expert input and advice from specialists, particularly across primary care and radiology services
- a review of international literature on best practice.

The *National Criteria for Access to Community Radiology* has been developed to:
- assist primary care practitioners to manage radiology patients effectively in the community by ensuring they get appropriate access to diagnostics
- provide district health boards (DHBs) with a minimum benchmark of service provision.

The criteria provide:
- a nationally recommended minimum level of radiology access to help primary care practitioners to manage patients in the community
- a practical guide on radiology referral for primary care practitioners (including nurse practitioners)
- a basis for DHBs to develop local access criteria to prioritise resources to those with the greatest clinical need and most potential to benefit.

The Radiology Services Committee has reviewed these criteria and recommend they be adopted by the HBDHB.

Hospital Imaging Guidelines

These guidelines are in the development phase and are now out for consultation. This will also come back to the RSG and then to Clinical Council for adoption.

A CME session for GPs and other primary care referrers on rational use of ultrasound is planned for later this month.

Attachment:
National Criteria for Access to Community Radiology

MINISTRY OF HEALTH
MANATŪ HAUORA

newzealand.govt.nz

National Criteria for Access to Community Radiology

2015

15.1

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Contents

15.1

Acknowledgements

The Ministry of Health wishes to acknowledge and thank the following members of the National Radiology Referral Criteria Review Panel for their participation and contribution in developing the *National Criteria for Access to Community Radiology*:

- Dr Kate Aitken (clinical leader and chair), radiology general practitioner (GP) liaison (Waitemata DHB), clinical leader of the Northern Region Radiology Network and clinical chair of the National Radiology Advisory Group
- Margaret Colligan, nurse practitioner, Auckland DHB
- Dr Vivienne Coppell, GP
- Dr Dianne Davis, GP liaison, Northland DHB
- Dr Kieran Holland, Canterbury DHB Community Referred Radiology Manager, Canterbury Initiative
- Dr Jim Kriechbaum, GP liaison, Auckland DHB
- Dr Kim McAnulty, radiologist, Waikato DHB, national radiology clinical lead
- Gerard Walker, Director Workwise Christchurch, Accident Compensation Corporation.

Background

Radiological investigation is a basic component of primary health care. Improving primary health care practitioners' ability to diagnose and manage conditions and to make more appropriate referrals to secondary health care should lead to better patient outcomes.

The Ministry of Health originally developed the *National Radiology Referral Guidelines* in 2001. As a result of feedback from the sector, the Ministry has replaced the *National Radiology Referral Guidelines* with this set of criteria. The move from guidelines to criteria is carefully considered. Guidelines by definition identify the best practice management of a given condition, but do not take into consideration resource limitations and (in the case of radiology) the need to manage demand for diagnostic imaging or the access of primary care providers to specific types of imaging.

These criteria were developed by a panel of clinicians comprising primary care, radiology, nursing and occupational health representatives.

The process to develop these criteria included:

- a stocktake of current access criteria across all DHBs
- a review of DHBs' existing access criteria
- expert input and advice from specialists, particularly across primary care and radiology services
- a review of international literature on best practice.

These criteria will be updated, to consider new technology and changing clinical practice.

Primary and secondary care integration

These criteria support the Ministry of Health's strategic intent to provide better integrated care between primary and secondary care. An integrated health system supports greater clinical integration and the use of clinical networks.

Clinical pathways assist clinicians to choose the most appropriate diagnostic examinations in the correct sequence, and are preferable to standalone access criteria. District health boards need to develop and implement appropriate locally agreed clinical pathways for common conditions presenting to primary and secondary care. The Ministry expects DHBs to develop pathways according to broad clinical consensus and through primary and secondary care partnerships.

The Ministry has developed these criteria in the absence of a full set of clinical pathways, which include imaging steps. Locally agreed clinical pathways supersede these criteria.

Purpose of these criteria

The *National Criteria for Access to Community Radiology* has been developed to:

- assist primary care practitioners to manage radiology patients effectively in the community by ensuring they get appropriate access to diagnostics
- provide district health boards (DHBs) with a minimum benchmark of service provision.

The criteria provide:

- a nationally recommended minimum level of radiology access to help primary care practitioners to manage patients in the community
- a practical guide on radiology referral for primary care practitioners (including nurse practitioners)
- a basis for DHBs to develop local access criteria to prioritise resources to those with the greatest clinical need and most potential to benefit.

These criteria are not mandatory. Some DHBs have already developed, or are in the process of developing, their own criteria for access to radiology. In this case, DHBs can use the criteria to check and update their own criteria. Other DHBs may find these criteria useful to help develop their own criteria.

Implementing these criteria

Successful implementation of these criteria will be dependent on:

- local engagement between primary and secondary care clinicians
- integration with clinical pathways and processes for triage and/or retrospective feedback on referrals.

As a general guide, service providers should implement these criteria by:

1. embedding the criteria into clinical workflow; for example, through an electronic referral system. This saves the time required to link to paper guidelines or other electronic versions, and improves the timeliness of information sharing
2. smart functionality, to alert referrers to provide necessary prerequisite information
3. reserving clinical prior authorisation for complex, or very high cost, or unusual cases, or when a clinician has a history of not following the agreed recommended clinical guidelines.

If a condition is on the list of exclusions but a primary care practitioner considers the patient would benefit from imaging, the practitioner should consult with a specialist. To this end, radiology departments should ensure that specialists are readily contactable by phone and their contact details, along with criteria for accessing their services, easy to find.

Scope of these criteria

The scope of community radiology is set out in the National Community Radiology Service Specifications. For the purposes of these criteria, however, providers should note the following facts.

1. Imaging covered by ACC or other funding streams, including under the Section 88 Primary Maternity Services Notice, is outside the scope of these criteria.
2. Imaging that is part of screening or surveillance programmes is outside the scope of these criteria.
3. The age band covered by the paediatric criteria has not been specified, acknowledging local paediatric service age group variation.

Prioritisation and wait times

The Ministry suggests prioritising referrals based on clinical need:

- **acute** – same day
- **urgent** – within 1–2 weeks
- **routine** – within six weeks.

In many DHBs, acute imaging requests are provided through a primary options or acute care scheme; the Ministry expects that local pathways will define the process for these.

The Ministry encourages referrers to communicate expected wait times to their patients and communicate with radiology services where they feel a referral is other than routine.

Provision of all routine imaging within six weeks is a 'working towards' benchmark in DHB radiology departments.

The Ministry expects that reporting of all procedures will be completed within 24 to 48 hours, and strongly recommends electronic distribution of reports. Radiology departments should telephone significant findings to referrers on the day of imaging. All referrers should include telephone numbers on the request form, to ensure ready contact.

Managing demand

Managing the demand for diagnostic imaging is essential to:

- ensure services are safe, efficient, effective and sustainable
- manage radiology volumes and budgets, and reduce the wait time for patients in the community.

Some factors that can impact on demand include:

- lack of access to previous imaging reports or other clinical information
- pressure from patients
- factors affecting the clinician, such as inexperience.

Managing demand focuses on ensuring referrals are appropriate. The term 'appropriate' here refers to a way of working based on agreed guidance: typically access criteria or clinical pathways.

Best practice for referrals

Referrals may be inappropriate because a health practitioner refers a patient:

- for a particular investigation when an alternative would have been preferable as it had greater benefit and less risk
- for an investigation at the wrong time
- for an investigation when none was needed (either there was no relevant question to be answered, there was no change in diagnosis or no management change would result).

It is also inappropriate not to refer a patient for an investigation when they need one.

Indications for diagnostic imaging may not always be clear-cut; primary health practitioners should discuss with radiologists or refer for clinical review relevant specialists where appropriate.

A useful investigation is one in which the result – positive or negative – may alter management and improve the outcome for the patient. A significant number of radiological investigations do not fulfil these aims, and may add unnecessarily to patient irradiation.

Health practitioners should take particular care in considering whether to order tests that involve ionising radiation, especially in younger people.

A chest X-ray delivers approximately 0.04 mSv – the equivalent of eight days of natural background radiation, while a CT of the abdomen and pelvis is approximately 14 mSv, or eight years of natural background radiation. The Ministry expects all radiology providers to ensure their equipment and imaging protocols are kept up to date, to deliver radiation doses that are as low as practicably achievable.

The Ministry has developed the following principles to assist DHBs to establish effective demand management processes.

Local governance

District health boards should establish formal local governance processes so that accountability for managing the demand for community radiology referrals is clear and so that services can maintain capacity and capability within budgets to the highest possible quality. The governance process should allow for feedback on performance against the established guidelines and 'fair' usage expectations.

Managing budgets

All decision-makers (funders, providers and referrers) should regularly assess budgets and volumes of referrals. In managing community radiology budgets, DHBs should make use of alliancing arrangements, and make sure professions formally share information on clinical management and budget decisions.

Prior authorisation

Prior authorisation from a DHB radiologist or relevant clinical specialist should only be required for complex, or very high cost, or unusual cases, or when a referrer has a history of not following the agreed recommended clinical pathways.

District health boards should make nominated consultants available to provide primary care practitioners with advice on case management.

Clinical practice and ongoing education

District health boards should undertake regular clinical audit, to facilitate a shared understanding of 'reasonable practice' between all decision-makers. They should offer clinical education on the outcome of audits.

Legislative requirements of DHBs

The Ministry of Health requires DHBs' annual plans to ensure primary care services have direct access to a complete suite of X-rays and ultrasound services (that is, abdomen, pelvis, renal, small parts, deep venous thrombosis and musculoskeletal).

The Ministry also expects DHBs to provide mammography and fluoroscopy services; however, these criteria do not apply to those services as service models and resource availability for them vary across the country. Service provision of local nuclear medicine, double energy X-ray absorption and magnetic resonance imaging currently varies. This document does not specify minimum access criteria for these modalities; however, subsequent versions may do so.

These criteria fulfil the requirements of the National Community Radiology Service Specifications, which require DHBs to define access criteria and expected waiting times for diagnostic imaging. (These service specifications are due to be updated, but this requirement is expected to remain.)

Criteria for access to radiology

The following pages outline community radiology access criteria. The criteria indicate when imaging is indicated and when it is not indicated, and provide guidance for referrers, under the following headings:

- X-ray
- ultrasound
- CT scans
- paediatric imaging.

X-ray

Abdomen

Standard indications for X-ray referral:

- diagnosis of constipation where patient history is unobtainable (eg, patient with autism or special needs)
- follow-up of radio-opaque (ie, evident on CT scout view) renal tract stones with a kidney, ureter, bladder (KUB) X-ray
- suspected renal tract stone according to local renal colic pathway criteria, where CT KUB is unavailable.

Referral for community X-ray not typically indicated:

- acute abdomen: discuss with acute surgical services or emergency services
- vague central abdominal pain
- suspected colorectal neoplasm (refer to colorectal cancer guidelines)
- suspected constipation (other than in specific patient groups as above).

Ankle

Standard indications for X-ray referral:

- undiagnosed pain present more than four weeks where the X-ray is expected to change management
- ankle pain with red flags
- known osteoarthritis with symptoms meeting local criteria for surgical consideration (not required if previously X-rayed within six months)
- pain in previous arthroplasty
- swelling, deformity or mass near the joint.

Red flags include:

- persistent deep pain unrelated to activity
- night pain in the absence of an obvious cause.

Referral for community X-ray not typically indicated:

- suspected septic joint: refer for acute review at emergency department or orthopaedic department
- acute gout.

Chest

Standard indications for X-ray referral:

- X-ray result will change patient management.

Referral for community X-ray not typically indicated:

- screening for lung cancer in asymptomatic patient
- pneumonia doesn't require routine chest X-ray (CXR) follow-up unless there are risk factors or red flags, including age > 50 years, significant smoking history, suspicious radiologic findings on initial CXR or incomplete clinical resolution at six weeks (this is a guideline only – there may be local pathways that apply) [1]
- routine assessment of hypertension
- routine monitoring of known pulmonary sarcoidosis
- routine X-ray for asbestos exposure surveillance
- follow-up of nodules detected on chest X-ray or CT other than where recommended by reporting or reviewing specialist (consider referral for respiratory specialist review)
- initial investigation of heart murmur, unless signs of complications such as heart failure
- routine follow-up of asymptomatic patients on amiodarone.

Elbow

Standard indications for X-ray referral:

- undiagnosed pain present more than four weeks where the X-ray is expected to change management
- elbow pain with red flags
- known osteoarthritis with symptoms meeting local criteria for surgical consideration (not required if previously X-rayed within six months)
- pain in previous arthroplasty
- swelling, deformity or mass near the joint.

Red flags include:

- persistent deep pain unrelated to activity
- night pain in the absence of an obvious cause.

Referral for community X-ray not typically indicated:

- suspected septic joint: refer for acute review
- acute gout.

Hand/wrist

Standard indications for X-ray referral:

- undiagnosed hand/wrist pain present more than four weeks where the X-ray is expected to change management
- hand/wrist pain with red flags
- known osteoarthritis with symptoms meeting local criteria for surgical consideration (not required if previously X-rayed within six months)
- pain in previous arthroplasty
- swelling, deformity or mass near the joint.

Red flags include:

- persistent deep pain unrelated to activity
- night pain in the absence of an obvious cause.

Referral for community X-ray not typically indicated:

- suspected septic joint: refer for acute review
- acute gout.

Guidance

Dedicated wrist views do not typically provide additional information to that obtained via single postero-anterior (PA) hand view. Where inflammatory arthritis is suspected, consider requesting an antero-posterior (AP) feet X-ray as well.

Hip

Standard indications for imaging referral:

- undiagnosed hip pain present for more than four weeks where the X-ray is expected to change management
- hip pain with red flags
- known osteoarthritis where symptoms meet local criteria for surgical consideration (not required if previously X-rayed within six months)
- pain in previous arthroplasty
- swelling, deformity or mass near the joint.

Red flags include:

- persistent deep pain unrelated to activity
- night pain in the absence of an obvious cause.

Referral for community X-ray not typically indicated:

- suspected septic arthritis: refer for acute review at emergency department or orthopaedic department
- mild symptoms and normal examination findings
- follow-up of known or suspected osteoarthritis unless red flags develop or patient meets local criteria for surgery.

Knee

Standard indications for X-ray referral:

- undiagnosed knee pain present more than four weeks where the X-ray is expected to change management
- knee pain with red flags
- known osteoarthritis with symptoms meeting local criteria for surgical consideration (not required if previously X-rayed within six months)
- pain in previous arthroplasty
- swelling, deformity or mass near the joint.

Red flags include:

- persistent deep pain unrelated to activity
- night pain in the absence of an obvious cause.

Referral for community X-ray not typically indicated:

- suspected septic arthritis: refer for acute review at emergency department or orthopaedic department
- mild symptoms and normal examination finding
- follow-up of suspected or known osteoarthritis unless red flags develop or patient now meets local clinical criteria for surgery
- suspected meniscal and ligament injury.

Guidance

Routinely request standing knee X-rays. Such views demonstrate the magnitude of any cartilage loss, which reflects the severity of any osteoarthritis.

Shoulder

Standard indications for X-ray referral:

- undiagnosed shoulder pain present more than four weeks where the X-ray is expected to change management
- shoulder pain with red flags
- known osteoarthritis with symptoms meeting local criteria for surgical consideration (not required if previously X-rayed within six months)
- pain in previous arthroplasty
- swelling, deformity or mass near the joint.

Red flags include:

- persistent deep pain unrelated to activity
- night pain in the absence of an obvious cause.

Referral for community X-ray not typically indicated:

- recent onset pain in the absence of red flags
- frozen shoulder (unless the condition does not follow its expected natural history)
- prerequisite for a trial of steroid injection (when a reasonable clinical diagnosis has been made and red flags are excluded)
- suspected septic arthritis: refer for acute review at emergency department or orthopaedic department.

Sinuses

Guidance

Plain films are no longer recommended.

Skull

Standard indications for X-ray referral:

- presence of a palpable vault abnormality that feels bony.

Referral for community X-ray imaging not typically indicated:

- trauma: discuss with emergency department consultant. CT head may be appropriate
- headache
- epilepsy
- cognitive impairment
- middle or inner ear problems
- suspected intracranial space occupying lesion.

Guidance

Refer suspected pituitary problems to a local relevant specialist.

Spine

Standard indications for X-ray referral:

- spine pain more than eight weeks
- spine pain with red flags
- spine pain and osteoporosis or prolonged use of corticosteroids
- focal neurological deficit (where recommended by local relevant specialist)
- significant spinal deformity.

Red flags include:[2]

- persistent deep pain unrelated to activity
- night pain in the absence of an obvious cause
- a history of cancer.

Referral for community X-ray not typically indicated:

- acute uncomplicated spine pain without red flags (benign self-limiting condition).

Guidance

Where there is high clinical suspicion of infection or cancer, consult a local relevant specialist.

Ultrasound

Abdomen

Standard indications for ultrasound referral:

- abdominal mass or other palpable abdominal abnormality
- painless jaundice without obvious cause
- suspected gallstones: persistent/recurrent right upper quadrant pain
- suspected pancreatic disease (limited resolution in obesity)
- clinically suspected or radiologically suspected aortic aneurysm (AAA)
- follow-up of AAA as per local guideline
- abnormal liver function tests (LFTs); both gamma glutamyl transferase (GGT) and alanine aminotransferase (ALT) elevated to greater than 1.5 times the upper limit of normal for more than three months with no other clinical cause
- abnormal LFTs suggestive of biliary tract obstruction or malignancy (persistently raised alkaline phosphatase (ALP)/GGT± bilirubin).[3]

Referral for community ultrasound not typically indicated:

- infective hepatitis
- acute abdomen or suspected bowel obstruction (discuss with local relevant service)
- dyspepsia
- suspected colorectal neoplasm (refer to colorectal cancer guidelines)
- clinically evident hernia in adults
- screening for AAA.

Guidance

Discuss suspected pancreatic disease with a relevant local specialist. A CT scan may be more appropriate.

Breast

Standard indications for ultrasound referral in the absence of local breast pathway:

- women under 40 years of age with clinically benign or uncertain lump, or localised change in texture
- men with unexplained or suspicious unilateral breast enlargement
- axillary lymph node enlargement or suspected lymph node enlargement in the absence of obvious infectious cause.

Referral for community ultrasound not typically indicated:

- breast pain alone
- bilateral male breast enlargement.

Guidance

- Referral to a local breast service for advice/assessment and multidisciplinary work-up, is preferable, and where such a service is available locally (this supersedes these recommendations).
- Mammography (± ultrasound) is the appropriate investigation modality for women over 40 years. If there is no breast clinic service available, refer these women directly for mammography and ultrasound if required.

Carotid Doppler

Standard indications for imaging referral:

- history of transient ischaemic attack or stroke with minor deficit where presentation meets local pathway criteria
- where no local pathway is in place and a relevant specialist has recommended a carotid Doppler ultrasound.

Referral for community/outpatient imaging not typically indicated:

- asymptomatic carotid bruits.

Groin

Standard indications for ultrasound referral:

- non-reducible groin mass present for longer than three weeks. (If mass is suspicious of cancer, discuss with local specialist.)

Referral for community ultrasound not typically indicated:

- lymph nodes < 1.5 cm diameter and present less than three weeks
- groin pain with no palpable mass.

Guidance

Most hernias can be diagnosed by clinical examination; ultrasound is rarely needed.

Hip

Referral for ultrasound not typically indicated:

- suspected trochanteric bursitis. The underlying pathology in greater trochanteric pain syndrome is most commonly gluteus tendinopathy, and ultrasound is not routinely required. Referral for hip X-ray is recommended to identify bone or joint pathology.[4]

Neck

Standard indications for ultrasound referral:

- salivary gland mass persisting for more than three weeks
- suspected lymph node or undifferentiated neck mass – where swelling has persisted more than three weeks, is > 1.5 cm size and there is no obvious infectious or other medical cause.[5]

Guidance

- If a neck mass is suspicious for malignancy, discuss with a relevant local specialist.
- If a patient has a prior history of a salivary gland tumour or cutaneous squamous cell carcinoma SCC of head or face or has onset of facial nerve symptoms, discuss with relevant surgical specialist; referral to a clinic may be more appropriate.

Pelvis

Standard indications for ultrasound referral:

- intrauterine contraceptive device (IUCD) strings not visible on examination
- post-menopausal bleeding after one year of amenorrhoea
- pelvic mass on examination. Request a Ca125 and an urgent scan if there is a high index of suspicion for ovarian malignancy
- suspected ovarian cyst (unilateral pelvic pain for more than four weeks and/or pelvic mass or unilateral tenderness)
- pelvic pain more than six weeks unrelated to menstrual cycle, with pelvic inflammatory disease excluded. Pre-referral expectation is that cervix has been visualised and swabs and smear taken
- abnormal pre-menopausal bleeding > 45 years old. Pre-referral expectation is that if IUCD was present it has been removed for 3+ months.[6]
- abnormal bleeding < 45 years old and one or more of the following risk factors for endometrial hyperplasia:[6]
  - weight >90 kg
  - history of unopposed oestrogen or tamoxifen use
  - nulliparity
  - chronic anovulation ± infertility.

Referral for ultrasound not typically indicated:

- routine follow-up of known fibroids[7]
- follow-up of simple ovarian cyst < 5 cm diameter in asymptomatic premenopausal/low-risk woman[8]
- primary dysmenorrhoea
- suspected endometriosis in the absence of a palpable mass
- polycystic ovary syndrome where the required two out of three diagnostic criteria are fulfilled by clinical and biochemical features (eg, oligomenorrhoea and clinical or biochemical hyperandrogenism).[9]

Guidance

- Refer women with acute non-pregnant pelvic pain in the absence of a palpable mass to the appropriate specialty service.
- For prolonged and/or heavy vagina bleeding after termination of pregnancy (TOP) or post-partum, refer under Section 88 Primary Maternity notice up to two weeks post miscarriage/TOP and six weeks post-partum).

Renal

Standard indications for ultrasound referral:

- estimated glomerular filtration rate eGFR is consistently reduced for age after repeat testing with the patient well hydrated:[10]
  - < 70 years : eGFR is reduced to < 45 mls/min
  - > 70 years: eGFR is reduced to < 30 mls/min
- painless haematuria:
  - persistent microscopic haematuria on two or more uncontaminated (epithelial cell count < 15 x 10^6/L) mid-stream urinalyses (not dipstix), or
  - macroscopic haematuria
- polycystic kidneys: ultrasound screening when > 20 years age and a positive family history with one or more first-degree relatives affected
- recurrent urinary tract infections (UTI) in females with one or more of these risk factors for an identifiable underlying cause:[11]
  - repeated (more than two episodes) pyelonephritis (fever, chills, vomiting, costo-vertebral angle tenderness)
  - persistence of infection on urinalysis after completion of a prolonged three-week course of appropriate antibiotics (ie, laboratory confirmed sensitivity)
  - gross haematuria or persistent microscopic haematuria (> 15 x 10^6) on two separate specimens) after resolution of infection
  - recurrence of infection after three months of completed antibiotic prophylaxis
  - urea-splitting organisms (eg, proteus, klebsiella, pseudomonas)
  - history of abdomino-pelvic malignancy or immunocompromise
  - history of urinary tract surgery or calculi
  - obstructive symptoms with straining and weak stream

- recurrent or persistent UTI in males
- suspected renal colic in pregnancy. For all other patients, consider referral for CT KUB
- suspected urinary retention with palpable/suspected enlarged bladder.

Referral for community ultrasound not typically indicated:

- recurrent uncomplicated UTIs in adult females (underlying abnormalities are uncommon)
- investigation of hypertension
- elevated prostate-specific antigen
- lower urinary tract symptoms
- investigation of isolated proteinuria (discuss with local relevant specialist)
- serial ultrasounds for polycystic kidneys, unless there are clinical symptoms.

Scrotum

Standard indications for imaging referral:

- scrotal masses with concerning features (eg, testicular mass, painless, non-transilluminating, rapidly growing (urgent urology referral recommended))
- scrotal masses where either the clinical diagnosis is in doubt or it is unclear if the swelling is testicular or extra-testicular
- new hydrocoele in adults (may be secondary to testicular cancer).

Referral for community imaging not typically indicated:

- non-solid (transilluminating) scrotal masses
- hydrocoele in children
- long-standing hydrocoele in adults
- acute inflammatory conditions – only refer for ultrasound if symptoms and/or swelling fail to resolve with antibiotics
- chronic testicular pain in the absence of abnormality on examination.

Guidance

Refer urgently to surgical service for surgery if the following conditions are suspected:

- testicular torsion
- testicular cancer
- strangulated inguinal hernia.

Scrotal masses can often be diagnosed clinically. If unsure, seek a second opinion from a general practitioner colleague or specialist.

Shoulder

Standard indications for ultrasound referral:

- pain and restricted movement that persists after eight weeks of conservative treatment including physiotherapy and/or cortisone injection
- when a full thickness tear is suspected and immediate surgical repair is being considered.

> **Guidance**
> - Radiology is not a prerequisite for a trial of steroid injection when a reasonable clinical diagnosis has been made and red flags have been excluded.

Soft tissue

Standard indications for community imaging referral:

- soft tissue mass with red flags; however, specialist assessment is preferred, so only request imaging if there is likely to be a delay before the patient is seen
- suspicion of a foreign body where not covered by ACC.

Red flags include a soft tissue mass with any of the following characteristics):[12]

- growing
- > 5 cm in size
- deep to deep fascia (limited mobility, less mobile with muscle flexion)
- painful (most malignant lumps are painless; pain suggests nerve or bone involvement)
- recurring after a previous excision.

> **Guidance**
> - Apply caution in the use of ultrasound, as its ability to characterise solid mass lesions is limited and incorrect diagnosis can lead to significant treatment delays.
> - Consider requesting a plain X-ray as well.
> - If a sarcoma is suspected, reserve biopsy for an orthopaedic or sarcoma specialist.

Thyroid

Standard indications for ultrasound referral:

- palpable nodules
- euthyroid goitre.

Referral for community ultrasound not typically indicated:

- thryotoxicosis (with or without goitre)[13]
- goitre with hypothyroidism.

Guidance

Red flags for thyroid malignancy, consider discussing with a local relevant specialist service where a patient presents with:

- < 20 years or > 60 years
- history of head or neck malignancy
- family history of thyroid cancer
- rapid growth of a nodule
- hard, ill-defined or fixed nodule
- hoarseness, dysphagia or dysphonia
- cervical lymphadenopathy.

Vascular

Standard indications for ultrasound referral:

- pulsatile mass for investigation
- suspected DVT (refer to local pathway if available)
- proximal superficial thrombophlebitis in thigh.

Referral for community ultrasound not typically indicated:

- suspected venous and arterial insufficiency – unless directed by local pathway.

Guidance

For patients with progressive uni- or bilateral lower limb oedema, consider referral for abdomino-pelvic ultrasound, to exclude proximal lymphatic obstruction.

CT scans

CT head

Standard indications for CT referral:

- undiagnosed cognitive impairment with one or more high-risk feature:[14]
  - age < 60 years
  - rapid (ie, one or two months) unexplained decline in cognition or function
  - recent and significant head trauma
  - unexplained neurological symptoms (eg, new onset of severe headache or seizures)
  - history of cancer (especially in sites and types that metastasize to the brain)
  - use of anticoagulants or history of bleeding disorder
  - history of urinary incontinence and gait disorder early in the course of dementia (as may be found in normal pressure hydrocephalus)
  - any new localizing sign (eg, hemiparesis or a Babinski reflex)
  - unusual or atypical cognitive symptoms or presentation (eg, progressive aphasia)
  - gait disturbance

- headaches where at least one of the following apply:
  - new onset > 50 years
  - change in pattern of headaches with increase in frequency or severity
  - aggravated by exertion or Valsalva
  - associated with nausea and vomiting
  - background systemic illness with cerebral complications or involvement; especially malignancy (breast, lung, melanoma).

Guidance

While CT may be appropriate as part of the work-up, initially discuss with local relevant specialist for patients who have:

- focal neurological signs
- acute cognitive decline or change in personality.

CT abdomen

CT KUB

Standard indications for CT KUB referral:

- non-pregnant patients with renal colic according to local pathway.

CT colonography[15,16, 17, 18]

Standard indications for CT colonography (CTC) referral in patients where colorectal cancer is suspected:

- symptomatic patients over 80 years
- patients with co-morbidities when colonoscopy presents a higher risk (eg, patients on warfarin therapy, respiratory risk from sedation)
- patients presenting with abdominal mass
- following failed or incomplete colonoscopy
- patients with symptoms which are average to low risk for malignancy (patients who previously would have been referred for barium enema).

Referral for CTC not typically indicated (ie, refer for colonoscopy):

- diarrhoea as the predominant presenting symptom
- known polyp syndromes (including familial) where biopsy/removal is likely to be required
- suspected inflammatory bowel disease where mucosal visualisation and biopsy are required for diagnosis
- young patients (< 40 years).

Guidance

Referral is not typically indicated for either CTC or colonoscopy where there is:

- abdominal pain alone
- constipation as a single symptom
- irritable bowel syndrome (consider specialist referral first)

- uncomplicated CT-proven diverticulitis without suspicious radiological features.

The local DHB is likely to triage referrals for investigation of bowel symptoms to either CTC or colonoscopy, depending on clinical presentation and resource availability.

CTC requires bowel preparation similar to colonoscopy, including fasting. The procedure involves rectal air insufflation and changing position on the scanner table.

Where patient fitness level would preclude active treatment if a cancer is diagnosed, a minimal preparation CT colon (MPCT) should be considered. Discussion with local radiologist recommended.

The 'miss' rate of lesions > 1 cm with both well-performed colonoscopy and CTC is approximately 6 percent.

CTC is not intended for the detection of diminutive polyps <5mm.

CT sinus

Guidance

Sinus CT is not generally indicated without failed medical management. The main role of sinus CT is for pre-surgical planning, rather than determining the need for surgery.

Paediatric imaging

X-ray – chest

Standard indications for X-ray referral:

- lower respiratory tract disease (including asthma/bronchiolitis/pneumonia) unresponsive to treatment
- inhalation or suspected inhalation of foreign body.

Referral for X-ray not typically indicated:

- incidental finding of a murmur
- uncomplicated (afebrile) presentation of asthma/bronchiolitis.

X-ray – lower limb

Referral for X-ray not typically indicated:

- Osgood-Schlatters, Sever's and other apophysitides

X-ray – pelvis/hips

Standard indications for X-ray referral:

- pain
- limp
- risk factors/soft signs or suspected developmental dysplasia of the hip (DDH).

Guidance

- Capital femoral epiphyses ossify on average at 5–6 months of age; DDH can usually be reliably excluded from this age onwards on X-ray.[19]
- Slipped upper femoral epiphysis requires urgent orthopaedic referral.

Ultrasound – hips

Standard indication for ultrasound referral:

- unstable or dislocated hip in child less than 3–4 months age; also refer to orthopaedic specialist.

Referral for ultrasound not typically indicated:

- soft signs (asymmetric buttock creases, leg length discrepancy, clicky hips) or risk factors (breech presentation, family history): refer for plain X-ray at 5–6 months.

Ultrasound – neonatal spine

Standard indications for ultrasound referral:

- sacral dimple or pit: non-simple (ie, with at least one of the following criteria):[18]
  - outside the natal cleft (> 2.5 cm from anal verge in neonate)
  - associated with cutaneous stigmata of spinal dysraphism – hairy tuft, haemangioma
  - > 5 mm diameter
  - deep (bottom of dimple not visible).

Referral for ultrasound not typically indicated:

- simple isolated dimples within the gluteal cleft
- child more than eight weeks age: ultrasound spine not technically feasible with ossification of the posterior elements. Suggest discussion or review by local specialist.

Ultrasound – renal

Standard indications for ultrasound referral:

- child < 12 months with first-time documented UTI
- child of any age with recurrent UTI (no previous imaging)
- child of any age with complicated UTI (eg, pyelonephritis, atypical UTI)
- follow-up of antenatal hydronephrosis or other renal abnormality as recommended by reporting radiologist.

Referral for ultrasound not typically indicated:

- asymptomatic bacteriuria.

Abbreviations

AAA	Abdominal aortic aneurysm
ACC	Accident Compensation Corporation
CT	Computed tomography
CTC	CT colonography
CXR	Chest X-ray
DEXA	Double energy X-ray absorption
DDH	Developmental dysplasia of the hip
DHB	District health board
DVT	Deep venous thrombosis
GGT	Gamma glutamyl transferase
eGFR	Estimated Glomerular filtration rate
IUCD	Intrauterine contraceptive device
KUB	Kidney, ureter, bladder
LFT	Liver function tests
MRI	Magnetic resonance imaging
TOP	Termination of pregnancy
UTI	Urinary tract infection

Endnotes

1. Tang KL, Minhas-Sandhu JK, et al. 2011. Incidence, correlates, and chest radiographic yeild of new lung cancer diagnosis in 3398 patients with pneumonia. *Archives of Internal Medicine* 171: 1193.

2. Downie A, Williams CM, Henschke N, et al. 2013. Red flags to screen for malignancy and fracture in patients with low back pain: systematic review. *British Medical Journal*: 347: f7095.

3. Auckland DHB Gastroenterology and Hepatology. URL: www.healthpoint.co.nz/specialists/gastroenterology-hepatology-liver/auckland-dhb-gastroenterology-and-hepatology/?medpro=show (accessed 1 December 2014).

4. http://journals.lww.com/anesthesia-analgesia/Fulltext/2009/05000/Greater_Trochanteric_Pain_Syndrome__A_Review_of.49.aspx

5. Northern Region Head and Neck Multidisciplinary Group. 2013.

6. National Collaborating Centre for Women's and Children's Health. 2007. *Heavy Menstrual Bleeding*. London: Royal College of Obstetricians and Gynaecologists' Press.

7. Working Party of the New Zealand Guidelines Group. 2000. *An Evidence-based Guideline for the Management of Uterine Fibroids*. Wellington: Working Party of the New Zealand Guidelines Group. URL: www.health.govt.nz/system/files/documents/publications/050623_uterine_fibroids_summary_refreshed.pdf (accessed 1 December 2014).

8. Levine D, Brown DL, Andreotti RF, et al. 2010. Management of Asymptomatic Ovarian and Other Adnexal Cysts Imaged at US: Society of Radiologists in Ultrasound Consensus Conference Statement. *Radiology* 256: 943–54.

9. Farquhar C, Johnson N. 2008. Understanding polycystic ovary syndrome. *Best Practice Journal* 12: 7–13.

10. Auckland DHB Renal Medicine. URL: www.healthpoint.co.nz/specialists/nephrology/auckland-dhb-renal-medicine/?medpro=true (accessed 1 December 2014).

11. Dason S, Dason JT, Kapoor A. 2011. Guidelines for the diagnosis and management of recurrent urinary tract infection in women. *Canadian Urological Association Journal* 5(5): 316–22.

12. National Sarcoma Working Group. 2013.

13. Elston MS, Conaglen JV. 2005. Thyrotoxicosis: Pathophysiology, assessment and management. *Consultant Endocrinologist* 32(6): 407–13.

14. Gauthier S, Patterson C, Chertkow H, et al. 2012. Recommendations of the 4th Canadian Consensus Conference on the Diagnosis and Treatment of Dementia (CCCDTD4). *Canadian Geriatrics Journal* 15(4): 120–6.

15. Atkin W, Dadswell E, Wooldrage K, et al. 2013. Computed tomographic colonography versus colonoscopy for investigation of patients with symptoms suggestive of colorectal cancer (SIGGAR): a multicentre randomised trial. *Lancet* 381: 1194–202.

16. Sanders A, Stevenson C, Pearson JF, et al. 2013. A novel pathway for investigation of colorectal symptomswith colonoscopy or computed tomography colonography. *New Zealand Medical Journal* 126(1382): 45.

17. Banerjee S, Van Dam J. 2006. CT colonography for colon cancer screening. *Gastrointestinal Endoscopy* 63: 121–33.

18. Starship Clinical Guidelines. URL: www.starship.org.nz/for-health-professionals/starship-clinical-guidelines (last accessed 2 December 2014).

19. Zywicke HA, Rozzelle CJ. 2011. Sacral Dimples. *Pediatrics in Review* 32(3): 109–14.

Clinical Council Report

Clinical Advisory and Governance Committee

Date:	14 June 2016	Time:	5.30pm
Item	**Summary**		
4. Presentations 4.1 Proof of Concept improving engagement with LMC in Early pregnancy	Jules Arthur, Midwifery Director, Hawke's Bay DHB presented the findings of the proof of concept project which ran last year in three general practices. Jules sought guidance and advice from the Committee around the roll out plans, leaving practice with a LMC booked appointment and improving communication between LMC and general practice. The Committee provided guidance on the need to ensure clinically correct doses of folic acid (0.8mg or 5mg) if prepacked medicine packs were to be given and a request for same information to be shared between LMC and general practitioner regardless of which professional did the first antenatal visit, i.e. expectation that if LMC did first visit, communication to the GP was consistent with the information an LMC would expect should the GP do the first antenatal visit. Communication from the LMC to the GP, particularly around current contraception, is also needed when the patient is discharged from LMC care.		
4.2 Whānau Ora Model Of Musculoskeletal Care	Hawke's Bay District Health Board (HBDHB) & Health Hawkes Bay have been successful in moving to the RFP phase (deadline early July 2016) of the MOH Mobility Action Plan. A presentation was provided to the Committee outlining the proposed Musculoskeletal Service to Reduce Health Inequities. It is a co-created and co-designed Whānau Ora model of care targeted at Māori, Pacific and quintile 5 patients who have experienced joint pain for more than three months and who are not eligible for ACC funding. The emphasis will be on early intervention. Pilot sites will be located in Wairoa, Takapau, Flaxmere and Maraenui. The service comprises a "core" team of private physiotherapy, Māori Stanford self-management programme and a Māori Lifestyle Collective (a suite of kaupapa Māori healthy lifestyle services including Iron Māori and Patu programmes). The Clinical Advisory and Governance Committee ENDORSED this approach.		
5. Decision papers 5.1 CAG Committee Workplan 2016/17	The Committee ENDORSED the work plan (meeting outline) for those held between July 2016 and June 2017. Over the next 12 months the Committee core business is the review of the Annual Plan Reporting, Quality Plan Reporting, PHO Performance reporting , review of clinical content of new contracts and activity reports for our contracted services. In addition each meeting will spend time on a different clinical governance theme - reviewing current PHO activities which reflects this theme and explore information that would support clinical governance around this theme.		
5.2 Mental Health Service Review – **Late paper**	The Committee ENDORSES the Mental Health Service Review which has come as a request from this Committee and has been conducted by Chiplin Consulting. Discussion supported the focus of this programme for patients with acute mild to moderate mental health challenges, requesting that it not be modified to bridge the gap for those with chronic mild to moderate mental health or overcapacity from secondary care services; with continued dialoge with the DHB around these challenges. The Committee acknowledged need to support IT and self management along with strengthening the practice nurse roll but only with back full funding, a program of credentialing and by those nurses that were interested in mental health. Ultrabrief advice guidance reserved until more information and evidence of benefit provided.		
5.3 MIMS Integrated - Group subscription renewal – **Late Paper**	Following endorsement by the PHO Leadership Team, the Committee has also ENDORSED the PHO renewing the subscription for MIMS integrated which the PHO funds on behalf of the practices. This annual subscription provides access to MIMS, Quick Reference and interactions, monthly updates so that the PMS reflects the Pharmac changes each month, access to MIMS Gateway (www.mimsgateway.co.nz), and access to iMIMS NZ/MIMS Android (MIMS apps) for all prescribers in participating practices		
5.4 Brief Update	The Committee ENDORSED the sharing of this with Clinical Council (see end of document) and general practice via Health Hawke's Bay Portal.		

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6. Discussion papers 6.1 Annual Plan Reporting Q3 6.2 IPIF – Q3 report	 Acknowledged Acknowledged with recommendations to management around deadline, plans and action should deadline not be met by 1 July 2017.
7. Information papers 7.1 DHB Contract Reporting 7.1.1 CVD Contract 7.1.2 CPO A. Skin Lesions B. Acute Care C. High Cost Gynae D. PCSA E. Sexual Health F. Hospital discharge G. engAGE	Taken as read with following discussion: Request for information around plan to correct low uptake of services by Māori male youth. Request to consider review of criteria due to undersubscription; particular during winter months

June 2106, Agenda Item 5.4

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

	Content/Comments	**Management Lead**
Transformation		
engAGE	Follows – see appended.	Paul Malan/Sarah Shanahan
Clinical Programmes and Team updates		
Whanau Wellness	The programme is into its fifth month of delivery. Utilisation rates have been steady however Health Hawkes's Bay foresees an increase in GP utilisation over the winter months. Heath Hawke's Bay presented the programme at the Central Regions PHO Networking Forum on 27/5/16 and there was a lot of interest shown in the project. A Ministry of Health staff member also showed an interest in the programme. The Shore-Whariki Evaluation Team will commence analysing utilisation data in June 2016 post their analysis of General Practice/NGO Sector and Whanau Wellness Participants feedback gathered from Quarterly Sessions.	Lillian Ward
Health Literacy	The online training modules are complete. Health Hawkes's Bay are planning a launch of the online training modules in June 2016.	Lillian Ward
Social Workers in VLCA practices	Health Hawkes's Bay working with Te Wāhanga Māori Hawke's Bay District Health Board to plan aligning Social Work provision to The Doctors Hastings and Gascoigne Medical as a resource within the newly planned Emergency Department High Flyers Programme.	Lillian Ward
Health Hawke's Bay Staff Directory		
For further information on any of the above information please contact the indicated management lead or author:		
Nicola Ehau	nicola@healthhb.co.nz	06 871 5669
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Adrian Rasmussen	adrian@healthhb.co.nz	06 871 5658
Lillian Ward	lillian@healthhb.co.nz	06 871 5661
Sonya Harwood	sonya@healthhb.co.nz	06 871 5653
Haley Petkovich	haley@healthhb.co.nz	06 874 5654

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

Community MDTs:

All 6 weekly MDT meetings now operational across Napier, Hastings, Taradale and Havelock North. Most of larger practices now connected to one of these groups. Work to streamline and standardise processes on-going. 12 practices have been offered a Letter of Agreement with a yearly lump sum contribution to acknowledge the work being done to collaborate with engAGE, Clinical Pharmacist Facilitators and DN/GP alignment. Recruitment to the MDT is on-going. All Social Work positions filled from 7th June. Physiotherapy recruitment remains difficult (due to a national shortage) and a decision has been made to recruit more Occupational Therapists to fill these vacancies.

16.1

ORBIT Team:

The ORBIT team is now fully staffed and has been covering 7am-7pm, 7 days in ED/AAU per week since November 2015. Analysis of the impact of this extension is on-going but initial reports are positive. In the first 4 months of this extended service the team saw an extra 289 patients who would not otherwise have been seen and approximately half of these patients were discharged home following appropriate discharge planning. Workloads at the weekend have been high from the start and the later hours are contributing to better patient flow. Since late February the team have opened up to taking referrals from City Medical for older people with minor illness/ injury impacting on function. Initial referral rates have been low and the team are considering how to build relationships with the team there and encourage appropriate referrals. Work has been done with St John's ambulance service and plans are in place for ORBIT to start taking referrals from them by early June. It is envisaged that providing this service to older people seen by St John in their homes will negate the need for some to be transported to hospital meaning less pressure on ED and better outcomes and experience for patients.

engAGE in ARRC (intermediate and short stay beds):

This service rolled out at the end of February providing an alternative to hospitalisation or earlier discharge from hospital for some frail older people. Initial utilisation rates have been high with 41 patients having availed of the service since 29 February. GPs can access the short stay service independently of the engAGE MDT for up to 5 days and patients needing a longer stay and MDT assessment can be referred for the intermediate stay service of up to 6 weeks with engAGE MDT in-put. This service is available at all 13 facilities in Hawkes Bay that have both hospital and rest home level of care. Work to streamline and standardise processes and paperwork on-going

HAWKE'S BAY District Health Board Whakawāteatia	**BUSINESS CASE: Healthy Eating and Activity Programme in Low Decile Primary Schools in High Deprivation Hawke's Bay Communities**
	For the attention of: **Executive Management Team**
Document Owner: Document Author(s):	Caroline McElnay, Director Population Health Shari Tidswell, Team Leader/Population Health Advisor
Reviewed by:	n/a
Month:	July 2016
Consideration:	For Approval

RECOMMENDATION

That EMT:

Approve and release the funding bid for the school based obesity programme.

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BACKGROUND

The Healthy Eating and Activity Programme is part of the delivery of the "Best Start: Healthy Eating and Activity Plan which was endorsed by the HBDHB in May 2016. The programme also aligns with the National Childhood Obesity Plan (MoH) and the recommendations for the Ending Childhood Obesity Report (WHO).

Why a school based programme?

- Addressing childhood obesity is important as overweight and obese children are likely to be obese adults and be more likely to have resulting health issues such Type 2 diabetes, heart disease and some cancers1.
- Local stakeholder engagement supports the development of a co-designed primary school healthy eating and activity programme which is inclusive of whānau and changes to the obesogenic environment
- Short term benefits: Healthy eating and activity messages delivered consistently across the multiple settings children and whanau interact with; reduced consumption of sugary food/drinks and fast foods; reducing the availability and marketing of unhealthy food and beverages to enable sustainable healthy eating and activity behaviour change.
- Long-term benefits: reducing child obesity rates which lead to adult obesity throughout the lifespan; improving health outcomes and reducing inequity for Maori, Pasifika and those living in high deprivation; reducing the burden of primary and secondary healthcare costs.
- Influences positive lifestyle changes across a number of settings including homes, workplaces, events and retail.

[1] Morton, S.M.B., Maternal nutrition and fetal growth and development, in Developmental Origins of Health and Disease, P.D. Gluckman, Hanson, M.A., Editor. 2006, Cambridge University Press: Cambridge. P. 98-130.

This is a three staged approach to co-design, co-ordinate, deliver and evaluate a Healthy Eating and Activity Programme in Hawke's Bay primary schools.

A three phase programme is proposed with Phase 1 to commence from July 2016.

	Phase 1 2016/17	Phase 2 2017/2018	Phase 3 2018/19	Ongoing
Programme coordinator salary/contract	$85,000	$85,000	$85,000	$85,000
Services delivered; resource development, publishing/printing	$30,000	$5,000	$5,000	$5,000
Contracted community providers delivering sugar reduction programme	$70,000	$5,000	$5,000	$5,000
Community providers delivering Healthy Eating and Activity Programme	-	$90,000	$90,000	$105,000
Evaluation	$15,000	-	$15,000	-
Total	$200,000	$200,000	$200,000	$200,000

HAWKE'S BAY
District Health Board
Whakawāteatia

BUSINESS CASE

17

Healthy Eating and Activity Programme in Low Decile Primary Schools in High Deprivation Hawke's Bay Communities

Document Owners: Caroline McElnay/Shari Tidswell

Recommendation

Approve the release of the 2015 funding bid tagged for obesity prevention in children ($200,000 per annum) to fund a Healthy Eating and Activity Programme in low decile primary schools in high deprivation communities.

1.0 Background

The Healthy Eating and Activity Programme is part of the delivery of the "Best Start: Healthy Eating and Activity Plan which was endorsed by the HBDHB in May 2016. The programme also aligns with the National Childhood Obesity Plan (MoH) and the recommendations for the Ending Childhood Obesity Report (WHO).

Why a school based programme?

- Addressing childhood obesity is important as overweight and obese children are likely to be obese adults and be more likely to have resulting health issues such as Type 2 diabetes, heart disease and some cancers[1].
- Local stakeholder engagement supports the development of a co-designed primary school Healthy Eating and Activity Programme which is inclusive of whānau and changes to the obesogenic environment.
- Short-term benefits: healthy eating and activity messages delivered consistently across the multiple settings children and whānau interact with; reduced consumption of sugary food/drinks and fast foods; reducing the availability and marketing of unhealthy food and beverages to enable sustainable healthy eating and activity behaviour change.
- Long-term benefits: reducing child obesity rates which lead to adult obesity throughout the lifespan; improving health outcomes and reducing inequity for Māori, Pasifika and those living in high deprivation; reducing the burden of primary and secondary healthcare costs.
- Influences positive lifestyle changes across a number of settings including homes, workplaces, events and retail.

2.0 Situational Analysis

2.1 Current Situation / Problem

In New Zealand, obesity has surpassed tobacco use as the leading risk factor to health and contributes to health inequity. Rates are significantly higher for Māori, Pasifika and those living in our most deprived areas. Across Hawke's Bay one in two Māori adults (compared to one in three non-Māori) and 19% of Māori children aged 2–14 years (compared to 12% non-Maori), are obese. Two in three Pasifika adults are obese (64%).

The Population Health Service has previously explored options for a primary school-based programme for Decile 1 and 2 schools with a Healthy and Active Schools programme being recommended and accepted in the 2015 funding bid process. In preparation for this business case a scoping project was undertaken and a fixed-term Population Health Advisor – Obesity Action position appointed. This enabled a stocktake of healthy eating and activity initiatives offered to Hawke's Bay primary/intermediate schools. These resources have been used to inform this business case. The Population Health Advisor also completed a programme options paper which provided an outline of the programme options and the aligned activity funded outside the budget bid, for an effective schools based programme. (See appendix). These options have been integrated into this business case.

[1] Morton, S.M.B., Maternal nutrition and fetal growth and development, in Developmental Origins of Health and Disease, P.D. Gluckman, Hanson, M.A., Editor. 2006, Cambridge University Press: Cambridge. P. 98-130.

The stocktake found the following key themes:

1. Healthy eating & beverage policies need to be better understood by their users and consistently implemented.
2. All food & beverages provided in schools must meet NZ Food Nutrition Guidelines.
3. Access to sugar sweetened beverages (SSBs) & high fat, processed foods on the journey to/from school & in the home environment undermines school healthy eating & drinking ethos.
4. Food insecurity is a contributing factor.
5. Sustainable healthy eating behaviour change is transferrable across school, wider community & home environment.
6. Whanau should feel empowered to participate in programme development and activities including desired outcomes.
7. A school-based physical activity programme that encourages whanau participation is needed for all children.
8. Programme components must have the capacity to be tailored to local needs.

Key components for an effective school programme were identified as:

1. Increasing school healthy eating ethos
2. Increasing access to healthy food and drink choices at school and home
3. Increasing whanau knowledge of healthy foods and beverages
4. Increasing access to healthy activities for children and whanau

2.2 Strategic Alignment

The programme supports the delivery of the Ministry of Health Childhood Obesity Plan and the Hawke's Bay Healthy Weight Strategy. It also aligns with the WHO – Ending Childhood Obesity Plan.

The programme supports:

- Transform and Sustain by reorienting delivery of services to promotion and prevention and using a whole of community approach
- Reductions in inequity by focusing on high deprivation communities.[2]
- Health gains by delivering key outcomes from the "Best Start: Healthy Eating and Activity" Plan

[2] Aligned documents:

- WHO Ending Childhood Obesity (ECHO) Report
- World Cancer Research Fund International 2015
- Ministry of Health's Childhood Obesity Strategic Plan 2015
- New Zealand Beverage Guidance Panel 2014
- HBDHB Health Equity Report by targeting school communities with high Maori, Pasifika and high deprivation populations

Proposal

2.3 Healthy Eating and Activity Programme for low decile schools in high deprivation communities

This proposal outlines the developmental work required to co-design, co-ordinate, deliver and evaluate a Healthy Eating and Activity programme in Hawke's Bay primary schools.

A three phase programme is proposed:

Phase One:

- Co-design and trial a programme in low decile primary schools which focuses on 'water only' and reducing sugar consumption across each school and associated whānau and community settings.

Phase Two:

- Co-design with school communities a healthy eating and activity school programme, develop supporting resources and trial in a high deprivation community school cluster, working with existing school partners (Health Promoting Schools programme, public health nurses, Sports Hawke's Bay and community providers i.e. Patu and Hawke's Bay Basketball Academy).
- Review, expand and implement the sugar free programme developed in phase one across all decile 1-10 primary schools in Hawke's Bay, working with partners including school communities, Ministry of Education, health promoting schools and public health nurses

Phase Three:

- Maintain and expand both water only and healthy eating and activity programmes across Hawke's Bay primary schools.
- Identify and support community providers to deliver programmes in school settings.

A programme coordinator and development role will be established. This role will initially be fixed-term for a period of two years and focused on community engagement, co-design and development. It is recommended that this role be part of the HBDHB's Population Health Advisory team in order to maximise coordination of work under the Healthy Eating and Activity Action Plan.

Monitoring, review and evaluation are critical at all phases of the programme to ensure the programmes are having a positive impact on healthy eating and activity.

Phase One: June 2016-July 2017

Establish project coordinator role (complete co-design, trial and review the programme)	$85,000
School trial (contracted community providers to deliver in three trial schools)	$30,000
Roll-out to remaining decile 1-2 schools	$70,000
External evaluation (collect baseline data, evaluating programme impact, redesign, establishing measures of success)	$15,000

Phase Two: June 2017-July 2018

Project coordinator	$85,000
School trial phase two (healthy eating and activity) - contracted providers to deliver in cluster schools	$30,000
Maintain sugar reduction in current schools (supporting schools developed initiative to reduce sugar consumption)	$5,000
Contract with local providers (meeting gaps in current service and school delivery, including food literacy, physical activity, resources and training)	$65,000
External evaluation	$15,000

Phase Three: June 2018–July 2019

Review ongoing need for coordination support and programme development. Determine if in-house provision or contracted to provider. Establish a role/function as per review findings	$90,000
Implementation of healthy eating and activity programme in all 12 decile 1 and 2 schools (providing nutritional advice and support, delivering activity programmes in schools, providing training, food literacy)	$100,000
Maintain sugar reduction programme in current schools	$10,000

Population Health Funder

	Phase 1 2016/17	Phase 2 2017/2018	Phase 3 2018/19	Ongoing
Programme coordinator salary/contract	$85,000	$85,000	$85,000	$85,000
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Evaluation	$15,000	-	$15,000	-
Total	$200,000	$200,000	$200,000	$200,000

3.0 Summary of Analysis

Cost

The sugar reduction programme has the potential to reach 60 primary school over three years. The Healthy Eating and Activity programme will deliver to 12 schools focussing on the most deprived communities (12 schools with a total of 3,530 students). Resources from both programmes can be used across all schools creating further cost-efficiencies. Similar programmes in the Waikato has shown cost-effectiveness and reductions in BMI for children (Project Energise).

Outcome

School settings have been shown in healthy eating and lifestyle change programme to have a significant impact i.e. road safety, BMI and immunisation. We would expect to see an increase in healthy food consumption and physical activity in participating schools. There is clear evidence to show that these behaviours have positive influence over a person's lifetime. (Reference: Best Start: Healthy Eating and Activity Plan for details of evidence)

A reduction in the consumption of sugar sweetened beverages has the immediate impact of reducing tooth decay and the long-term impact of reducing weight. Children are at school for at least six hours per day so this is a significant period of time where they will not be consuming sugar sweetened beverages. This behaviour change has also been shown to influence family consumption with children applying the rule at home as well. This programme will impact on all primary school aged children.

Buy-in

These programmes rely on strong wider-school community engagement. The stocktake report (Appendix 1) provides evidence that our communities want initiatives that change the obesogenic environment in order to enable sustainable change at the whānau level (lifestyle).

Meeting local need

Both the sugar reduction programme and the healthy eating and activity programme meet the key themes and components which have come from the stakeholder stocktake.

Sustainability

The structured environment of a school supports the use of policies to support and maintain change. They can also influence the behaviour of the school community by engaging whānau, local retailers and community services to ensure children are eating healthy food and being physically active. The children themselves reinforce the behaviour at school and at home.

Appendix 1

Healthy Eating and Physical Activity Stocktake:

An overview of programmes/initiatives/activities offered in Hawke's Bay Primary Schools

HAWKE'S BAY
District Health Board
Whakawāteatia

Kim Williams, Population Health Advisor/Population Health Team
January 2016

Background

Approximately 12% of our Hawke's Bay children aged 2 – 14 years are obese. Rates are significantly higher in Maori children (19%) and Pasifika children (25%) and children living in our most deprived areas are 3 times more likely to be obese than those living in our least deprived areas[1]. Overweight children are more likely to develop adult obesity[2] which is associated with adverse health outcomes such as dental decay, heart disease and diabetes. For these reasons the Hawke's Bay District Health Board's (HBDHB) Obesity Strategy recommends targeting resources toward prevention in the early years, Maori, Pasifika and high deprivation communities to make the greatest gains in health and reduce inequity.

Following on from our HBDHB Maternal Nutrition and Physical Activity Project activities (0 – 4 years), it has been proposed that resources be targeted to children aged 5 – 12 years within primary school settings. Evidence shows that early intervention programmes delivered in primary schools are effective because they are delivered in structured environments and have close links with family/whanau[3]. The findings in this stocktake report support the idea that these links are opportunities for reinforcing sustainable behaviour change across the wider school and home environment.

Purpose

After exploring options for a primary school-based programme it was agreed that a stocktake of healthy eating and activity initiatives offered to Hawke's Bay primary/intermediate schools was required. Rather than being all-inclusive the intention was to develop an overview of the types of activities provided and how they were viewed by the community. This allowed for participants to be recruited throughout the engagement period as they were identified.

Aims

The aims of this stocktake report are:

1. To provide an overview of healthy eating and physical activity programmes/initiatives/activities offered to Hawke's Bay Decile 1 – 4 primary/intermediate schools and their subsequent uptake.
2. To explore the views of stakeholders providing these programmes within the primary school community setting to understand the current challenges regarding access, implementation and uptake and to consider opportunities for further support.
3. To explore the views of community groups to gain an understanding of family/whanau views on healthy eating and activity issues.
4. To identify themes and approaches to inform the design and development of a new healthy eating and activity programme focussing on children aged 5 – 12 years.

[1] McElnay, C. (2014). Health Equity in Hawke's Bay, Hawke's Bay District Health Board.
[2] Sundborn, G., Mwerriman, T.R., Thornley, S., Metcalf, P., Jackson, R. (2014). An 'End-Game' for sugar sweetened beverages? Pacific Health Dialog. Vol 20 (1).
[3] World Health Organisation. (2015). Draft Final Report of the Commission on Ending Childhood Obesity. Geneva, Switzerland.

1. Healthy eating and activity programme overview in Hawke's Bay Decile 1 – 4 Primary Schools					
1.1 National initiatives with a nutrition focus					
Initiative/Provider	**Programme/Provider**	**Participation/Uptake**	**Comments**	**Strengths/Barriers/Gaps**	**Capacity**
Breakfast in Schools	*KickStart/Sanitarium* *Milk in Schools/Fonterra* *KidsCan/Food for Kids*		Schools combine the support of these providers to deliver targeted breakfast programmes according to need	Sanitarium pay an incentive to schools – 40 cents per 'Up & Go' sold from vending machines	Available to all Decile Schools
KidsCan	*Kaweka Lunches*	41 schools	Supply ready-meals; need identified by schools Require microwaving Supplied in 2 portion packs e.g. bangers & mash/curry & rice Fresh not frozen	Schools lack sufficient heating resources but they don't want to lose them – so Principals give to parents who identify as not having enough food for the family Do not appear to align with NZ Nutrition Guidelines	
	Snack boxes		e.g. scroggin; jelly fruit pottles	Content does not appear to align with Nutrition Guidelines	
	Breakfast items – see above				
Fruit in Schools	*United Fresh*	Appear to be in most schools			Now available to all Decile schools; recent update indicates 1-2 + retains those that have moved up a Decile in the latest rating change
Heart Foundation	*Food For Thought*	9 schools completed		One school identified via HPS PHN that this programme was not culturally appropriate re food choices which limited buy-in;	

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				they felt it was 'pitched' at higher Decile schools	
	Fuelled4life	Many schools use	Guides healthier food and drink choices at school	Query food/drink content re alignment with NZ Nutrition Guidelines Query provider intent	
	HEAT Training	No caterers from HB schools have completed this training	HF delivers training on behalf of ServiceIQ		
	Heart Start Award	16 schools	Schools choose 5/12 modules that support the following: 1. Developing and implementing a nutrition policy 2. Tuck Shop rules 3. Food insecurity 4. Whole of school community health promotion 5. Brain boosters for students 6. And staff 7. Increasing participation in physical activity 8. Student health initiatives 9. Engaging with wider community 10. Healthy changes at our local shops 11. Fuelled4life 12. Jump Rope 4 Heart	Other providers' feedback about the modules is very positive Query coordinator's capacity to fully engage at the level required	
Garden to Table (Trust)	*Framework for providing, training kitchen & garden specialists & support from Area Coordinator*	1 school – not Decile 1 - 4	Set up cost: $2,500 Annual fee: $550 (waived first year		

			Requires some school allocated funding & volunteer support		
5 + A Day Charitable Trust	*5+ A Day school and ECE challenge5+ A Day Health Professional Champions*	Introducing and promoting consumption of fresh fruit and vegetables at least 5 days/week Using 5+ A Day key messages in HP activities			
1.2 National and local initiatives with a physical activity focus					
Bikes On NZ Charitable Trust	*Provides support to access:* *Riding track* *Bikes & helmets* *Bike storage* *Pump track/skills track* *Cycle skills training*	14 Dec 1 - 4 schools have participated at various levels			
Sports Hawke's Bay	*Sport Skills in Schools*	59 schools 9 sports/codes 550 classes	Regional Sports Organisations (RSOs) deliver sport specific programmes in schools 5 week course Years 4-8 Creates a pathway for continuing sporting activities outside of school environment		
	Targeted Schools	12 schools	Programme targeting schools to increase participation in sporting activities; works with BoT, Principal, TiC sport/PE to identify gaps and develop 3 year plan		

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	Targeted Schools - Kura Kaupapa	5 schools	As above taking a Maori physical activity approach		
	Fundamental Movement Skills (FMS)	36 teachers trained (over 12 months) 64 f/up sessions delivered	One-day workshop with on-site visits to follow		
	Physical Activity Leaders Programme (PALS)	49 schools 550 students trained	One-day workshop & f/up session		
	Cycle Skills Training	39 schools (19 Decile 1 - 4)	Contracted by HDC One-day programme; focus on safety		
	Move-it	12 schools	Focus on walking/cycling/scooting to school instead of driving		
	HB Primary School - Management Committee	Sport Management Committee Principal Association Sport Coordinators Student Sports Council Teacher in Charge (TiC) of Sport	Leadership & direction to education sector		Suggest membership on Taskforce/steering group
1.3 National initiatives with a nutrition *and* physical activity focus					
Heart Foundation	*Healthy Heart Award*	See above			
Sport Hawke's Bay	*GRx Active Families*	Targets 5 – 18 year olds Supports children & families to sustain physical activity & nutritional habits over a 12 month period Provides group activity sessions	<u>FMS and Sport skills</u>: Mon 4 – 5 pm at Flaxmere Community Centre Wed 5 – 6 pm Tamatea Gym <u>Learn to Swim</u> at Napier Aquatic Centre – Term 1 & 4 <u>Cooking Classes</u> at Flaxmere Community Centre – Term 2 & 3	<u>Barriers:</u> Access - shift work; transport; childcare; don't understand that it's for the whole family; poor referral information Delivering one group activity to cover all age groups CHB – no capacity to deliver activities <u>GAPS identified</u>:	Capacity - 45 families

		Uptake - Currently supporting 20 children from 20 families		1. use a settings-based approach to learning e.g. School programme delivered at lunch time 2. have a separate group activity for 15 – 20 age group 3. Wairoa – there has been no capacity to deliver activities; Sport HB has contracted Patu to accept Active Families' referrals to support physical activity component	
Sports Hawke's Bay: Delivered prior to the Primary school setting	*Active Families Pre-School*	Targets 3 – 5 years Approximately 25 families supported	Main issue identified as being diet NOT lack of physical activity	Barriers: Lack of translators Too many organisations going into the home	
	Maternal GRx	Targets pre-natal – post natal (2 years)	Assessment completed and goals set Links to specific providers Monthly support against goal progress	Barrier: Hasn't been able to support physical activity component Limited motivation Less interested in group sessions GAP identified: Would like to take a weekly group activity session; within scope but no capacity (?)	Approx. 80 families supported currently
Health Promoting Schools	*Priorities:* *1. Healthy eating* *2. Healthy drinking* *3. Fitness programmes* *4. Food security* *5. Adult role modelling* *6. Policy*	18 Decile 1 - 10 schools identified some/all of these priorities to focus on Of the Dec 1-4 schools 6 chose *healthy eating* 3 chose *healthy drinking* 3 chose *fitness programmes*	The school (mainly the Principal) is supported to view the school environment through a HP lens to identify priorities they would like to focus on improving		Provided by 5 DHB PHNs partially contracted & programme coordinator

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	7. After school/lunchtime programmes	2 chose *lunch time/after school programmes* 3 chose *adult role modelling* 5 chose *inadequately fed children* 2 chose *Policy*			
1.4 Hauora programmes influencing healthy eating and physical activity outcomes					
Te Taiwhenua o Heretaunga	Te Whare Oranga school-based nursing Oranga niho – oral health	Provide a range of kaupapa Maori hauora services: exercise and nutrition dental education			Hastings and Napier
Kahugngunu Executive	*School based nursing*				Await further contact
Te Kupenga Hauora - Ahurihi	*Dental Health Educator* *Healthy Lifestyles Coaches* *School-Based Nursing* *Mobile Primary Whanau Ora Nursing & Health Promotions:*	Working with whanau to improve the oral health of their children Programme centred on improving health and wellbeing through better nutrition and regular exercise, education, promotion and assessments on a range of conditions/topics such as heart disease, cancer, diabetes, nutrition		Unavailable for comment until January 2016	Registered Nurse for tamariki/rangatahi at Decile 1 schools in Napier and their whanau.
Te Whatuiapiti Trust: Central Health	*Kura Tuatahi – Ki Te Whakangao i nga Rangatira Mo Apopo (investing in tomorrow) school project:* *Tailor made, on site programme for each school*	Terrace School Porangahau School Te Kura Kaupapa O Takapau Nga Kohanga x 5 Otane School	Addressing the leading factors contributing to the rise of NCDs for Maori: physical inactivity; poor diet; and tobacco use by targeting tamariki as the best opportunity to create sustainable behaviour change	<u>Strengths:</u> Whanau orientated Needs identified by school Tailored response <u>Barriers</u>: Getting parental support to deliver programmes	*Terrace School:* healthy lunches provided to 270 students *Kia Tunua healthy eating/cooking programme* – delivered to 104 tamariki and their whanau

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				Teacher attitudes to/perception of healthy eating General parenting healthy eating skills/knowledge Access to healthy food options in the home environment	*Kura Tuatahi activity programmes*: 630 tamariki took part in 1 or more; 8 Primary schools took part in *Touch* module
Choices: Kahungunu Health Services	*School based nursing – Iwi-based*	Camberley School Paki Paki School Kimiora School Mangateretere TKKM Riverslea	Health Promotion small part of role Works in partnership with PHNs Broader scope; can practice holistically	<u>Barrier:</u> Limited capacity	Areas covered: Hastings, Flaxmere, Waipukurau and Napier
1.5 Local Initiatives - Other					
Choose Water HB – local project initiative	*Group of concerned dental clinicians offering schools support to ban the sale/consumption of SSBs in schools and promote Water-Only Policies*	1 school	Issue linked to truancy issues i.e. providing junk food & fizzy drinks within school grounds	<u>Barriers:</u> No traction with this initiative apart from pilot school – Taradale Intermediate Group agrees framework needs a rethink Hindered by commercial incentives – see Sanitarium above	However, feedback suggests the letter has started the conversation and some schools are actually in the process of/or planning to remove SSBs
U-Turn Trust	*Access to Marae Gardens* *Support for school gardens* *Supports Flaxmere families in need*			<u>Strengths:</u> Whanau based; focus on local community <u>Barrier:</u> Vandalism of community gardens	
Maraenui Donations	*Prepare and deliver daily lunch packs to local schools*	2 schools	<u>Need:</u> Children are often kept home because they don't have any lunch community initiated group Funded via grants, fund raising opportunities & 'just finding it!' School signals need	Would like to roll out to other schools in their area	

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			Group makes sandwiches		
Patu	*Fitness/weight loss programme based on 9 week Hinu Wero (challenge)* *starts with assessment & weigh-in* *Uses a Patu-developed health indicator tool* *Includes nutrition workshops*	Schools 5 Prison Workplaces	<u>Strengths:</u> Whole-of-whanau approach Expectation whanau invest in their own health and well-being Able to go mobile Train the Trainer approach ensures quality and sustainability Delivered for Maori by Maori Uses Te Ao concepts Targets Maori community leaders Incentive based <u>Barrier:</u> Limited by how fast they can expand		Looking to expand MOH showing interest Excellent local buy-in Expanded concept by using a licensing approach - HB satellite gym opening in Napier; 4 trainers now based in Wairoa Creating national satellites (Kaikohe)
Iron Maori	*IRONMAORI Tamariki-Rangatahi*	3 – 5 schools	Based on building the skills required to enter the triathlon Will hold activities at Pandora Pond for the older kids	Works well with adults because it provides opportunities to open up wider conversations about the connection between exercise & health & wellbeing; particularly good nutrition – messaging doesn't work quite so well with kids	
Examples of school initiated/funded programmes	*Whanau Breakfast - Once a term*	Marewa Primary	Organised by a 'driven' teacher & relies on whanau engagement		(70/200) participate

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	Healthy Lunch Programme	Te Awa Primary	Once per term Organised by driven Pastoral Care staff member Culturally based food choices		
	Tailored Healthy Eating Model	Kowhai & Fairhaven	School leading whanau evening with dietician & PHN to discuss options re adapting a Nelson programme to address weight issues		

2. Provider feedback summary

Public Health Nurses (PHNs)	*Health Promoting Schools PHNs* <u>General comments</u> • 3 felt their schools (Hastings/Flaxmere) already have a good understanding of healthy eating and beverages within the school environment due to established programme activities, however behaviour change is not necessarily transferrable to the home/whanau environment. • Heart Foundation's 'Food for Thought' programme was cited as a good example of above • 1 described the main issues across all schools she is responsible for (Napier, both Special Schools) as: o Food security - hungry kids; poor quality; access; cost o Most appearing to have Healthy Eating/H20-only/SSB policies but they tended to be very generic, have limited buy-in, are poorly understood, not consistently applied or monitored o Having limited compliance due to easy access to SSBs and fast foods to/from school and within the home environment and the poor food knowledge of parents/caregivers o Having limited application due to transient student numbers – role can double in very short timeframe o Reflects anecdotally that when asking the kids what they had for dinner the night before – 90% would say takeaways & 90% of households are NOT smokefree

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	○ Kowhai and Fairhaven Special Schools - Obesity is a major issue & barrier to participation (e.g. wheelchair access/mobility assistance) & intellectual disability • 1 stated that her schools perceive health eating and physical activity as issues the school should focus on but ○ feel other issues take greater priority ○ have the awareness but not the capacity ○ food security is a major issue i.e. cost verses awareness <u>New programme framework suggestions</u> • Must be an all-of-community approach during development including desired outcomes • must be inclusive of and engage with parents/caregivers/family/whanau • must target the journey to/from school e.g. dairies and fast food outlets <u>Recommendations suggested</u> • steer clear of Flaxmere for the pilot area as these schools have been over targeted • alternatively, target a cluster of schools primed for behaviour change that already have proactive principals, an inclusive approach and work collaboratively - cluster suggested: Camberley, Raureka & Heretaunga Intermediate • Consider a long term goal of being a curriculum-based programme *Generic PHNs* <u>General comments</u> • Approached regularly by teachers/social workers etc. to talk to families of students who have been identified as overweight - finds this an unsatisfactory / awkward process that skirts around the subject; wonders if this is the right approach?
Oral Health Coordinator	<u>General comments</u> • many existing policies are likely to be historical Healthy Eating policies from HEHA days perhaps shelved/not updated (once mandatory school tuck shop policies were lifted) • Language is important - suggests rewording “policy” conversations to be more about “re-committing to their HE & Beverage” priorities which will lessen the “we’re already doing that” conversations • Oral Health should be represented on the Obesity Prevention Taskforce and it requires a higher profile as it is associated with poor health outcomes other than dental caries • The new programme will require an incentive approach

	<u>Choose Water HB Initiative</u> • So far there hasn't been sufficient buy-in for this approach/support • From 30 letters sent to schools they have had only 3 replies • Suggested framework needs revisiting with a view to this initiative being included as part of the new school programme • Agreed to post-pone further approaches to primary/intermediate schools – will continue with high schools
Sports HB Coordinators	• see above

Pasifika Health Promotion	<u>General Comments</u>
	• Focus should be about improving healthy eating and activity across a continuum (lifespan)
	  o E.g. active transport as part of everyday life, throughout life, as opposed to just event training
	  o Should link with HB's biking infrastructure
	• Schools need better family/whanau engagement and to know the diversity of PI communities better – not a one-size-fits-all approach
	• Include family/whanau in a school-based physical activity
	• We need blunt messaging – paint a picture of the outcomes for Pasifika if obesity issues are not addressed
	• The proposed programme must be inclusive of school, whanau and wider community
	• We need to have baseline data and then have the capacity to measure outcomes/targets
	
	<u>Healthy Eating Gains</u>
	• Notes that food provided at Cook Island Community Committee gatherings is much improved
	  o Lots of vegetable variety/colour; salads; cooked in umu; some events are water-only
	
	<u>Healthy Eating Barriers</u>
	• Portion size/control – unless packaged in tinfoil container food is offered in buffet style which means people go back for more & more
	• Special occasions e.g. Children's birthdays there are fizzy drinks & sweets
	• Other PI events tend to be predominately high carb; high fats; lots of meat

Central Health	<u>Kura Tuatahi Programme Strengths</u> • Responds to local need identified by each school; results in a tailored support package • Whanau orientated approach increases overall participation in programmes • Existing local/community staff relationships based on trust create buy-in

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	• Several schools have gained or working on Heart Foundation Awards • Making small, gradual steps with healthy eating options in school canteens <u>Healthy Eating Barriers</u> • Getting schools to prioritise and develop Health Eating Policies continues to be difficult • Teacher attitudes/perceptions of and access to, healthy eating choices undermines school progress • Parents continually ask what actually constitutes 'healthy' food and drink items for lunch boxes. • Parents lack general knowledge re content and how much e.g. often 9-10 items will be provided – all of which tend to be of poor nutritional value • Some parents *perceive* healthy options such as sandwiches as reflecting their inability to provide quality food for their children whilst perceiving lots of pre-packaged 'branded' food items as having a higher status • Poor eating habits and poor cooking methods in the home environment contribute to overall issue and undermine the success of the initiatives provided within schools • Parents *perceive* their children as having a healthy body weight despite being clinically overweight/obese

TTOH	<u>Barriers</u>
	• Food insecurity
	  o Kids going to school with no breakfast or lunch
	  o Kids buying the wrong food on the way to school (pies)
	  o Kids turning up late to the breakfast club & missing out
	  o Schools gate-keeping the breakfast in school's initiative in fear that it will become unmanageable
	• Family dynamics:
	  o Parents working long days leaving teenagers in charge of children including meal times
	  o Parenting arrangements; often grandparents are providing care
	  o Parents not taking responsibility for feeding their children healthy foods
	• Family issues: Neglect; family violence; low incomes
	• Access
	  o Lack of transport
	  o What's available in the local shopping area e.g. Flaxmere New World; the argument that the retailer is just supplying what the community wants vs targeting the potential for the highest volume of sales in a high deprivation area market
	  o What's available in school canteens & on the way to/from school
	• Entrenched food habits
	  o Lack of healthy food knowledge
	  o It's a cycle that starts in childhood due to family dynamics & continues throughout the lifespan & through generations

	○ Parents learn survival techniques e.g. unhealthy foods can/appear to be cheaper than healthy options & these thought patterns influence their children's perceptions & attitudes to food ○ Cultural celebrations & their tendency to provide too much of the wrong foods <u>Opportunities to address barriers</u> • Need more control over the types of foods provided in school canteens • Parents/whanau need better access to & knowledge of healthier food options • Agrees with a school cluster/hub approach • Agrees that some schools are trying to be proactive but need more support
Choices	• School-based nurse caseload: Kimi Ora; Mangateretere; Riverslea; Te Kura Kaupapa; Paki Paki • All schools are very keen to address access to healthy foods and drinks within school • Schools have expressed interest in growing school gardens but don't know to resource them <u>Barriers</u> • Family/whanau perceive children as having a healthy body weight • Teachers not always role-modelling healthy eating behaviour • Access to unhealthy food and beverages in the Family/whanau home environment and weekends • Access to unhealthy food and beverages before/after school is a major issue
Te Kupenga Hauora	<u>Contributing factors</u> • Poor nutrition/malnourishment biggest problem • Complex / multiple issues with families • Lack of food • Bullying of obese/overweight kids leading to self-esteem issues • Unemployment • Intergenerational beneficiaries <u>Process & funding issues</u> • Funding for programmes being cut e.g. HEHA • Short term programmes don't work – not sustainable • Behaviour change needs to be supported at a higher level • How far should schools need to go without outside support? • Whanau get frustrated when funding pulled for projects <u>Breakfast club feedback</u>

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	• Not in favour of this initiative • Perceives it as absolving parental responsibility • Opposite to the messaging Te Kupenga deliver • Fine line between interdependence/dependency • These things need to be considered when delivering programmes <u>What is needed</u> • Need to work with family & school as it's a complex issue • No short term fixes
3. Community feedback summary	
U-Turn Trust	• food security is the biggest issue - the gardens are surrounded by whanau who struggle to feed their children wholesome foods • supports Flaxmere schools to grow and manage their own garden produce • supports local families in need

Patu	• Gateway - Patu can be the first point of contact for whanau to address health and wellbeing as they often don't go to GPs
	• looking to develop nutritional information – e.g. recipes/cooking skills to supplement workshops
	• Takes a partnership approach –
	  ○ Sport HB (Wairoa – Wero incentive)
	  ○ Akina Foundation – business acumen
	  ○ EIT – research and evaluation
	  ○ Iwi – supporting Train the Trainer pilot in a cluster of schools (Richmond, Maraenui, William Colenso, Henry Hill)

Iron Maori	<u>General comments</u> • Need to address activity & diet - there are lots of opportunities to address these issues • In particular we need to tackle whanau eating habits – the wrong foods too often ○ Likes the new MOH Obesity campaign messaging re loving our kids too much by overfeeding them the wrong foods • Should be a national strategy re SSB tax & removal of GST from water • Local community gardens (Waipatu & Te Aranga Marae) encourage whanau to harvest fruit & vegetables free & payback by weeding • Feels that food culture is slowly improving in Marae <u>Barriers</u> • Children are still going to school without breakfast

	• Has worked with whanau who don't know if their children have eaten breakfast before leaving for school & don't know what breakfast cereals are e.g. porridge & weetbix staples • Kids lack quality nutritional lunches & afternoon snacks • Journey to/from school provides too many opportunities to access SSBs & fast foods/processed foods • Kids are influenced by whanau poor eating habits & lack of exercise • Some whanau lack basic food content knowledge • Whanau lack basic cooking skills & nutritional knowledge <u>Suggested strategies</u> • Kids are motivated by fun exercise incentives: competitions, stickers etc. • Make it fun & quirky with simple messaging • Structure the exercise throughout the year vs a 10 week programme that fizzles out • Make active transport an everyday thing not just focussing on sporting events • More active kids will feel empowered & motivated to participate in other sports • Whanau involvement & role modelling are key • Whanau need cooking lessons using local seasonal produce & everyday accessible foods
Raureka Community Group	<u>Raureka Community Hub Project Background</u> • *Raureka BoT* was granted DIA Community Development funding - $80,000 over 3 years • *Raureka Community Trust* is a stakeholder in the project • Group already approached Rotary; granted funding for a tool shed • Came about from the Raureka Community Meeting; community members have agreed to be assigned various roles to manage the use of the shed & its contents • Approached council to fix up the Coben Park grounds • Established a community garden on school grounds <u>Project scope</u> • establishing a hub for the whole community and sourcing funding for a physical space • employing a fulltime community development coordinator – acts as a connector to facilitate community consultation/action • to offer a range of sustainable services: health/well-being and social <u>General comments</u> • Greg Riceman - Principal of Raureka Primary School is an active member of the Trust • PHN is very involved & has a high profile in the community • Manager of West End Community Tennis Club next to Ebbett Park is keen to support the project <u>Community identified needs</u>

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	• Nutrition: Healthy eating; health education; breakfast classes/days; cooking facilities and classes; gardening • Exercise: kids' bike day; bike lanes; IRON Raureka; Patu

Te Roopu a Iwi Trust	• As a geographical area Maraenui feels over-researched but underfunded i.e. frequently approached by funders to identify at risk/vulnerable families for support programmes
	• School holiday programme (Christmas break) - free
	  o Caters for 30 children during January when parents have run out of money
	  o Based at Maraenui Primary School gym with outings to
	  o e.g. swimming at Waimarama beach or Pandoro Pond, waka rides
	  o Funded via the Trust with the use of volunteers and community services
	  o E.g. local surf club and Community Police
	  o Pays EIT students at a ratio of 1/6 children
	• Barrier: Food insecurity - Families being in debt to GP practices

William Colenso High School	<u>School canteen</u> • Had historical mandated canteen food policy – feels this should still be a mandatory requirement • Has a loosely implemented healthy eating policy that bans sweets and fizzy drinks within school grounds but is not regulated <u>Barriers</u> • Vicinity of local dairy; access to SSBs, sweets and junk food • Previous owners of dairy have been contracted to provide food for the canteen • No food at home • Trying to 'police' bringing junk food into school grounds • Mixed attitudes/perceptions of staff re what constitutes healthy food and drink and the effect that has on role modelling <u>General observations</u> • SBHS has observed an increase in weight management concerns from female students quite recently – maybe due to it being a hot topic in the media • Advises cutting down/eliminating sugar from diets • Tends to raise BMI concerns with year 9 boys at health checks
4. Key themes, initiatives and approaches recommended to inform programme design and development	
4.1 Key themes identified	

Increasing school healthy eating and drinking ethos

- All food and beverages provided in schools must be consistent with the NZ Food Nutrition Guidelines for Healthy Children and Young People (2-18 years)
- Healthy Eating and Beverage Policies/Guidelines must be better understood by their users and consistently implemented

Increasing access to healthy food and drink choices

- Food insecurity is a contributing factor; schools clearly see a need for supported breakfast and lunch provision within the school environment
- Access to SSBs and high fat, processed foods to/from school and within the home environment undermines the school healthy eating/drinking ethos

Increasing whanau knowledge of healthy foods and beverages

- Sustainable healthy eating behaviour change is transferrable across school, the wider community and home environments
- Family/whanau should feel empowered to participate in programme development/activities including the desired outcomes

Increasing access to healthy activities for kids and whanau

- A school-based physical activity programme that encourages whanau participation is needed for all children
- Programme components must have the capacity to be tailored to local needs

4.2 Initiatives for consideration

4.2.1 Reducing access to SSBs and unhealthy food choices before, during and after school

What?	How?	Why?	Who/What can add value? (NB taskforce/steering group potential)
Support school communities to understand the importance of reducing SSB and unhealthy food consumption/access within school and on journeys to/from school by promoting drinking water-only	• Develop Healthy Eating and Beverage Guidelines for schools (see Healthy Auckland Together' • Develop health literacy programme for all school staff to gain buy-in to the Guidelines • Engage with and support the 'Choose Water HB' Working Group to reframe their approach to focus on Guidelines instead of HE Policy • and consider leading this group • partner with councils to promote 'Water-Only' at events e.g. Nelson council's sponsorship of their water truck combined with	• SSBs are a leading risk factor for non-communicable diseases such as obesity, type 2 diabetes and dental caries[4] • SSBs are a leading source of sugar for NZ children[5] • People living in deprived areas are more likely to consume SSBs than people living in the least deprived areas [3]	• Primary Schools Association • Dental association • Choose Water HB initiative • Councils • Healthy Auckland Together examples • Healthy Events Project

[4] Beaglehole, R. (2014). Sugar sweetened beverages, obesity, diabetes and oral health: a preventable crisis. Pacific Health Dialog. Vol 20 (1).
[5] Ministry of Health. 2003. NZ Food, NZ Children: Key results of the 2002 National Children's Nutrition Survey. Wellington: Ministry of Health.

	• 'Drinking Tap Water Campaign'(Healthy Auckland Together)		
Support families/whanau to understand the importance of reducing SSB consumption within the home environment for the whole family by promoting drinking water-only	• Develop and implement a community partnered school-based initiative modelled on the Dr Fizz/Che Fu mini-event programme (social media, poster & rap competition) targeting SSB content awareness, consumption and access and • Create a local SSB-free champion **or** • Consider approaching Dr Fizz to host their programme in HB	• A study of carbonated beverage consumption in NZ found that 58% of children (13-17 years) who reported fizzy drinks being available at home were in the high consumption group[6] • Waist circumference is significantly associated with fizzy drink consumption[6] • Reducing access to fizzy drinks in the home is likely to reduce overall consumption in youth[6] • Developing effective relationships with parents to ensure health promotion activities are reflected in the home environment supports long-term behaviour change[7]	• Retail association • Supermarkets • Local/national celebrities
Support local dairies and fast food outlets to stop selling fizzy drinks and promoting high sugar/fat content foods as takeaway lunches to students (in uniform?)	• Engage with and build the capacity of a provider/programme e.g. Heart Foundation/Heart Start Award's 'Student Health Team' and 'Healthy changes at our local shop' modules that promote student-led initiatives • Support local communities to approach dairies/fast food outlets e.g. Tobacco-free retailers project	• Reducing access to and provision of energy-dense, nutrient poor foods and SSBs in places where children gather is an effective way to target the obesogenic environment[3] • The student council at Rhodes Street School in Hamilton lobbied 6/7 local dairies successfully to stop selling SSBs and lollies to students in uniform	• Local councils • Retail association • Supermarkets • Primary school association (?) • Ministry of Education • Heart Foundation • Choose Water HB initiative
4.2.2 Increasing access to healthy lunches and after school snacks at school			
Fund and pilot a school-initiated lunch and afternoon healthy snack programme	• Support an existing school/parent-initiated programme (e.g. Maraenui Donations) or • Contract a provider	• 5 HB Decile 1 – 4 schools identified inadequately fed children as a HPS priority	• Parent / teacher association? • This could function as the incentive

[6] Sundborn, G., Utter, J., Teevale, T., Metcalfe and R Jackson. (2014). Carbonated beverages consumption among New Zealand youth and associations with BMI and waist circumference. Pacific Health Dialog. Vo1 20 (1).

[7] Clelland, T., Cushman, P and J Hawkins. (2013). Challenges of parental Involvement Within a Health Promoting School Framework in New Zealand. Education Research International. Vol 2013. http://dx.doi.org/10.1155/2013/131636.

		• "Healthy food choices should be readily available and affordable in disadvantaged communities"[3] (p.17)	
4.2.3 Increasing access to lunchtime and after school physical activity programmes			
Develop and pilot a school-based lunch time and after school physical activity programme that incentivises/motivates whanau participation Encourage active modes of transport to school	• Increase the capacity of the local initiative Patu – potential to create inter-school cluster challenges • Increase the capacity of the GRx Active Families 5 – 18 programme • Increase the capacity of the Sport HB Targeted Schools Programme • Partnership with Iron Maori	• 5 Decile 1 – 4 schools identified physical activity/after school/lunchtime programmes as HPS priorities • The GRx Active Families Coordinator and Patu have identified a gap/need for an activity programme to be provided within the school setting (captured audience)	• NB: Schools and whanau could choose from a list of providers • NB: this programme could also be run during school holidays
4.2.4 Supporting whanau health literacy			
Develop and pilot a programme that increases healthy eating/drinking literacy for family/whanau	• Develop a manual & training to support local communities to facilitate practical workshops for family/whanau e.g. Healthy First Foods • This could support providers e.g. Patu • Support the capacity of an existing provider e.g. HF coordinator to tailor the HH Award programme for family/whanau in the home environment or • Investigate the potential to model pilot on the Faimafili Tupu: Pasifka Churches Healthy Heart Award programme • Fund and support the Garden To Table Trust initiative	• Improving the nutrition literacy and food preparation skills of family/whanau leads to sustainable behaviour change[3] (p. 26)	• Marae • Church organisations • Garden To Table Trust

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4.3 Approaches for consideration
4.3.1 Develop a new programme to be piloted in 3-4 Decile 1 and 2 primary/intermediate school clusters • This would involve the above initiatives (4.2.1 – 4.2.4); note pilot schools could choose initiatives • In the absence of a funded programme coordinator (e.g. Energiser project) this would require contracting separate providers under a coordinated project framework e.g. Maternal Nutrition Programme
4.3.2 Take a single-focus approach across all Decile 1 – 4 primary school wider communities inclusive of family whanau and the obesogenic environment • For example targeting SSB consumption based on those initiatives
4.3.3 Take a coordinated lifespan-pathway approach • which follows on from the Maternity programme work (0-4 years) • referrals generated from the B4SC (Before School Check) programme (new target) • partners with SHB (increases capacity) or contracts a community provider (e.g. Patu/Iron Maori)
4.3.4 Create healthy eating and activity school community hubs • partnership between health and education e.g. supporting a school-based healthy eating and activity champion • providing nutrition and activity initiatives for the wider community within primary school settings • includes family/whanau • contract local provider (e.g. Patu) to deliver activity component
4.3.5 Take a coordinator role approach • a facilitated 'do for' role e.g. Active Families Coordinator or Project Energiser coordinator role • links to HPS work e.g. identified priorities

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Appendix 2

Hawke's Bay
District Health Board
Position Profile / Terms & Conditions

Position holder (title)	Population Health Advisor
Reports to (title)	Team Leader / Population Health Advisor
Department / Service	Population Health Service
Purpose of the position	To promote population health by: • Planning and implementing evidence-based health promotion strategies with a particular focus on school aged healthy eating and activity. • Growing the capacity and capability of contracted providers for school aged healthy eating and activity programmes. • Providing leadership, oversight and coordination to the Sugar Reduction and Healthy Eating and Activity programmes • To ensure and prioritise a focus on patient safety and quality relating to care and processes within the Population Health Service. • Delivery of organisational KPIs including relevant MOH targets, financial budgets and service plans. • To recognise and support the delivery of the Hawkes Bay Health sector vision

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Working Relationships

Internal	External
• Population Health Service, including Portfolio Managers and Population Health Advisors delivering Nutrition and Physical Activity portfolios • Integrated Care Services • Maori Health Unit • Advisory Committees • Maternal Child & Youth service • Kahungunu Hikoi Whenua contracted providers • Oral Health Services	• Government agencies • Community • Lead Maternity Caregivers • Ngāti Kahungunu Iwi Inc • Non-Government organisations • Contracted providers in the Sugar Reduction and Healthy Eating and Activity programmes • PHO • Community Groups • Maori, Pacific and other providers (e.g. Oranga Niho Service) • National Organisations • Health Promotion Agency • Ministry of Health

Appendix 2

Dimensions

Expenditure & budget / forecast for which accountable	N/A
Challenges & Problem solving	Meeting the outcomes of the Best Start: Healthy Eating and Activity Plan. Support and guidance for contracted community based provider. Ensuring Population Health supports delivery of school aged healthy eating and activity.
Number of staff reports	N/A
Delegations & Decision	N/A
Other Indicators	Use evidenced based information and knowledge to identify risks, barriers and solutions.

Appendix 2


Our vision
HEALTHY
HAWKE'S BAY
TE HAUORA O
TE MATAU-Ā-MĀUI
Excellent health services working in partnership to improve the health and wellbeing 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

Appendix 2

Key Accountabilities

Strategic Planning	
Tasks (how it is achieved): ▪ Plan and implement evidence-based health promotion strategies, with a special focus on school aged children. ▪ Contribute to the development of HBDHB plans and strategies.	**How it will be measured (KPI):** Sugar Reduction and Healthy Eating and Activity programme project plan is implemented Contribution to HBDHB strategies and plans.

Evidence-Based Practice And Research	
Tasks (how it is achieved): ▪ Critically analyse and disseminate research, reports and literature relevant to school aged healthy eating and activity and other portfolio areas from time to time. ▪ Promote the use of evidence to inform population health programmes. ▪ Identify opportunities for research or evaluation and conduct or coordinate where appropriate.	**How it will be measured (KPI):** Research analysed and disseminated. Evidence-based population health programmes developed. Programmes researched and evaluated.

Capacity And Capability Building	
Tasks (how it is achieved): ▪ Develop the capacity and capability of sugar reduction and healthy eating and activity contracted providers to support deliver of programmes. ▪ Create/coordinate opportunities for integration, collaboration and shared learning between health promotion providers, schools and wider health services. ▪ Provide advice and support other organisations to deliver effective school aged healthy eating and activity health promotion programmes.	**How it will be measured (KPI):** Effective workforce development plans developed and implemented. Evidence of facilitation, suppoprt and coordination for contracted providers and others in the health and education sector.

Leadership – School aged healthy eating and activity	
Tasks (how it is achieved): ▪ Continue monitoring the progress toward implementing outcomes in the Best Start: Health Eating and Activity Plan and report these to Team Leader, Popluation Health Director and Ministry of Health ▪ Provide leadership, oversight and coordination to the region's school based programmes, including: o Providers with contracts funded via the Population Health Funder o Schools o Public Health Nurses o DHB oral health services ▪ Develop the capacity and capability of health providers across the DHB region to deliver school aged healthy eating and nutrition	**How it will be measured (KPI):** Reports delivered. Evidence of facilitation and coordination of regional providers. Evidence of capacity and capability building for providers delivering school aged healthy eating and activity health promotion Steering group term of reference complete and group meeting.

Appendix 2

health promotion programmes. ▪ Contribute to development and dissemination of messages that contribute to improving school aged nutrition. ▪ Support the establishment of a steerting group to guide the development and ongoing implementation of school aged healthy eating and activity programmes.	

Advocacy And Influencing	
Tasks (how it is achieved):	**How it will be measured (KPI):**
▪ Influence organisations operating within and outside the health sector to focus on health determinants and wellbeing. ▪ Provide information that highlights effective areas for change that can be actioned by other agencies. ▪ Empower communities and other agencies to advocate for themselves. ▪ Use submission and other policy change processes to advocate for healthy public policy (e.g. breastfeeding friendly workplaces).	Monthly and six monthly reports. Information promoting change provided to non-DHB agencies. Evidence of submissions.

Relationships and Collaboration	
Tasks (how it is achieved):	**How it will be measured (KPI):**
▪ Work collaboratively with HBDHB's service including Oral Health, Child Health, Strategic and others engaged in healthy weight outcomes. ▪ Establish, maintain and enhance networks and relationships with stakeholders in school aged healthy eating and nutrition. ▪ Identify opportunities for joint working across sectors. ▪ Build and facilitate intersectoral coalitions and strategic alliances.	Evidence of positive working relationships with HBDHB's services. Evidence of positive working relationships with key stakeholders developed and maintained. Intersectoral groups supported, and where appropriate, led

Community Development/Action	
Tasks (how it is achieved):	**How it will be measured (KPI):**
▪ Support/empower community action to identify and address health need, particularly with Māori and Pacific and Low income groups. ▪ Be open and responsive to community needs. ▪ Ensure programmes support whanau engagement with oral health services.	Demonstrates a commitment to working with and for the community, particularly Māori Pacific and Low income groups. Communities supported to identify and address need. Improvement in attendance oral health services.

Professional Development	
Tasks (how it is achieved):	**How it will be measured (KPI):**
▪ Maintain and develop professional knowledge and skills ▪ Identify, develop and maintain professional networks ▪ Achieve health promotion competencies specified in the knowlege and skills clusters	Evidence of participation and/or achievement at training courses. Evidence that professional networks have been developed and maintained. Evidence of achievement of health promotion competencies.

Appendix 2

OCCUPATIONAL HEALTH & SAFETY	
Tasks (how it is achieved): Displays commitment through actively supporting all health and safety initiatives. Ensures all staff/colleagues maintain adequate safety standards on the job through consultation, training and supervision. Ensures own and others safety at all times. Complies with policies, procedures and safe systems of work. Reports all incidents/accidents, including near misses in a timely fashion. Is involved in health and safety through participation and consultation.	**How it will be measured (KPI):** Evidence of participation in health and safety activities. Demonstrates support of staff/colleagues to maintain safe systems of work. Evidence of compliance with relevant health and safety policies, procedures and event reporting.

Key Competencies

CUSTOMER SERVICE	
Tasks (how it is achieved): Open and responsive to customer needs. Demonstrate an understanding of continuous quality improvement.	**How it will be measured (KPI):** Demonstrates a commitment to customer service and continuous quality improvement, through interaction with patient/clients and other customers. Identifies customer needs and offers ideas for quality improvement. Effective management of customers/situations.

HONOURING TREATY OF WAITANGI OBLIGATIONS	
Tasks (how it is achieved): Demonstrates understanding of the principles of the Treaty of Waitangi. Ensure the principles of partnership, protection and participation are applied to day to day work. Ensures procedures do not discriminate against Maori.	**How it will be measured (KPI):** Evidence of the principles applied in work practice.

Appendix 2

Essential and Desirable Criteria: Qualifications / Skills / Experience

Essential	
Treaty of Waitangi Responsiveness (cultural safety)	Demonstrates the ability to include cultural safety of the health consumer when relating to care and processes within the Service. Demonstrates ability to apply the Treaty of Waitangi within the Service.
Qualifications (eg, tertiary, professional)	Tertiary qualification in health promotion or public health
Business / Technical Skills (eg, computing, negotiating, leadership, project management)	▪ Health promotion and education ▪ Programme planning and evaluation ▪ Project management ▪ Effective interpersonal skills, relating to wide range of people ▪ Strong relationship development skills ▪ Strong written and oral communication skills ▪ Experience and skill at facilitating and participating in intersectorial networks ▪ Effective time management skills ▪ Proficient in Microsoft Office – Word, Excel, Outlook, Powerpoint ▪ Current driver's licence ▪ Working knowledge of Te Tiriti O Waitangi ▪ Knowledge of Ottawa Charter ▪ Knowledge of determinants of health
Experience (technical and behavioural)	Shows commitment to, and demonstrates the behaviours of the health sector: ▪ 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)
Desirable	
	Degree or post-graduate qualification in health, social services or public policy
	▪ Clinical experience and/or knowledge of school aged nutrition ▪ Knowledge of Tikanga Maori and Te Reo ▪ Experience working with the media ▪ Marketing and promotion skills

Recruitment Details

Position Title	Health Promotion Advisor- School Aged Healthy Eating and Activity
Hours of Work	80 per fortnight Fixed term for 24 months
Salary & Employment Agreement Coverage	In accordance with the DHBs/PSA Allied, Public Health & Technical Multi Employer Collective Agreement (MECA). $ 69,460.00 to $74,749
Date	29 June 2016

HAWKE'S BAY District Health Board Whakawāteatia	**Business Case 2015/16 for new position Clinical Midwife Specialist - Diabetes**
	For the attention of: **Clinical Council**
Document Owner: Document Author(s):	Chris McKenna Jules Arthur, Andrea Rooderkerk
Reviewed by:	HSLT and EMT
Month:	June, 2016
Consideration:	For Information

RECOMMENDATION

Clinical Council:

- To note contents of paper and endorsed by EMT

OVERVIEW

As part of the 2015/16 new investment application process, Clinical Council prioritised and approved in principle, an application for investment of a Clinical Midwife Specialist - Diabetes to go through approval process 3 business case for new investment that will demonstrate integration of the role in the maternity and diabetes services with particular emphasis on diabetes education.

The request for funding is to employ 0.5FTE Clinical Midwife Specialist in Diabetes who will lead the development of a midwife/diabetes nurse specialist led service for women experiencing gestational diabetes mellitus during pregnancy. This position would be located alongside the multidisciplinary team in Antenatal Clinic and will support and provide midwifery care, support, management and education to women experiencing diabetes during pregnancy. This position will be employed under the DHB/NZNO Nursing & Midwifery MECA at Grade 4 of the Designated Senior midwifery scale

This new position is in response to:

1. The publication of the national ministry of health guidelines for screening, diagnosis and management of Gestational Diabetes Mellitus (2014) which clearly identifies the importance of timely diagnosis, treatment and continued follow up are essential to prevent and/or minimise adverse outcomes for both the mother and baby.
2. An increasing recognition of diabetes early in pregnancy and evidence of increasing numbers of women requiring early intervention and management during pregnancy (MOH,2014)
3. The need to evolve our current model of care for gestational related diabetes (GDM) to improve continuity of care, navigation and patient journey and resolve capacity issues of existing high risk antenatal clinic.
4. Continuing to improve multi professional team working for the benefit of the woman – streamlining access, ensuring robust care planning and working in partnership with the woman to meet her health needs.
5. To support improved links with primary care and the ongoing health management of women after the baby is born and discharged from midwifery care

The rates of diabetes in the general population and diagnosis of diabetes in pregnancy is rising significantly. The introduction of HbA1c screening at pregnancy booking with a Lead Maternity Carer last November 2015 is already impacting on volumes coming through the high risk antenatal clinic.

The introduction of the clinical midwife specialist role provides the ability to streamline the care provision further for women with gestational diabetes. The role will work closely with the Specialist Diabetes MDT to develop and provide a model of care and resources that ensure women with gestational diabetes have quality pregnancy and diabetes care; with appropriate access to specialist antenatal care during pregnancy. The role will also provide a single point of contact to assist these women with the navigation of health services during pregnancy and in transition of care following the pregnancy.

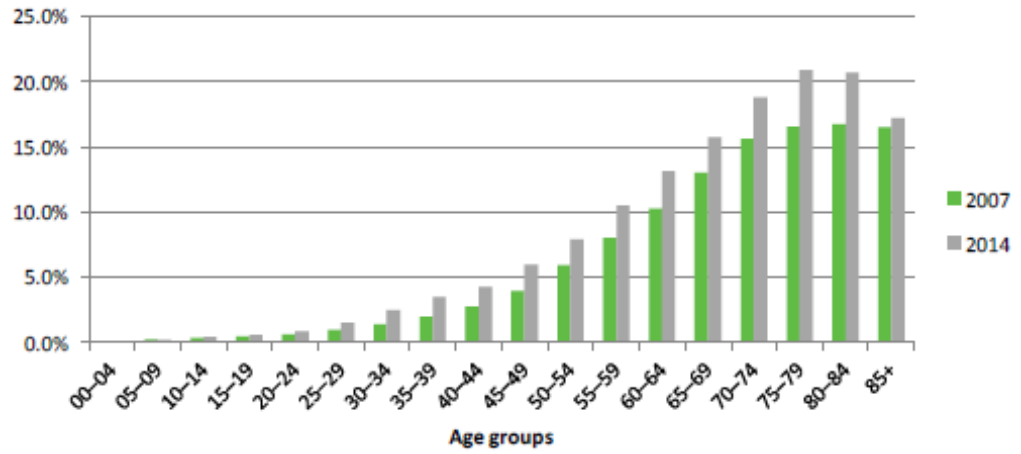
The attached position profile gives more detail on the purpose, scope and functionality of the Clinical Midwife Specialist Diabetes

BACKGROUND

National and Local Drivers for change

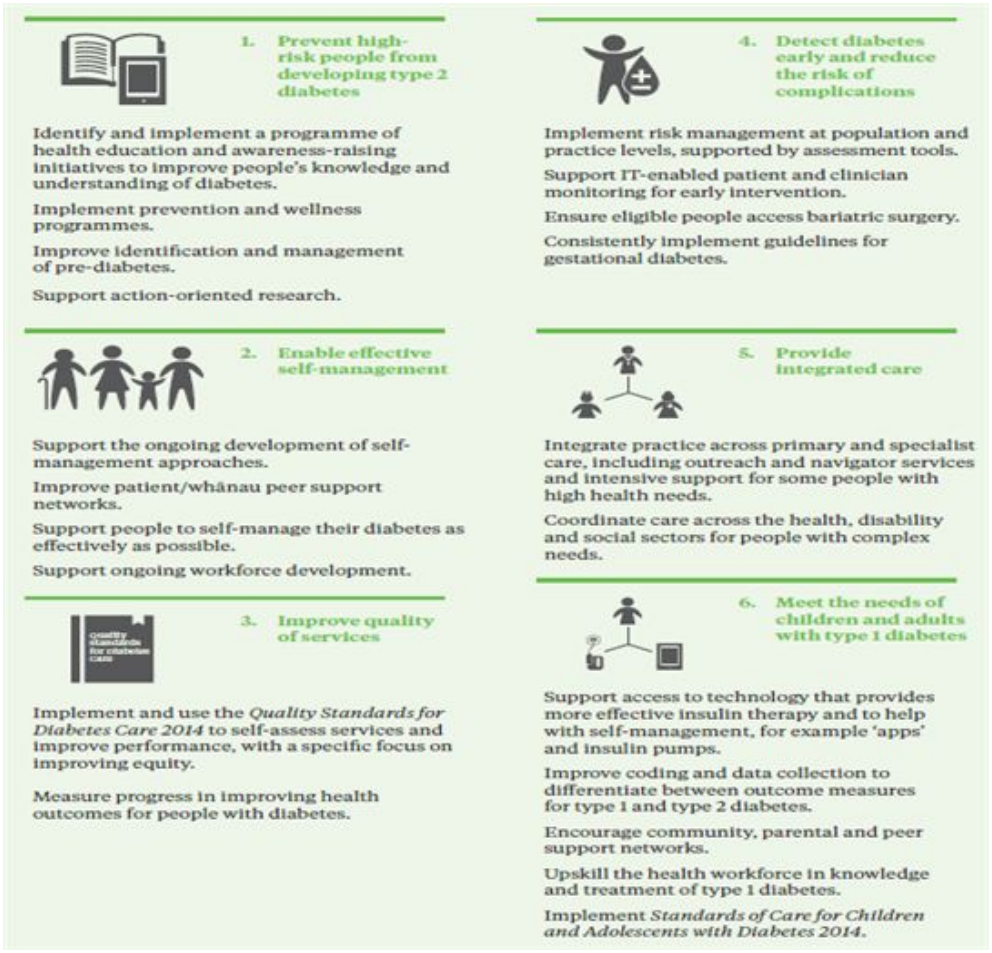
Diabetes is a chronic condition for an increasing number of our population. Approximately 257,000 people in NZ have Diabetes Mellitus. The prevalence of diabetes has been rising at an average of 7% per year for the last 8 years and this prevalence is increasing across all ethnic groups and age groups. The increase in diabetes is consistent with trends in obesity.

Gestational diabetes affects 3000-4000 women per annum; affects 5-10% of all pregnancies per annum and the prevalence of gestational diabetes, and type 2 diabetes is increasing, particularly affecting women of Maori, Pacific Island and South Asian ethnicity. Of our local population in 2015 37.4% (695 women) are Maori which is significantly higher than the national average. In 2015 1895 women had a baby and 89 women had diabetes in pregnancy, 33.7% were Maori, 12.3% were Pacific Islanders, 16.8% Asian and 30.3% were NZ Euro with 5.6% of other ethnicities.



Source: Virtual Diabetes Register, Ministry of Health (2015)

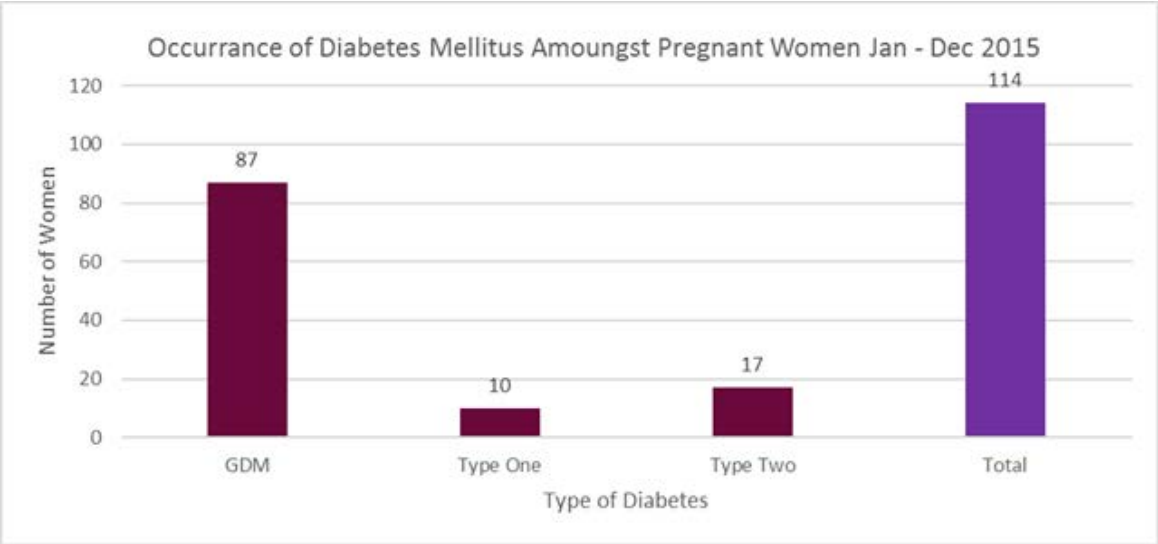
From the Ministry Of Health “Living Well with Diabetes: a plan for people at high risk of or living with diabetes 2015-2020” there are six priority areas for action:



Of these six priority areas numbers 1,3,4 and 5 relate to women with diabetes during pregnancy.

Local drivers underpinning the need to appoint a Midwife Specialist in Diabetes include:

- HBDHB annual plan
    - Priority goal 1 responding to our population – providing timely and accessible care that is seamless across the health sector and across health providers for women with a pregnancy complicated by diabetes
    - Priority goal 2 delivering consistent high quality care. Making sure we provide evidence based best practice to ensure the best outcomes for the pregnant women and their babies
    - Priority goal 3 ensuring best use of resources. Making best use of resources to provide the most efficient and effective service in the best way with the woman and her family/whanau at the centre
- Providing value for money service that achieves quality of care and clinical and financial sustainability (Transform and Sustain strategy)
- Our HBDHB data is demonstrating evidence of increasing numbers of women experiencing diabetes during pregnancy and the introduction of early screening at confirmation of pregnancy is revealing undiagnosed type 2 diabetes.



During 2015 there have been 114 pregnant women referred to the diabetes service for shared care. The graph indicates that three quarters of these women (76.3%) have been diagnosed with gestational diabetes mellitus (GDM), whilst 14.9% had pre-existing type two diabetes and 8.7% with pre-existing type one diabetes.

The volume of pregnancies in women with type one diabetes mellitus has been reasonably static over the last three years with around ten women presenting to our service each year, however, 2015 sees a rise in type two presentations from eleven to seventeen and the continual rise of GDM diagnosis which has increased from 50 in the 2013/14 year to 66 in the 2014/15 year to 87 in the 2015 calendar year. This rising trend of gestational diabetes is having an impact on services and service provision.

Co-ordination of care remains a challenge for this service with key issues identified:

- increasing demand for the services with the evident upward trend
- avoidable delays between a positive screen and the receipt of referral to antenatal clinic/diabetes service
- current clinic capacity and physician availability at maximum
- sufficient resources to respond to referrals in a timely manner
- ensuring ongoing postnatal screening for diabetes mellitus in primary care occurs

BENEFITS AND OUTCOMES

A pregnant woman with diabetes either pre-existing or gestational is a high risk pregnancy with a demonstrable increase in:

- pregnancy associated hypertension (1.5x more likely)
- Caesarean section (1.45 x more likely)
- 3rd/4th degree perineal tears (2x more likely)
- Operative vaginal birth
- Development of Type 2 DM in later life (50-60% risk within 10 years of having GDM)
- Preterm labour (1.42 x more likely)
- Postpartum haemorrhage
- Polyhydramnios

The burden of GDM for the baby includes an increased incidence of:

- Birth trauma (shoulder dystocia, bone fractures and nerve palsy)
- Macrosomia (1.81 x more likely)

- Neonatal hypoglycaemia
- Congenital malformation (due to undiagnosed maternal diabetes in early pregnancy)
- Small for gestational age
- Respiratory distress syndrome
- Stillbirth
- Childhood obesity
- Developing type 2 DM later in life
- Developing metabolic syndrome later in life

The establishment of the clinical midwife specialist diabetes role will provide an ability to improve early engagement, referral and continuity of care antenatally and postnatally as an identified care coordinator. This role will also act as a liaison to support integration between primary and secondary services improving a seamless care pathway and journey for the woman. The clinical expertise expected of this role will enable information, education and resources to be developed locally to raise skills, knowledge and expertise of clinicians providing this care and the establishment of resources for the women and whanau that meets their needs.

Benefits of this new position triple aim profile	**Outcome**	**Measure**
1. Improved quality, safety, patient care	• National guideline supports consistent evidence based way of treating all pregnant women • Women seen in appropriate timeframe from referral to Antenatal Clinic • Improved experience of care • Improved management of diabetes in pregnancy reducing morbidities for woman and baby • Improved access to dietetic advice and improved weight management	• Consumer feedback • Improved timeframes from referral to clinic • Reduction in time between screening test for GDM and receipt of referral for specialist care • Reduction in operative deliveries • Reduction in macrosomia and SGA babies • Reduction in BMI (Healthy weight gain in pregnancy)
2. Improved population health outcomes, equity	• Improved outcomes for Maori, Pacific and Asian women • Improved experience of care • Improved relationships with primary care • Increased levels of attendance at postpartum screening for type 2 diabetes	• Primary care feedback • Longer term outcome around health outcomes for Maori, Pacific and Asian women • Increased Attendance for postpartum screening
3. Best value for health system	• Decreased variation in clinical practice improving use of resources • Practice is evidence based against national guideline • Establishing a clinical midwife led diabetes service for GDM pregnancies with the	• Meet national guideline recommendations • Demonstrable consistency in screening practice and referral • CMS/CNS clinic established

	current clinical nurse specialist	

FINANCIAL IMPLICATIONS OR OTHER KEY ISSUES AS REQUIRED

- The budget bid identified Senior Midwifery scale Grade 4 Step 1-3 ($83,292-89,350pa)

	$000's
Salary cost at 0.5fte	$43,300-46,500pa
Other operational costs (e.g. APC, mandatory educational requirements and backfill for leave)	$3,700pa
Total costs	$47,000-50,200pa

FINANCING THE POSITION/S

- This is a 2015-2016 approved budget bid.

- **This Business Case has been approved by EMT on 5 July** for the 2015/16 new investment application for a Clinical Midwife Specialist Diabetes.
- **EMT have approved recruitment** to the new senior midwifery position of Clinical Midwife Specialist Diabetes, senior nurse and midwifery scale, Grade 4. 0.5fte salary plus associated ongoing full annual cost of $43,300-46,500

APPENDIX

- Appendix 1: Position Profile

Hawke's Bay
District Health Board
Position Profile / Terms & Conditions

POSITION HOLDER (title)	Clincial Midwife Specialist - Diabetes
SERVICE/DIVISION	W, C& Y Directorate – Maternity services: High Risk Clinic
LOCATION	Maternity Service, Hawke's Bay
REPORTS TO	Midwifery Director
PROFESSIONAL ACCOUNTABILITY TO	Midwifery Director

PREFACE	This document contains elements that are consistent across the District Health Boards (DHB5454s) in the Central Region[1], and is applicable for employed Registered Midwives. The Midwifery Council of New Zealand (MCNZ) governs the competence of all midwives to ensure the safety of mothers and babies ("the public"). DHBs recognize that all midwives are accountable to the MCNZ for their competence and will facilitate the achievement of the knowledge and skills required to maintain competence.
POSITION OVERVIEW	This position works principally within the service or division specified above. However, all employees at Hawke's Bay District Health Board may be required to undertake duties in other areas of the organisation e.g. maternity or neonatal units which promote the efficient and effective operation of the DHB and which reasonably fall within the general parameters of this position and the employee's scope of practice.
PURPOSE OF THE POSITION	To work in partnership with women and provide continuity of antenatal and postnatal midwifery care to women with Diabetes in pregnancy who have the DHB as their care coordinator; providing necessary support and advice during pregnancy and postpartum up to six weeks. To meet the needs of women and their families/Whanau, co-ordinating their care when a secondary/tertiary referral for diabetes management is required. Promoting midwifery care that is in line with recommended best practice, is appropriate and effective. To provide formal and informal education and support to other health professionals in the primary and secondary maternity care settings to manage pregnant women with diabetes To contribute clinical expertise to the planning, development, maintenance and/or review of quality/service issues and activities which include policies, procedures and wider initiatives concerning Diabetes in Pregnancy across service To support integration between primary and secondary services and act as a liaison between secondary services. To lead and improve the quality of professional midwifery practice and promote high standards of care by supporting an environment where excellence can flourish

Working Relationships

[1] The six DHBs that make up the central region are MidCentral, Whanganui, Wairarapa, Hawke's Bay, Hutt Valley and Capital and Coast DHB.

INTERNAL	
Clinical Midwifery Manager	Facilitate management and supervision for an effective, functional and cohesive multi-disciplinary workforce within the maternity services
Midwifery Director	Professional and Strategic leadership, guidance and support
All Maternity Unit staff (including O&Gs, RMOs, Midwives, RNs, LMCs, LCs, support staff), Specialist Diabetes Service MDT	Function effectively and efficiently as a member of the multi-disciplinary team, demonstrating own professional development in order to enhance quality service delivery Effective interaction and communication, identifying issues of concern and communicating these clearly Delivering effective midwifery care which contributes to a positive and meaningful outcome for the woman and her family/whānau Develop and maintain positive working relationships
Other DHB health care providers e.g. Paediatric staff, Theatre staff, social workers, maternal mental health (etc.)	Develop and maintain positive working relationships Function effectively and efficiently as a member of the multi-disciplinary team Effective interaction and communication, identifying issues of concern and communicating these clearly Support to provide woman-centred care
EXTERNAL	
Iwi providers	Maintain cultural safety and awareness and develop strategies for improving the health status of Māori
Well Child providers/GPs/ any other agencies involved with the woman/family	Liaise and communicate with other health care providers in order to promote consistent ongoing care
Women	To uphold and respect choices/wishes whilst providing quality, safe standards of practice
Family/whānau	To include/incorporate families/whanau with a whanau ora approach to health care offered to women/clients

MIDWIFERY SCOPE OF PRACTICE	
You must be able to demonstrate that you are registered with the New Zealand Midwifery Council and that your scope of practice enables you to undertake the duties of this position.	
SCOPE OF PRACTICE (as per the Midwifery Council)	The midwife works in partnership with women, on her own professional responsibility, to give women the necessary support, care and advice during pregnancy, labour and the postpartum period up to six weeks, to facilitate births and to provide care for the newborn. The midwife understands, promotes and facilitates the physiological processes of pregnancy and childbirth, identifies complications that may arise in mother and baby, accesses appropriate medical assistance, and implements emergency measures as necessary. When women require referral, midwives provide midwifery care in collaboration with other health professionals. Midwives have an important role in health and wellness promotion and education for the woman, her family and the community. Midwifery practice involves informing and preparing the woman and her family for pregnancy, birth, breastfeeding and parenthood and includes certain aspects of women's health, family planning and infant well-being. The midwife may practise in any setting, including the home, the community, hospitals, or in any other maternity service. In all settings, the midwife remains responsible and accountable for the care she provides.

Key Accountabilities

MIDWIFERY ACCOUNTABILITIES **The midwife works in partnership with the woman throughout the maternity experience (in the context of services provided by the DHB) providing expert midwifery care to women within Diabetes in Pregnancy Service**	
Tasks (how it is achieved):	**How it will be measured (KPI):**
Centres the woman as the focus of care Promotes and supports continuity of midwifery care Is culturally safe Recognises and respects the woman's ethnic, social and cultural context, communicates effectively with the woman and her family/whanau, supports the woman with informed decision-making Works in partnership and facilitates good communication with the women, their family, their LMC and other involved health professionals to plan and coordinate individualised are of women appropriate to their needs Where HBDHB takes up the role as named maternity provider, the midwife assists in the coordination of the secondary care for the women, and provides antenatal and postnata outpatient midwifery care Uses advanced knowledge and skills to assess, plan, implement and evaluate women, baby and family / whanau needs. Upholding each woman's right to free and informed consent throughout the childbirth experience. Provides midwidery care to women to promote healthy outcomes for woman and their babies. . Empower women and their families / whanau to care for themselves and their newborn babies in the community by promoting partnership with women. Collates and documents comprehensive midwifery assessments and plans of care of the woman and / or baby's health and well being. Maintains purposeful, ongoing, updated records, documenting decisions and midwifery actions. Has advanced knowledge of pharmacology and is able to assess the effect and dose of oral hypoglycaemics / insulin. Has advanced knowledge of pathophysiology and disease processes.	Consistently acts as the woman's advocate in the provision of care Demonstrates support of the continuity of care model Provides examples of culturally safe care Provides evidence of effective communication with women in the midwifery partnership Women and whanau express satisfaction in the care they received
The midwife applies comprehensive theoretical and scientific knowledge with the effective and technical skills needed to provide effective and safe midwifery care	
Tasks (how it is achieved):	**How it will be measured (KPI):**
Provides and is responsible for midwifery care of the woman and her family/whanau during pregnancy and/or the postnatal period, when HBDHB is the lead maternity carer, especially for women with complexities Orders and interprets relevant investigative and diagnostic tests, carries out necessary screening procedures, and systematically collects comprehensive information concerning the woman's health and well-being	Maintains BFHI education requirements Demonstrates ability to work across the midwifery scope of practice Assists women to make informed choices demonstrating evidence based practice Provides evidence, for example QLP portfolio, or an example of a case where deviation from normal is recognised and appropriate referrals are made

Assesses the health and well-being of the woman and her baby, recognising any condition which necessitates referral to another health professional Attends, supports and regularly assesses the woman and or her baby and makes appropriate, timely midwifery interventions Proactively protects, promotes and supports breastfeeding Demonstrates the ability to prescribe/dispense and administer medicine, vaccines and immunoglobulins safely and appropriately within the midwife's scope of practice and the relevant legislation Utilises evidence based practice in facilitating midwifery care and informed choice by the woman and her family/whanau Facilitates and documents decisions made by the woman Provides accurate and timely written clinical notes identifying midwifery care offered/ provided or declined Models expert midwifery skills within the clinical practice area Demonstrates skilled mentoring / cloaching, teaching and supervision of midwifery staff, students Participates in regular case review and debriefing activities as required Acts as a midwifery resource, providing expert advice and education to women, midwives and other health professionals Contributes to the education and upskilling of clinical staff delivering care to women with diabetes in pregnancy Designs, creates and reviews teaching tools, maintaining educational resources that are current and up to date Teaches students and orientates new staff to function of Diabetes in Pregnancy service and their role in delivering diabetes care Progresses through service specific assessment tool under the supervision of the Specialist Physician	Demonstrates an understanding of the legislation related to midwifery prescribing Identifies, plans and delivers formal and informal staff education and professional development based on knowledge of service need
The midwife promotes practices that enhance the health of the woman and her family/whanau and which encourage their participation in her health care	
Tasks (how it is achieved): Encourages and assists the woman and her family/whanau to take responsibility for their health and that of the baby by promoting healthy life-styles Educates and provides women and whanau with diabetes education and information regarding management through pregnancy, labour, birth and postnatal period Demonstrates the ability to offer learning opportunities to women and their families/whanau to meet their specific needs Promotes and encourages exclusive breast feeding Supports the woman's family to participate in the health and wellbeing of the woman and baby as appropriate	**How it will be measured (KPI):** Demonstrates practices such as health promotion, education and information sharing across all settings Provides an example of health promotion for the woman or her family; this may be included in the QLP portfolio Promotes breastfeeding despite adversity Demonstrates an awareness of external support agencies for mothers and their baby/babies

Works collegially, collaborates and co-operates with other midwives, health professionals, community groups and agencies when necessary Compiles and maintains up to date diabetes information and education resources for women and their whanau Ensures the woman has information about available services to access other health professionals and agencies as appropriate	
The midwife upholds professional midwifery standards and uses professional judgment as a reflective and critical practitioner when providing midwifery care	
Tasks (how it is achieved):	**How it will be measured (KPI):**
Demonstrates leadership within the service	Evidence of leadership qualities: professional, expertise, role modelling values of organisation, resource person
Contributes to evidence based midwifery practice in relation to diabetes in pregnancy	
Promotes effective teamwork and collaborative relationships within the Obstetric and Diabetes multi-disciplinary teams and across health services	Working alongside the multidisciplinary team
Provides clinical leadership and support to midwives to provide midwifery care to women with diabetes	Positive peer feedback
Role models culturally safe midwifery practice	Respect, sensitivity, cultural awareness is evident in interpersonal relationships
Identifies barriers and solutions to access for women, family or Whanau	The service is accessed by Maori women
Assists in the implementation and management of initiatives to address differential access to health care services for Maori	Women are referred to other health care agencies as is appropriate
Contributes to the development of integrated service delivery across the continuum of care	Maori Health unit is involved
Contributes to the development and implementation of clinical pathways	Refinement and adoption of Diabetes in pregnancy pathway of care
Fosters the implementation of organisational and midwifery values and goals	
Actively enhances nursing and midwifery practice and performance by participating in appropriate local, regional, national and international forums	
Identifies when the progress of pregnancy, birth and postpartum has deviated from normal and takes appropriate action	
Has specialist knowledge in caring for women with diabetes, recognised through internal competency assessment	
Recognises own values and beliefs	
Demonstrates an accurate and comprehensive knowledge of legislation affecting midwifery practice	
Recognises personal responsibility and accountability for their practice across the pregnancy, childbirth and postpartum continuum to the woman, midwifery profession, the community and New Zealand Midwifery Council	
Is aware of and complies with the New Zealand Midwifery Council Code of Conduct	Provides evidence of participation in MSR process

Is aware of own limitations and consults with others, or seeks advice when appropriate Demonstrates commitment to quality improvements, risk management and resource utilisation Evaluates the effectiveness and safety of midwifery practice by participating in performance appraisal process and midwifery standards review Leads professional conduct by example Practices in accordance with legal, ethical, culturally safe and professional standards	Provides evidence of reflection and learning in her practice Provides an example of supporting others in their professional development

Key Competencies

OCCUPATIONAL HEALTH & SAFETY	
Tasks (how it is achieved):	**How it will be measured (KPI):**
Displays commitment through actively supporting all health and safety initiatives. Ensures all staff/colleagues maintain adequate safety standards on the job through consultation, training and supervision. Seeks support for difficult situations and raises this with the appropriate person e.g. manager, professional leader, EAP etc. as required Ensures own and others safety at all times. Complies with policies, procedures and safe systems of work. Reports all incidents/accidents, including near misses in a timely fashion. Is involved in health and safety through participation and consultation.	Evidence of participation in health and safety activities. Demonstrates support of staff/colleagues to maintain safe systems of work. Evidence of compliance with relevant health and safety policies, procedures and event reporting.
CONTRIBUTES TO OWN SELF DEVELOPMENT	
Tasks (how it is achieved):	**How it will be measured (KPI):**
Maintains and develops own clinical expertise and knowledge in midwifery practice and in diabetes Pro-actively participates in own performance development review Actively participates in in-service education and quality initiatives Demonstrates a commitment to ongoing learning and professional development Discusses annually with manager at performance review Quality Leadership Progression (QLP) progression with an expectation to complete, or already having attained the leadership domain within 12 months of commencing employment	Evidence of active participation Evidence of recognition of knowledge deficit and action to address Evidence of and maintaining leadership domain of QLP

Fosters inquiry, critical thinking and research skill acquisition among the midwifery workforce to advance midwifery practice and improve outcomes for women and babies Works to ensure the recommended best practice guidelines / policies are research based and relevant	
COMMUNICATION & INTERPERSONAL SKILLS	
Tasks (how it is achieved): Builds an effective level of rapport with people within a short period of time Communicates clearly in written and verbal forms, responding with respect, empathy, tact and diplomacy Provides effective advocacy for women/whanau when required Understands and works within privacy and confidentiality requirements Is flexible, tolerant and responsive to situations, particularly focusing on effective resolution and de-escalation techniques when dealing with conflict	**How it will be measured (KPI):** Evidence of integrated health care planning demonstrating effective multiagency team work Demonstrates ability to adapt as requirements of the woman, team or situation change Provides evidence of feedback on communication skills and technique
TEAMWORK	
Tasks (how it is achieved): Treats multidisciplinary team members with dignity, respect and honesty Actively participates in and contributes to department goals and activities Fosters a team approach to providing solutions in decision making Recognises the needs of individuals within the whole team and is supportive of others Promotes and actively seeks integrated team work Coaches others to develop knowledge and skills, and to accomplish tasks	**How it will be measured (KPI):** Is recognized by others in the team as an effective and positive team member Is able to demonstrate participation in departmental activities and initiatives Evidence of coaching opportunities
HONOURING TREATY OF WAITANGI OBLIGATIONS / CULTURAL SAFETY	
Tasks (how it is achieved): Demonstrates understanding of the principles of the Treaty of Waitangi. Ensure the principles of partnership, protection and participation are applied to day to day work. Ensures procedures do not discriminate against Māori. Applies the principles of cultural safety to the midwifery partnership and integrates Turanga Kaupapa within the midwifery partnership and practice	**How it will be measured (KPI):** Attends a Treaty of Waitangi workshop or a Māori Health paper or recognised online learning module Demonstrates consistent application of Treaty of Waitangi/ Cultural Safety principles in practice

Essential and Desirable Criteria: Qualifications / Skills / Experience

ESSENTIAL

Treaty of Waitangi Responsiveness (cultural safety)	Demonstrates the ability to include cultural safety of the health consumer when relating to care and processes within the Service. Demonstrates ability to apply the Treaty of Waitangi within the Service
Qualifications (e.g., tertiary, professional)	**ESSENTIAL** New Zealand Registered Midwife A current practising certificate with the Midwifery Council of New Zealand Expert midwifery practitioner **DESIRABLE** Postgraduate diploma or working towards Diploma and/or Masters Completion, or willing to complete Diabetes in pregnancy postgraduate paper Current full drivers licence
Experience (technical and behavioural)	Shows commitment to, and demonstrates the behaviours of the health sector: • 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) **ESSENTIAL** Evidence of recent effective, competent midwifery practice at confident domain or higher Ability to work effectively within a busy environment with competing demands **DESIRABLE** Demonstrated understanding of maternity care delivery in New Zealand

Essential and Desirable Criteria: Qualifications / Skills / Experience continued

Skill and Competencies	**Interpersonal/Communication Skills** • Good communication/interpersonal skills ensuring the ability to interact positively and enable cooperation/coordination between: • women who use maternity services and their families/whanau • all maternity practitioners • Positive, enthusiastic and proactive manner that instils confidence in clients and colleagues • Demonstrated initiative, innovation and flexibility in practice • Awareness of and sensitivity to individual and cultural differences **Written Communication Skills** • Sound written communication skills • Pitch, style and tone of message is appropriate for context and purpose required • Ability to learn a range of specialist terminology **Excellence Focus** • Demonstrated adaptability and personal accountability • Demonstrated problem solving skills • Ability to work rostered and rotating duties • Ability to proactively manage conflicting demands on time • Has resilience to cope effectively with situations that involve emotional strain and seeks support and guidance from others as appropriate • Has a sound level of insight into own strengths and weaknesses, and is committed to addressing areas where development is required • Commitment to ongoing education that leads to continuous improvement of clinical work practices and communication • Demonstrates fit with the DHB's values: – Is enthusiastic and committed to caring for the community – Is enthusiastic and committed to working in a team environment – Is positive about focusing on safety issues at work – Applies the principles of the Treaty of Waitangi to their job • Completes hospital certifications within the timeframe required by the DHB (e.g. BFHI, IV etc.) **Computer literacy and technology** • Proficient keyboard/computer skills • Willingness to learn and incorporate new technology into practice

Recruitment Details

Position Title	Clinical Midwife Specialist - Diabetes
Hours of Work	40 hrs per fortnight
Salary & Employment Agreement Coverage	In accordance with the DHB's/NZNO Nursing and Midwifery Multi Employer Collective Agreement (MECA)Senior Nursing & Midwifery Scale Grade 4 $83,292 to $89,350 gross per annum according to qualifications and experience pro rata for hours worked
Date	**20 June 2016**

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:

20. Minutes of Previous Meeting
- Public Excluded

21. Matters Arising – Review of Actions
- Public Excluded

22. Member Topics of Interest

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

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