Hawke's Bay Clinical Council Meeting

Date: **Wednesday, 10 May 2017**

Meeting: **3.00 pm to 5.30 pm**

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

Council Members:

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

Apology: Chris McKenna and Lee-Ora Lusis

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

PUBLIC MEETING

Item	Section 1 – Routine	Time (pm)
1.	Apologies / Welcome	3.00
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	
5.	Clinical Council Workplan	
	Section 2 – Presentations / Discussion	
6.	Clinical Services Plan – Tracee TeHuia / Carina Burgess / Sapere Research Group	3.15
7.	ICU Progress Update – Kate Coley	3.45
8.	Health Literacy Principles & Implementation Approach – Kate Coley & Adam McDonald	3.50
9.	Best Start Healthy Eating and Activity Plan Update – Shari Tidswell	4.05
10.	Draft Annual Plan 2017 (presentation) – Tracee TeHuia and Carina Burgess	4.15
	Section 3 – Monitoring	
11.	Annual Maori Plan (Dashboard) Q3 Jan-Mar 2017 – Patrick Le Geyt	4.25
	Section 4 – Reporting Committees	
12.	HB Clinical Research Committee Update – Dr John Gommans - HB Clinical Research Annual Report 2016	4.35
13.	Infection Prevention Control Committee – David Warrington	4.50
	Section 5 – Information Only	
14.	Legislative Compliance – Kate Coley	-
15.	**Section 6 – Recommendation to Exclude the Public**	

PUBLIC EXCLUDED

Item	Section 7 – Routine	
16.	Minutes of Previous Meeting	5.00
17.	Matters Arising - Review Actions	
	Section 8 – General	
18.	Topics of Interest – Member Issues / Updates	

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE

NEXT MEETING - Wednesday, 14 June 2017

Interests Register
April 2017

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

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**
Dr Tae Richardson (GP and Chair of Clinical Quality Advisory Committee)	Loco Ltd	Shareholding Director	Private business	No	
	Dr Bryn Jones employee of MoH	Husband	Role with Ministry of Health as Chief Advisor in Sector Capability and	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Report on CQAC meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Life Education Trust Hawke's Bay	Trustee		No	
	Dr Bryn Jones employee of MoH	Husband	Deputy Chief Strategy & Policy Officer (Acting)	No	
	Pacific Chapter of Royal NZ College of GPs	Secretary		No	
Andrew Phillips (Director Allied Health HBDHB)	Nil	Not Applicable	Not Applicable	No	Nil
Dr David Rodgers (GP)	Tamatea Medical Centre	General Practitioner	Private business	Yes	Low. Provides services in primary care
	Tamatea Medical Centre	Wife Beth McElrea, also a GP (we job share)	Private business	Yes	Low. Provides services in primary care
	City Medical	Director and Shareholder	Medical Centre	Yes	Low. Provides services in primary care
	NZ Police	Medical Officer for Hawke's Bay	Provider of services for the NZ Police	No	
	Health Hawke's Bay (PHO) initially - from 1 July 2015 under HB District Health Board	Collaborative Clinical Pathways development	Was the Champion for the initial work, however on 1 July this moved under the HBDHB umbrella (with a community focus).	No	
	Advanced Care Planning	Steering Group member	Health and Wellbeing	No	
	Urgent Care Alliance	Group member	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues around the development of urgent care services.
	National Advisory Committee of the RNZCGPs	Member	Health and Wellbeing	No	
	Health Hawke's Bay (PHO)	Medical Advisor - Sector Development	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues in this area relating to the PHO.
Debs Higgins (Senior Nurse)	Eastern Institute of Technology (EIT)	Lecturer - Nursing	Education.	No	
	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
Anne McLeod (Senior Allied Health Professional)	Aeotearoa NZ Association of Social Workers	Member		Yes	Low
	HB DHB Employee Heather Charteris	Sister-in-law	Registered Nurse Diabetic Educator	Yes	Low
	Directions Coaching	Coach and Trainer	Private Business	Yes	Low: Contracts in the past with HBDHB and Hauora Tairawhiti.
Dr Robin Whyman (Clinical Director Oral Health)	NZ Institute of Directors	Member	Continuing professional development for company directors	No	
	Australian - NZ Society of Paediatric Dentists	Member	Continuing professional development for dentists providing care to children and advocacy for child oral health.	No	
Dr Russell Wills (Community Paediatrition)	HBDHB Community, Women and Children and Quality Improvement & Patient Safety Directorates	Employee	Employee	Yes	Potential, pecuniary
	HBDHB employee Mary Wills	Spouse	Employee	Yes	Potential, pecuniary
	Paediatric Society of New Zealand	Member	Professional network	No	
	Association of Salaried Medical Specialists	Member	Trade Union	Yes	Potential, pecuniary
	New Zealand Medical Association	Member	Professional network	No	
	Royal Australasian College of Physicians	Fellow	Continuing Medical Education	No	
	Neurodevelopmental and Behavioural Society of Australia and New Zealand	Member	Professional network	No	
	NZ Institute of Directors	Member	Professional network	No	
Lee-Ora Lusis (Clinical Nurse Manager, Totara Health)	Totara Health and Choices Kahungunu Health Services	Employee	Clinical Nurse Manager	Yes	Potential, pecuniary
	Hawke's Bay Primary Health Nurse Practitioner Group	Member / Nurse Practitioner Intern	Professional network	No	
	Hawke's Bay Nurse Leadership Group	Member	Professional network	No	
	College of Nurses Aotearoa (NZ)	Member		No	
	Fusion Group Committee	Representative		No	
	ED High Flyers	Representative		No	

MINUTES OF MEETING FOR THE HAWKE'S BAY CLINICAL COUNCIL HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE ON WEDNESDAY, 12 APRIL 2017 AT 3.00 PM

PUBLIC

Present: Chris McKenna (Chair)
Dr John Gommans (Co-Chair)
Dr Russell Wills *(arrived 3.10 pm)*
Dr Robin Whyman
Dr David Rodgers
Dr Nick Jones *(until 4.30 pm)*
Dr Kiri Bird *(arrived 4.20 pm)*
Lee-Ora Lusis
Andy Phillips
Debs Higgins
David Warrington

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

Apologies: Dr Mark Peterson, Billy Allan and Anne McLeod

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Chris McKenna (Chair) welcomed everyone to the meeting and advised that Dr John Gommans would be acting as Co-Chair today. She also welcomed Dr Nick Jones, Medical Director - Population Health.

Apologies were noted as above.

2. INTERESTS REGISTER

No conflicts were noted for agenda items.

Action: Dr Nick Jones to provide interests for the conflicts of interest register.

3. CONFIRMATION OF PREVIOUS MINUTES

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

Moved and carried.

4. MATTERS ARISING, ACTIONS AND PROGRESS

Item 1: Interest Register

Changes made to register as advised by Dr David Rodgers and Lee-Ora Lusis. *Item can now be closed.*

Item 2: ***Clinical Council Annual Plan 2016/17 Objectives***
Update from primary care on development of model of care to be provided.

Item 3: ***HB Palliative Care Strategy***
The strategy has been signed off by the Board. Discussion on outcome measures to be held. It was agreed that Andy Phillips and David Rodgers would discuss this with Paul Malan, Strategic Services Manager and bring back to a future meeting. The Chair also advised that the Clinical Governance Steering Group for Palliative Care is to be re-formed and that both Andy and David will be invited to be part of this group.

Item 4: **Maternity Governance Group Update**
Jules Arthur advised no further feedback on the report was received. *Item can now be closed.*

5. CLINICAL COUNCIL WORK PLAN

The work plan was included in the meeting papers. The May meeting will now be an ordinary meeting instead of a quarterly meeting with the Consumer Council.

The EDP&Q advised that the Values and Culture Business Case and the People Strategy items will be moved to the June meeting.

SECTION 2: PRESENTATION / DISCUSSION

6. BRIEFING ON WAIROA GP SERVICES

This item has now been moved to the May meeting agenda.

7. ESTABLISHING HEALTH & SOCIAL CARE LOCALITIES IN HB

Dr John Gommans (Co-Chair) welcomed Jill Garrett, Strategic Services Manager – Primary Care to the meeting. Jill Garrett advised that work is underway in the seed localities (Wairoa and Central Hawke's Bay) and the change leaders are in place. Strong foundations are being built for the work to come in the networks around relationship building and trust between providers. Challenges noted include were authority is placed, connection between the district wide strategic plans and the locality based plans, models of change being responsive to the diverse approach while getting commonalities and recognising skills that may or may not exist and how the "back bone functions" (planning, contracting, analysis and reporting) will be supported.

The Co-Chair commented that the paper is commendably short but with enough depth to inform and identifies the emerging challenges and learnings, which is about culture change across the whole sector and the importance of relationships.

The report was noted and the Clinical Council were happy with the work completed to date and the approach being taken.

SECTION 3: MONITORING

8. TE ARA WHAKAWAIORA / CARDIOLOGY (NATIONAL INDICATOR)

The Co-Chair advised that this report is on access to urgent cardiac angiograms. The issues with data collection have been resolved in a sustainable way. The ongoing challenge is access to urgent angiograms within three days. Part of the problem is that the bulk of these are done in Wellington, with issues relating to transport and access to beds in Wellington. There are only two local angiography lists per week and it is expensive to use locums and other resources to run a third session, which is not a sustainable model. The regional cardiac network has recommended that Hawke's Bay and Palmerston North should both consider local provision of a full service within the next 3-4 years. This will be investigated as part of the clinical services plan being developed later this year, including the future model of care for acute cardiology in Hawke's Bay.

9. RHEUMATIC FEVER TARGET 2016-17

The Co-Chair welcomed Nicky Skerman, Population Health Strategist to the meeting. Nicky Skerman advised that HBDHB will not meet the target for 2016/17, the Ministry of Health funding for the programme will change from 30 June 2017 and the funding for the primary care "Say Ahh" throat swabbing programme will discontinue from December 2017.

Brief discussion held around the importance of housing and how this affects wellness and noting the work being undertaken under the healthy housing coalition. The healthy homes strategy is being reviewed with a greater focus on housing supply, particularly rental housing in Hawke's Bay. Planning is also underway in West Flaxmere for a new type of housing development by Te Aranga Marae and U-Turn Trust in conjunction with Te Taiwhenua O Heretaunga and the Hastings District Council.

The Clinical Council noted the contents of the report.

Action: Social Inclusion Strategy presentation to be included at a future meeting.

SECTION 4: REPORTING COMMITTEES

10. HB NURSING MIDWIFERY LEADERSHIP COUNCIL UPDATE AND DASHBOARD

David Warrington, Chair of the Hawke's Bay Nursing and Midwifery Leadership Council noted five key points:

- A full audit of members and tenure is to be undertaken as some members are over their 2-year tenure
- Inclusion in the report of the nursing and midwifery dashboard – work in progress and links to the nursing and midwifery strategic plans
- The NZNO employment survey results and the themes which came from that survey are an accurate reflection of what is happening in the DHB on how nurses feel
- MECA negotiations – specific feedback received has been the importance of engaging with the senior nursing workforce
- International Nurses and Midwives Day 2017 – to be moved to a bi-annual ceremony, but will still be celebrated at team/service level yearly.

It was noted the dashboard included appropriate and interesting indicators with targets to aspire to and that each indicator had a member of the leadership council assigned as the owner.

The Chair noted that a highlight has been the Careerforce Kaiawhina Training, this has been a success story which steers unskilled, particularly Maori women and men towards the beginning of a qualification.

The Clinical Council noted the contents of the report.

11. COLLABORATIVE PATHWAYS

The Co-Chair welcomed Leigh White, Portfolio Manager, Long Term Conditions to the meeting. Leigh White advised that the paper is a short update. The work programme was on hold until July 2017 and requires advice from Clinical Council on next direction. The pilot with NexxT started yesterday. It was noted that there will not be enough information by 1 July to inform a decision.

A lot of progress has been made with the pathways being utilised. The data has shown an increase in use in ED and AAU as well as primary care. Hospital staff have utilised the pathways via a single login which has assisted with access in those areas.

It was noted that one challenge is that the use of Map of Medicine appears to be diminishing worldwide e.g. Canterbury Pathways has replaced Map of Medicine in Australia and has infiltrated into the central region. Our contract with Map of Medicine finishes on 30 June, the question will be do we review or change. Discussion on how eReferrals link in with Map of Medicine and Canterbury Pathways.

The Clinical Council work plan needs to include a paper in June to inform a decision for collaborative pathways going forward and continuation of funding for this work including use of Map of Medicine.

Action: ***June work plan to include decision paper on collaborative pathways going forward.***

12. HB RADIOLOGY SERVICES COMMITTEE

The report from Dr Mark Peterson, Chair of the Radiology Services Committee was included in the meeting papers.

Brief discussion on advisory group reports and how they will come to the Clinical Council in the future through the five clinical committees, noting that there is a mechanism for urgent issues to be elevated to the Clinical Council. This topic is included under item #15 on the agenda.

Jules Arthur advised that the Head of Department, Women Children and Youth is to discuss access to scan data and the issue of storage for images with Anne Speden, Chief Information Officer (CIO). A group is working with IT on a way forward. There are also some issues with the regional PACS information system and onsite access to regional images. The new CIO Manager is engaging well with clinicians. The problem will stay on the committee's agenda until it is resolved.

Dr David Rodgers commented that since this report, in regard to the US guided steroid injections another 150 referrals have been triaged and some will be sent back with a communication to GPs.

13. HB LABORATORY SERVICES COMMITTEE

The report from Dr Kiri Bird, Chair of the Laboratory Committee was included in the meeting papers.

Dr Andy Phillips advised that the Laboratory Testing Guidelines will come to Clinical Council next month. Regarding the issue of the urine pregnancy tests previously discussed, the hospital is still utilising blood testing for confirmation of pregnancy and we are awaiting results of the evaluation by the NZ Point of Care Advisory Group before making a final decision for primary care. The issue of cutting and pasting of laboratory results into discharge summaries is being reviewed with information services. The mark as read policy requires further work, two issues are access to ECA and there is no electronic way to note actions taken in regard to abnormal results; these still

need to be documented on paper. It was noted that the new Orion clinical portal go live is February 2018. Dr Russell Wills commented that once we have an electronic solution that works the Waikato DHB policy and business rules would work well here.

14. CLINICAL ADVISORY & GOVERNANCE COMMITTEE

Dr Tae Richardson advised that the February report was included in the meeting papers for information. Highlights include:

- National enrolment service – almost there with the single repository
- Patient Experience Survey is rolling out in primary care
- Social Workers pilot – being imbedded in some practices in Hawke's Bay. Brief discussion had around professional supervision/mentor support for social workers. This is a requirement for their registration.

SECTION 5: QUALITY & GOVERNANCE

15. IMPLEMENTATION OF THE HB CLINICAL GOVERNANCE COMMITTEE STRUCTURE

The Co-Chair advised that the paper outlines the proposed committees reporting directly to clinical council and their supporting advisory group structures, the proposed Chairs and the next steps. This has been discussed at length at previous meetings and we now need to implement.

It was noted that committees need to reflect in their TOR if they also have reporting requirements elsewhere e.g. MoH so the Clinical Council can be made aware of this.

Chris McKenna and Andy Phillips have had a discussion about Turiki reporting to the Professional Standards & Performance Committee as it is about workforce, Maori development and would be a dual report line and be part of a governance structure. They currently report directly to the Executive Director, Strategy & Health Improvement. It was agreed that any request in regard to Turiki needs to be considered in a formal way for a decision to be made. A separate paper with supporting information is to be completed for this.

Ken Foote, Company Secretary reminded Council that this is a clinical governance structure and there are many other structures within the organisation that have management/operational responsibility that do not fit the definition of clinical governance. There is a risk trying to bring everything into here and overtime some of the proposed advisory groups, when it comes to develop their terms of reference (TOR) and refer back to the definition of clinical governance, will not fit or need to fall under the clinical governance structure. If they do not meet the definition it does not mean there cannot be a linkage. The committees and advisory groups only have the power of recommendation or issuing directives on clinical practice on the health system.

Graeme Norton, Chair of the HB Health Consumer Council suggested that for the Patient Experience Committee the Chair could be the Consumer Council rep at the Clinical Council. He has also become the Chair of the Health Consumer Councils of New Zealand and has been helping other regions to get their consumer councils up and running. Tairawhiti is going to have a combined clinical and consumer council and this may be something for Hawke's Bay to consider.

Discussion regarding the proposed system integration and equity advisory groups and the purpose of having these as separate advisory groups. The Company Secretary commented that the importance of clinical governance is that it can hold management to account. It may not be appropriate to have an Executive Director as the chair of these advisory groups. Suggestion made that the Medical Director of Population Health could chair.

Following discussion the Clinical Council endorsed the recommendations in the paper and noted the next steps to be undertaken.

Action: ***Separate paper to be completed for decision on Turiki to be added to the clinical governance structure by Chris McKenna and Andy Phillips.***

16. CONSUMER EXPERIENCE FEEDBACK RESULTS - QUARTER 2

Kate Coley, Executive Director – People & Quality provided a presentation on the results for October to December 2016.

Key points noted:

- Feedback mechanisms
- Respondent and demographic details
- Themes and trends
- Next steps

Dr Russell Wills, Medical Director – Quality advised that the Marama patient survey reports results on the whole service in the mental health inpatient unit. His understanding of the evidence is that it is much more effective when you have reporting on an individual clinician. He will be the first to have an individual Marama report on him, to be trialled in Villa 7. The trial will be for three months and he will report back results to the Clinical Council.

It was noted that feedback from the workforce is important as well on how they feel at work. Kate Coley agreed that it is important to have the staff voice and how we enable change. Previously staff engagement surveys failed as information was not feedback to staff on what we were doing with the information. We need to work with directorates before going organisation wide to prove to our staff that we are listening to them.

17. RECOMMENDATION TO EXCLUDE THE PUBLIC

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

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

The meeting closed at 4.55 pm.

Confirmed: _____
Chair

Date: _____

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

Action No	Date issue raised	Action to be Taken	By Whom	By When	Status
1	08/03/17	***Clinical Council Annual Plan 2016/17 Objectives*** Request an update from primary care on development of the model of care.	Co-Chairs	Mar	
2	08/03/17	***HB Palliative Care Strategy*** Further discussion required re: outcome measures.	A Phillips / D Rodgers		
3	12/04/17	***Interest Register*** Dr Nick Jones to provide his interests for the register.	N Jones	May	
4	12/04/17	***Social Inclusion Strategy*** Presentation to be included at a future meeting	C-Chairs	TBC	
5	12/04/17	***Collaborative Pathways*** Decision paper to be completed for June Meeting		June	

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HB CLINICAL COUNCIL WORKPLAN 2016-2017

Meeting Dates	Papers and Topics	Lead(s)
14 Jun 17	Laboratory Testing Guidelines	Andy Phillips / Kiri Bird
	Youth Health Strategy Update for information	Nicky Skerman
	Consumer Experience Results (March, **June**, Sept, Dec)	Kate Coley
	Quality Accounts (draft)	Kate Coley
	People Strategy (2016-2021)	Kate Coley
	Values and Culture Business Case	Kate Coley
	Renal Services Review	Sharon Mason
	Social Inclusion	Tracee TeHuia
	Monitoring	
	Te Ara Whakawaiora / Oral Health (national indicator)	Robin Whyman
	Clinical Advisory & Governance Committee	Tae Richardson
12 July 17	Quality Accounts (draft)	Kate Coley
	Quality Dashboard (Clinical Council and FRAC)	Kate Coley
	Laboratory Service Committee Report	Kiri BIrd
	Radiology Services Committee Report	Mark Peterson
	Clinical Advisory & Governance Committee	Tae Richardson
9 Aug 17	**Annual Meeting 1.00pm start including lunch at 12.30pm Venue : TBA**	
	ICU Learnings Report – Action Plan update (qtly)	Kate Coley
	People Strategy Final	Kate Coley
	Quality Annual Plan review 16/17	Kate Coley
	Collaborative Clinical Pathways	Mark / Leigh White
	Monitoring	
	Te Ara Whakawaiora / Oral Health (national indicator)	Robin Whyman
	Te Ara Whakawaiora - Culturally Competent Workforce (local indicator)	Kate Coley
	Te Ara Whakawaiora - Mental Health and AOD (National and local indicators)	Sharon Mason
	Annual Maori Health Plan Q4 Dashboard only	Tracee TeHuia/Patrick
	Clinical Advisory & Governance Committee	Tae Richardson
6 Sept 17	**HB Health Sector Leadership Forum – venue East Pier, Napier**	
13 Sep 17	Orthopaedic Review – phase 3 draft	Andy Phillips
	Quality Accounts Final	Kate Coley
	Quality Annual Plan 2017/18 year	Kate Coley
	Consumer Experience Results (March, **June**, Sept, Dec)	Kate Coley

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

HAWKE'S BAY District Health Board Whakawāteatia	**Clinical Services Plan Introduction**
	For the attention of: **Māori Relationship Board, Clinical Council, Consumer Council**
Document Owner: Document Author(s):	Tracee Te Huia – ED Strategy and Health Improvement Carina Burgess – Head of Planning; Sapere Research Group
Reviewed by:	Clinical Services Plan Steering Group
Month:	May, 2017
Consideration:	For Information

RECOMMENDATION

That MRB, Clinical Council and Consumer Council:

1. Note the final Terms of Reference for the Clinical Service Plan Project
2. Note the approach to be taken by Sapere Research Group

OVERVIEW

Sapere Research Group, on behalf of the Hawke's Bay District Health Board are developing an integrated Clinical Services Plan covering the Hawke's Bay health system to align service delivery with current and projected population need, and to make the most effective use of available and future resources.

The project will explore service delivery in primary, community, and hospital settings. Opportunities will be identified to reduce hospital demand, reduce time spent in hospital and improve the patient flow through the system with a focus on improving health outcomes and health equity.

The plan will be realistic and implementable in Hawke's Bay within funding projections.

The plan will be developed "bottom up" from the patient's perspective. That is starting from how our population's requirements are met through supported self-care through to Primary Care, then moving into more expensive and specialist services and interventions, that is sequentially from community to local hospital and then to "out of area" hospital services.

FURTHER INFORMATION

The Terms of Reference for the Project are attached in appendix 1 and Sapere Research Group will be in attendance to give more insight into the approach they plan to take to develop a Clinical Services Plan that meets the requirements.

APPENDIX 1: CLINICAL SERVICES PLAN TERMS OF REFERENCE

Project Terms of Reference

Project Details

Project Name:	Clinical Services Plan
Version:	2.0
Date:	May 2017
Document Storage Address:	TOR_Clinical Services Plan_v2.0.docx
Template Version:	V0.2_Dec2016
Senior Responsible Owner:	Kevin Snee Chief Executive Officer
Project Sponsor:	Tracee Te Huia Executive Director of Strategy and Health Improvement
Author:	Tim Evans, Executive Director of Corporate Services Carina Burgess, Head of Planning
Reviewed By:	Executive Management Team

Authorisation

This document authorises the Project Manager to undertake the delivery of this project. There can be no changes to this document without Project Sponsor sign off of any amendments. This is a formal written process utilising the HBDHB project templates and procedures for change control.

Kevin Snee		
Senior Responsible Owner	Signature	Date
Tracee Te Huia		
Project Sponsor	Signature	Date
Carina Burgess		
Project Manager	Signature	Date
Kate Rawstron		
Project Management Office Manager	Signature	Date

1. Background / Business Case Outline

The District Health Board is on the threshold of a further step in its development. In our first step we recovered from a period of financial, and governance turmoil to achieve relative stability through a 3 year “Revitalisation” programme. In our second step we opened up to innovation and shifted our perspective to integration and the wider health system with a 5 year “Transform & Sustain” strategy. As we move into the second half of Transform and Sustain and look forward to our next strategic horizon we want to establish a clear long term clinical plan.

The first two steps have given the Hawkes Bay Health sector a sound platform to move forward with experienced leadership, transformed clinical and consumer engagement, a sound balance sheet, novel and effective governance structures, and a track record of tangible achievement.

This Clinical Service Plan will be a lynchpin for further progress and increasing system maturity. It will be consistent with Ministry of Health planning requirements, and will underpin and enable long term financial, capital investment, and Human Resource plans.

The approval for this project was provided by EMT and the final Plan will be approved by the Board

2. Project Goal

This project will deliver an integrated Clinical Service Plan covering the Hawke’s Bay health system to align service delivery with current and projected population need, and to make the most effective use of available and future resources. The project will explore service delivery in primary, community, and hospital settings. Opportunities will be identified to reduce hospital demand, reduce time spent in hospital and improve the patient flow through the system with a focus on improving health outcomes and health equity.

The plan must be able to be realistically implemented in Hawke’s Bay within funding projections. We do not want a proposal that is not evidence based, realistic and implementable.

The plan will be developed “bottom up” from the patient’s perspective. That is starting from how our population’s requirements are met through supported self-care through to Primary Care, then moving into more expensive and specialist services and interventions, that is sequentially from community to local hospital and then to “out of area” hospital services.

3. Scope Inclusions

We anticipate the following to be described in the plan:

- Current position of capability and capacity of services through document review, interviews/ workshops and analysis/ assessment
- Assess possible capability and capacity of services given the current models of service
- Research international, regional and national models of care and trends in clinical practice. Assess the options for adapting these to HBDHB environment.
- Develop and consult on a draft clinical services plan, engaging buy in through the process
- Finalise the clinical services plan and present the plan to required forums and committees, including HBDHB Board.

Project Scope

No.	Objectives	Deliverables / Outputs
1.	To describe our current position of capability and capacity of services through document review, interviews/ workshops and analysis/ assessment.	Detailed stocktake document. Summary included in Final Clinical Services Plan.
2.	To assess capability and capacity of services given the current models of service	Excel or equivalent Demand Forecast model Summary Included in Final Clinical Services plan.
3.	To research and document international, regional and national models of care, and trends in clinical practice. To assess the options for and benefits of adapting these to the HBDHB environment.	Documented literature review of models and trends. Summary included in Final Clinical Services Plan.
4.	To develop and consult on a draft clinical services plan, engaging buy in through the process	Documented interviews with stakeholders. Documented Patient journey workshops. Documented Stakeholder workshops. Summary included in Final Clinical Services Plan.
5.	To develop the costings for the plan which demonstrates that it can be delivered within reasonably anticipated financial resources	Costings documented and achievable Test the plan against the Three E's of VFM
6.	To achieve approval for the finalised Clinical services plan	Presentations on the plan to appropriate forums and committees, including HBDHB Board.

4. Scope Exclusions

This exercise is about developing a plan, not implementing it. It will almost certainly be necessary to implement through a number of follow on projects in specific disease pathways.

5. Benefits

Successful completion of this project is expected to result in the following high level benefits:

Project Benefits

No.	Benefit	Measure (KPI)
1.	A plan for clinical services which can be used as a blueprint for a number of consequent detailed service redesigns and implementations.	Endorsement of the plan by Clinical Council. Endorsement of the plan by Consumer Council. Delivery of top priority detailed plans.
2.	A plan for clinical services which is economic, efficient, effective, and affordable.	Overall costing of the plan which demonstrates that it can be delivered within reasonably anticipated financial resources. Test the plan against the Three E's of VFM.
3.	A plan for clinical services which is underpinned by evidence for better quality service.	Test the plan against the TEPEES Quality dimensions.
4.	A plan for clinical services which is underpinned by evidence for improved population health.	Test the plan against key requirement from the Health Inequity report.
5.	A plan for clinical services which evidences: • Clinical Council engagement • Wider clinical and staff input • Consumer experience input, and • Consumer Council engagement • Consideration of inequity, and • Maori Relationship Board engagement.	Check the plan for evidence of these inputs and engagements.
6.	A plan for clinical services which is consistent with this health sector's values and mission.	Test the plan against the mission statement and our 4 values.

It is important to note that benefits are constrained by the fact that this is an enabling exercise. The Plan in itself does nothing. In theory we could secure a very good plan, do nothing with it, and realize no benefits.

It is only implementation, probably requiring a number of consequent projects that will deliver real benefits in terms of population health, better outcomes, and better value.

6. Strategic Alignment

Successful completion of the project will enable significant improvements across the Triple Aim as follows:

Triple Aim Outcome Profile

Aim	Measure
1. Best Quality Care	Test the plan against the TEPEES Quality dimensions.
2. Better Health and equity	Test the plan against key requirement from the Health Inequity report.
3. Best Value for system resources	Test the plan against the Three E's of VFM.

7. Assumptions and Constraints

Assumptions

- All required participants will engage and will fully participate as required
- There will sufficient data available to complete initial analysis

Constraints

- Availability of data and analysis
- Availability of Clinical Staff / Participants
- Financial resources

8. Project Interdependencies

- The CSP will be consistent with National and Regional health strategies.
- The CSP will provide a platform for our strategic plan following on from "Transform & Sustain".
- The CSP will form a base for the development of underpinning plans for Finance, Human Resources and Capital Investment.

9. Delivery Approach

Quality coordination and support for delivering an agreed Clinical Services plan

The approach is based around data rich discussions with front line Hawke's Bay health staff, patients, and population and starting in primary and community first.

In the first stage, data and trends will be presented to clinicians in primary and secondary care with a view to establishing issues and challenges as well as the likely future implications of current models of care.

The second stage will challenge those models of care with patient journey workshops and structured discussions around key issues in service delivery. Integrative workshops will bring stakeholders together to discuss, challenge and validate the themes and the possible

directions. Finally, possible future directions will be discussed and alternative ways of organising the local health sector discussed.

A change process of listening, reflecting and challenging that is most likely to support any future change in direction underpins the approach.

The project oversight process you will follow HDBHB Project Management methodology which is based on PRINCE2 principles.

10. Project Timeline

No.	High Level Milestone	Estimated Date of Completion
1.	Project Start Up and Initiation – Management confirms mandate for project – HBDHB appoints project sponsor and project manager – Project Manager works with Project Sponsor to develop final TOR document for sign off – Steering Group formed and introduced to the project TOR agreed – Team engaged - Prepares detailed plan for project	May 2017

2.	Preparatory work: Desktop review of documents including relevant strategies, reports and working papers	May 2017
3.	Understanding the current state. a. Quantitative analysis of service data b. Forecasting demand c. Semi-structured interviews with stakeholders d. Report on current state	May 2017
4.	Challenging the status quo. a. Patient journey workshops b. Review and workshop material with clinical leadership group	May, June, July 2017
5.	Transforming the sector. a. Integrate quantitative forecasts and opportunities for change identified from patient journeys and current state interviews. b. Additional modelling as appropriate to explore impacts of options on workforce *c. Additional modelling as appropriate to explore cost impacts and affordability.* d. Stakeholder engagement in priorities and scope for change. e. Prepare draft clinical services plan including priorities for change and investment.	August, September, October, November 2017
6.	Formal acceptance. a. Present and explain Clinical Service Plan to District Health Board, and other governance bodies as required. b. Achieve formal adoption and endorsement.	December 2017
7.	Project closure - Project completion evaluation prepared including Benefits Realisation Assessment - Project completion Evaluation signed off - Administrative closure of project completed	February 2018

11. Financial Profile

Cost Type	Itemised Description	Planned Cost$	Budget Source
Senior Responsible Owner	Kevin Snee	$0	Prioritised in established FTE so opportunity cost.
Project Manager	Carina Burgess	$0	Prioritised in established FTE so opportunity cost.
Operational support team	CEO's EA and administration support Named Management Accountant Named Business Intelligence analyst	$0	Prioritised in established FTE so opportunity cost.
Project delivery	External consultancy - Sapere	Around $280k	Budgeted for 2016-18
Project engagement	Time for Clinician and Consumer engagement.	TBA	Some prioritised in established FTE so opportunity cost. Some (TBA) likely to be extra cost for backfill/ attendance.
TOTAL		**Around $280k**	

12. Engagement

The project will use one to one meetings, workshops, patient journey events, existing Executive management team, Clinical Council, Consumer Council, Maori Relationship Board, and District Health Board meetings to ensure appropriate clinical and consumer input is received during the identification of service requirements, in the approval of outputs and to validate outcomes:

The project team will ensure appropriate engage with consumers and providers during the life of the project to better understand their needs and cultural requirements of the project.

13. Communication Management

During the early initiation of the project, the Project Manager will ensure the development of an appropriate communication plan to guide communication with stakeholders throughout the project. This will include:

- Identification of all stakeholders and an analysis of their stake in the project.
- Key communication points and methods with all stakeholders as well as responsibilities for that communication management

14. Reporting

The Project Manager will provide monthly project progress reports to the Project Sponsor (cc. HBDHB Project Management Office) using the HBDHB template

15. Issue and Risk Escalation

Risks and issues will be managed in accordance with the processes and procedures specified by the HBDHB Project Management Office:

- The Project Manager will notify the Project Sponsor of all issues and risks that cannot be managed within the Project Manager's delegated authority – this will be in a timely way

16. Risk Management

The purpose of the risk management system is to effectively and efficiently manage project risk in order that project deliverables may be met within plan. A separate risk register is maintained during the project lifecycle as a living document.

Preliminary Risk Analysis:

Risk	Likelihood Hi/Med/Lo	Impact Hi/Med/Lo	Planned Response
If key clinical participants are not available to attend workshops/ meetings then the project will not achieve the necessary engagement required to successfully meet the desired outcomes	High	High	1. Forward planning and scheduling (e.g. 8 weeks in advance) 2. Effective communications planning 3. Build in 'value' for the participants where possible 4. Consider incentivising attendance
If communications are not clear and/or delivered in a timely fashion then the project will not achieve the necessary engagement required to successfully meet the desired outcomes	High	High	1. Effective, upfront communications planning 2. Use of multiple channels i.e. Face to face meetings 3. Clinical Leadership
If data is not available / made available as required then the quality of analysis will less robust impacting on decision making and the overall quality of the CSP	Med	High	1. Early engagement with BI team 2. PHO to take lead with GPs
If Primary Care / NGOs are not bought into the vision then the project will not achieve the necessary engagement required to successfully meet the desired outcomes	High	High	1. Build vision and engagement 2. Clear / timely comms regarding how the process will work (e.g. who will be involved and when) 3. Integrated planning
If stakeholder expectations around the scope & purpose of the project are not well managed then this may result in delays, stakeholders disengaging and project seen as unsuccessful.	Med	High	1. Clearly define project purpose and scope managed under change control 2. Effective communications action plan 3. Agreed up-front who will be involved (e.g. how wide the engagement will be)
If stakeholders view this plan as unwelcome change, retain entrenched views or are unable to agree then decision making may be stalled and as result 'standed' MOC developed	Med	Med	1. Effective, upfront communications planning and deliver of action plan 2. Clinical Leadership 3. Change Management planning 4. Effective project governance

If we do not identify and manage the potential challenges from CSP on in-flight activity (e.g. H&SCL) appropriately then we will lose the integrated 'Health System' view and benefits will not be fully realised.	Med	High	1. Integrated planning approach 2. Effective dependency management 3. Communication around potential impacts and need to remain flexible
If we do not ensure the reduction of equity is a theme within the CSP then we will not support our strategic intention and fail to realise full benefits	Med	High	1. Build into planning and approach e.g. Patient Journey 2. Selection of appropriate workshop participants
If the CSP is not aligned to our current and future financial resources then the plan developed is unlikely to be feasible/ sustainable resulting in a CSP that cannot be fully implemented	Med	High	1. Benefits realisation planning
If the impact on the workforce is not well understood then the plan developed may not be feasible/ sustainable resulting in a CSP that cannot be fully implemented	High	High	1. Representation of ED People & Quality on Steering Group 2. Benefits realisation planning
If we do not identify and plan for the transition of IP, techniques and tools effectively then the value of the CSP and process will not be fully realised and maintained going forward	Med	High	1. Effective transition planning 2. Training identified
If the competing priorities (i.e. clinical workloads) are not managed appropriately then this may result in significant delays to the delivery of the CSP and further planning developments (e.g. Long Term Investment Plan).	High	Med	1. Communication and early planning 2. Flexibility of consultant support

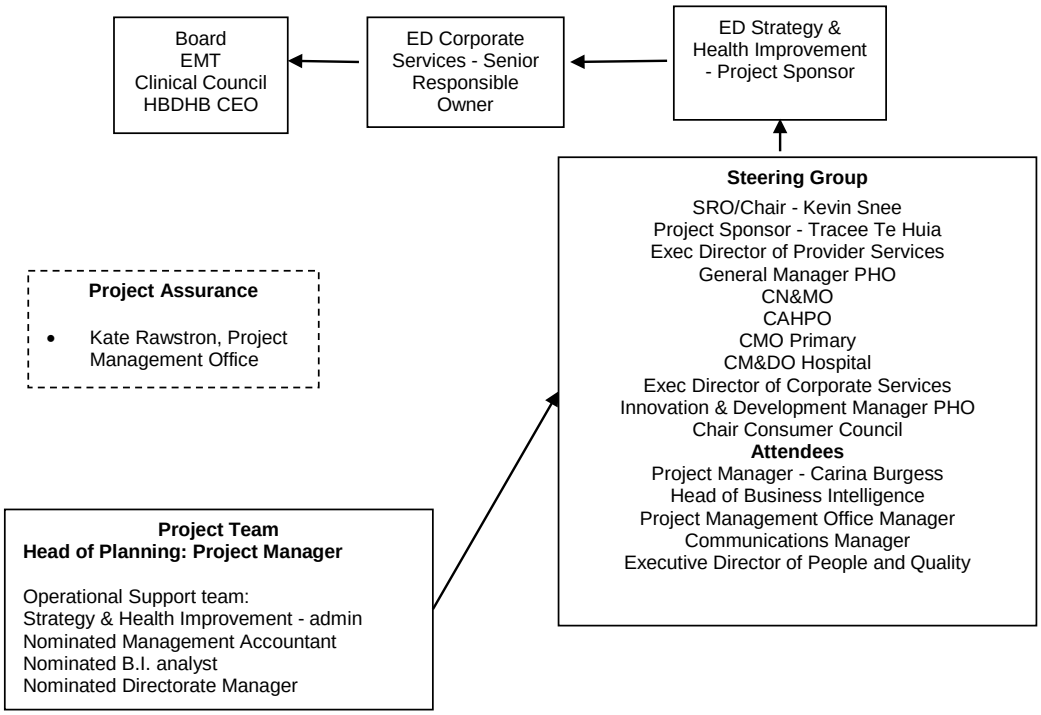
17. Quality Management

Project activity and deliverables will be consistent with:

- The agreed TOR for the project and work streams
- HBDHB Project Management Standards
- HBDHB Capital Investment Policies
- Relevant mandatory and industrial Health and Safety Standards
- HR Policies and Procedures
- Building Codes and Requirements
- Best Practice Contract Management
- Best Practice Change Management and Communication
- Generally accepted accounting practice (as defined in the Crown Entities Act 2004)
- Electronic transactions to comply with e-government standards
- Integration of systems with existing and future intended infrastructures.

All deliverables will undergo appropriate quality control and customer acceptance procedures.

18. Project Management Team Structure



Appendix 1: Project Role Descriptions

Senior Responsible Owner

- EMT Conduit and support for Project Sponsor
- Provides active support and leadership if required
- Resolves issues at Executive level

Project Sponsor

- ACCOUNTABLE for project delivery
- Acts as line manager for the Project Manager in relation to the project
- Escalates issues to the Senior Responsible Owner so no surprises
- Ensures expectation for delivery and outcomes are translated into the project plan
- Enables resources for the project
- Ensures resolution of barriers to progress

Clinical Lead

- Chief Medical Officer (Hospital).

Steering Group

- Represents those who will use the deliverables of the project to realise the benefits after the project is complete
- Works together with the Project Sponsor to resolve strategic and directional issues within the project which need the input and agreement of senior stakeholders to ensure the progress of the project.

Consumer Rep

- Chair of Consumer Council.

Project Manager

- Plan, delegate, monitor and control all aspects of the project
- Motivation of those involved to achieve the project objectives within the expected performance targets for time, cost, quality, scope , benefits and risks

Project Delivery Resources

- Completes tasks as required
- Works to agreed timeframes
- Report progress and elevates issues in a timely way
- Effective team member demonstrating pro-active and constructive problem solving

Project Management Office

- Provides pro-active project *assurance input* to support the project to use best practice processes to create the deliverables and appropriately follow the project management processes

HAWKE'S BAY District Health Board Whakawāteatia	**Learnings from ICU Review 2013 – Progress Update**
	For the attention of: **HB Clinical Council and Finance Risk and Audit Committee**
Document Owner: Document Author:	Kate Coley, Executive Director, People and Quality Kate Coley
Month:	May, 2017
Consideration:	For Information

RECOMMENDATION

That FRAC:

- Note the contents of this report.

EXECUTIVE SUMMARY

At the end of 2015 an urgent request was made to EMT, Clinical Council and FRAC to support a business case to appoint further senior consultants to ICU due to significant risks being identified in regards to SMO resourcing and an unsustainable and unsafe roster for the medical team.

A review was undertaken identifying a number of recommendations, with identified leads and timeframes for implementation. Attached is a copy of the action plan with progress updates.

Also attached is a second spreadsheet identifying the outstanding recommendations of the ICU 2013 review and progress against those that are outstanding. A significant number of these actions have been completed in the last few months.

Both these documents have been shared with EMT and Clinical Council.

Action	Responsibility	Implementation deadline	Progress Update
A documented job sizing process needs to be established and agreed between the DHB and ASMS with clearly defined roles and responsibilities with an agreed timescale, with a maximum of 12 months for the work to be completed	John Gommans, Colin Hutchison + Craig Sidoruk	Dec-16	ICU SMO job sizing in progress. Further discussions and considerations and options to be negotiated and worked through. Final decision to be made by end June 2017.
Undertake a full review of the current ICU SMO rostering practices.	Colin Hutchison	Sep-16	As above
Develop systems to ensure nurse staffing ratio's are appropriate for both ICU and HDU patients	Ian Elson/Chris McKenna	Nov-16	Draft paper being prepared for HSLT for consideration early May.
Review all recommendations from the 2013 Review, consider and implement any that are still relevant and outstanding	Paula Jones, Colin Hutchison, Ian Elson	Nov-16	Please see separate worksheet for an update.
Development of a TOR Guideline & process document	Kate Coley	Jul-16	Complete
TOR Template developed	Kate Coley	Jul-16	Completed
TOR Checklist developed	Kate Coley	Jul-16	Complete
HBDHB is to investigate the most time effective method for effectively and efficiently reviewing and approving SMO timesheets to ensure they accurately record actual hours worked and leave taken	John McKeefry - Now Kate Coley	Aug-16	Piece of work to be undertaken as part of the DRS Unit ransition following the reconfiguration in Health Services. Transition due for completion by September 2017.
Undertake a full audit of "actual hours worked" not necessarily contracted hours to determine whether SMOs / RMOs are working a significant number of hours over and above contracted hours	John McKeefry - Now Kate Coley	Aug-16	Pilot underway mapping SMO Timetables in Acute & Medical Services - actual hours worked versus contracted hours. Once pilot completed a full rollout will be undertaken as part of the DRS Unit transition. To be completed September 2017
Dependent on the results from the above audit consider and make a recommendation to EMT as to whether the DHB needs to consider ongoing tracing of actual hours worked and establishing a mechanism for identifying and escalating issues to senior leaders so that this issue is better managed.	John McKeefry - Now Kate Coley	Sep-16	Will form part of the DRS Unit transition following analysis of results of the pilot. To be completed September 2017.
Each Directorate will be required to develop an annual service plan to reduce the risk of 'crises' occurring in the future	Sharon Mason	Jul-16	Completed
Establish effective effective mechanisms for escalation of risks to relevant governance bodies in a more consistent and transparent manner.	Kate Coley	Immediate	Complete.
Monthly meetings set up with HS Directorate teams to review directorate risks & identify any actions, escalation that needs to occur	Kate Coley	Immediate	Complete
Risks identified that are significant to be discussed with HSLG and escalated to EMT/Clinical Council/FRAC as necessary	Sharon Mason	Immediate	Complete
Implementation of a new event system so that we will be able to triangulate information and allow us to understand where a risk is developing before it becomes critical	Kate Coley	Jan-17	RFP underway. Implementation by end of 2017.

Updated actions - May 2017					
Recommendation from report (Feb 2013)	**Actions carried out as at May 2016**	**May 2016 Actions planned**	**Lead / Responsible**	**By when**	**April 17 Update**
1. ICU level					
1.8. Consideration should be made towards using the registrar more effectively. Where registrars are junior, support should be provided to enable them to manage a proportion of calls (within their ability) and to escalate others.	At time of 2013 report, majority of ICU registrars were PGY2, After accreditation - advanced trainees, now aiming for PGY3 or above. Service is now budgeted for 7 Registrars (vs 6 in 2013)	Dedicated time required for SMO to train Registrars on rapid response. SMO job sizing outcome may support this. When new SMO roster in place, SMO time may become available to support.	Medical Directorate	**Complete**	7 SMO & 8 Registrar roster inplace allowing non-clinical time for registrar support and supported allocation of Registrar work in ICU, PAR Team and Flight
1.9. ICU specialists should consider whether preservation of the current arrangements are of such importance that reduction of other resources (such as bedside nurses) is a preferred alternative in the case of present or future funding shortfall.	The ICU technicians in ICU at time of review were, and remain an integral part of the ICU team alongside nursing. ICU technician roster changes worked through with Charge AT, implemented in 2015. ICU nurses trained in airway management and intubation.	Role of Anaesthetic Technicians in ICU will remain but role may change as outcome of Flight Review is implemented. No reduction in ICU nurses will occur as they remain the rate limiting step to ICU throughput now medical staffing issues addressed.	Medical Directorate	**Complete**	Current arrangement accepted as BAU by ICU team.
1.10. Utilise the organisation PDRP system to identify qualified critical care nurses.	All nurses are encouraged to do post grad education in critical care nursing and have current PDRP portfolio		ICU CNM	**Complete**	PDRP system and annual reporting into Australasian benchmarking utilised to identify nursing capability.
1.11. Determine the level of care provided to groups of patients with likely poor outcome to enable best utilization of resources	Needs to occur for best quality patient care and as a consequence best utilisation of resources. Admission / discharge criteria implemented 2015. Organisational support required for Goals of Care program.	Continue to highlight as service priority for implementation. Budget bid for 16/17 not prioritised.May be able to progressed be on an incremental basis once job sizing outcome confirmed. Align with PAR team implementation.	ICU HoD	Complete - Ongoing	ICU admission criteria implemented. PAR Team implementation in progress and progressing well. Advanced Care Planning and Goals of Care work will align with work occurring nationally.
1.17. Early discussion with colleagues around discharge plans for specific patients may reduce tension between the ICU and wards and facilitate a smooth discharge and care plan for the patient going forward.		Medical CD and HoD involvement in discussions with Physicians to meet agreement with physicians group	ICU HoD	**Complete**	PAR nurse implementation progressing well. Electronic discharge summaries from ICU implemented.
2. Hospital level 2.1. Continue to develop the MET team and CRN ward team to support care of the higher acuity patient on the ward. 2.2. Current concerns about risk that appear to be driving a proportion of HDU admission could be addressed by a functional, integrated deteriorating patient response and supportive outreach service. Given the limited ICU medical resource, consideration should be made to making the first responder of an outreach service an experienced RN. Most services in other hospitals are based in ICU (this facilitates positive interaction between ICU and wards). Hawke's Bay should consider such a model. Further education is required to explain the basis of the deteriorating patient response system. 2.3. Develop an organisational approach to discharging the ICU/HDU during office hours. 3.11. Review out of hours ward medical and nursing resources to enable better support for the deteriorating patient	EWS and RRT mechanisms developed and implemented with data collection tool in place. Patient at Risk Team (1.7fte) new investment bid supported by Clinical Council	Recruitment of 1.7 FTE PAR RN approved, recruitment underway. This resource will provide x7 AM shifts per week and will therefore need to be closely aligned to the after hours teams (CRN team and out of hours registrars) through good communication and handover processes. No medical resource approved in business case but are required to support PAR nursing team - job sizing and SMO roster change may provide some SMO capacity. Introduction of ALERT training for ward based teams awaiting organisational restructure. Rapid response team in place. Admission & Discharge policy in place.	ICU HoD & CNM	May-17	Early Warning Score (EWS) system in place across acute hospital. Patient at Risk (PAR) team implementation progressing. ALERT training program planned. 3.11 - not addressed.

3. Management					
3.1. HB Hospital need to consider value of a quality ICU service to quality care delivery at HB and maintenance of specialist surgical services	Clarification required on number of funded ICU and HDU beds, then develop plan to maintain staffing to budget. Operational guidelines developed for when ICU reaches capacity. Budget bid for increased RN to resource 4 HDU and 7 ICU beds not prioritised for approval.	Organisation Clinical Services Plan to determine the philosophy of care for HB hospital and HB ICU to determine level of service provision for Hawke's Bay. Current RN budget for 8 RNs per shift plus 1 ACNM 12 hr day shift. 8 RNs night shift 12hr. Patient care provision should be matched to available nursing resource. Paper being written to raise nursing resource constraints and patient safety risk to go to HS leadership.	HSLT	May-17	Important issue for Clinical Services Plan. ICU and Medical Directorate engaged with the Surgical Expansion Program. Current ICU status and challenges of resourcing and capacity being presented in paper to HSLT in May
3.2. HB Hospital should clearly identify funded bed capacity and devise clear operational guidelines for when ICU reaches funded capacity. This requires administrative responsibility and should not be left to the medical and nursing staff to resolve alone.		ICU - CCDM & VRM to clarify. Escalation Plan documented.Continuous review of staffing requirements v demand patterns. For further analysis and paper to HSLT	Medical Directorate	May-17	As for 3.1
3.3. Review number of physical beds required to meet population need and the type of service the organization wishes ICU to provide.		No guidance provided with external review	HSLT	May-17	As for 3.1
3.4. HBDHB should identify costs (financial and outcome) associated with increased transfer out of sick patients, should share this data with staff and utilize this in future planning discussions	Determine whether maintaining treatment for patients in Hawke's Bay is more cost-effective than transporting to tertiary care	Blueprint Escalation plan developed for times of surge in numbers and/or acuity of patients to be tabled to HS for agreement to support for implementation. Costs have been identified with flight review project. Changes require organisation support with regards to planning for 'at capacity' events	Medical Directorate	**Complete**	Transfer costs and impact on care understood by service. ICU Escalation plan reviewed and included in organisation plan.
3.5. Serious consideration should be made to reconfigure medical cover to ICU within a structure of safe working hours and reasonable roster	Recruitment of additional Intensive Care Physician position in 2015/16	Recruitment has allowed development of a safe roster but additional work including SMO job sizing under way.	Medical Directorate	**Complete**	7 SMO and 8 Registrar roster now in place. Business case for 8th SMO approved. Partially filled and remainder currently being recruited to.
3.7. Significant positive change has occurred and continuing. Administration take care to facilitate positive change and beware of applying excessive financial strain during a time of transition and transformation	Undertake a full review of the current ICU SMO rostering and authentication practices (as outlined in internal audit report) with view to enabling and requiring staff to electronically record actual hours worked. Implement recommendations from TAS internal audit - leave management and rostering Feb 2015. Agree threshold for actual hrs worked, training, on call based on health and safety legislation, employment agreements, safety parameters. Responsibility of individual and manager/HoD/MD to monitor hours.	Rostering paper presented to FRAC. Job sizing under way. Await outcome of job sizing project	Medical Directorate	May-17	The vulnerability around ICU medical staffing has significantly reduced with SMO and registrar increases. Once final outcome of ICU job sizing exercise completed this recommendation will be closed.

3.8. Develop systems to ensure minimum nurse staffing standards are adhered to. This will ensure there is a supernumerary nurse coordinating each shift, a 1:1 nurse patient ratio for ventilated patients and a 1:2 patient ratio for HDU patients	CNM reports monthly on casual nursing staff usage, extra shifts worked and nursing overtime in report to directorate leadership. Flow chart in place for times of 'unsafe' staffing situations	budget application 206/17 to fund nurses required to maintain roster. Nurse staffing shortages are recorded in event reporting system and raised with directorate leadership. Trendcare shift variance shows this in a regular report. Limit high risk elective cases at times of 'at capacity'.	Nurse Director and Service Director	May-17	Nursing staffing analysis completed and paper being presented to HSLT to HSLT in April. Options presented to address nursing resources.
3.9. Fill vacant ACNM position immediately to bring it back up to 3.5 FTE	Attempts to reinstate 4th ACNM unsuccessful	Previous budget bids not approved so unable to be completed.	HSLT	May-17	As for 3.8
3.12. ACNM office days be rostered and acknowledged as essential time to enable the team to achieve service goals, develop nursing practice and manage nursing staffs' professional development. At these times the ACNM should not routinely be pulled onto the floor for meal reliefs or to take admissions or discharges. Thus a planned roster must enable them to be completely off the floor and away from the day to day running of the unit	Attempts to reinstate 4th ACNM unsuccessful. Risk to service delivery, staff management, training not able to be delivered when not enough non clinical time for nursing leadership team.	Budget application 2015/16 to reinstate 4th ACNM was not prioritised. Therefore non clinical ACNM hours are unable to be rostered due to clinical duties taking priority. When able, non clinical time is rostered. CNM frequently trying to roster non clinical as able.	ICU CNM	May-17	As for 3.8
4. Anaesthetic Technicians and Flight					
The anaesthetic technician role has become vital within the unit. Their role includes maintenance of equipment, assistance with emergencies, intubations, percutaneous tracheostomies, intra-cranial pressure monitoring and transports. Most units have ICU technicians some of which are anaesthetic technicians and some are ex-ICU nurses who have left the nursing roster. The position requires resource irrespective of the ICU technician's background.	ICU nurses have been trained in airway management and intubation. ICU technician roster changes worked through with AT charge and implemented 2015.	Role of Anaesthetic Technicians in ICU will remain but role may change as outcome of Flight Review is implemented. No reduction in ICU nirses will occur as they remain the rate limiting step to ICU throughput now medical staffing issues addressed.	ICU HoD & CNM	**Complete**	Current arrangement of 1fte ICU technician is accepted as BAU by ICU leadership team.
Reduction or loss in Anaesthetic Technician cover will leave a large gap which could lead to equipment failures and shortages, increased complications, a reduction in nursing resource and increased number of flights by third party operators (at much greater cost). At present there are not enough ICU trained flight nurses to cover a 24/7 transport service. There must also be back up transport nurse/AT for times when urgent, time sensitive, transfers are required (eg Neurosurgical, cardiac and vascular patients).	response to recommendation from report - It is a clinical decision on who should make up the flight team for transfer of critically unwell patients, dependent on assessment of the patients, experience of the flight Reg and the experience of the flight nurse.		ICU HoD & CNM	May-17	ICU have developed a proposal that will be presented to HSLT in May that addresses this issue.

HAWKE'S BAY District Health Board Whakawāteatia	**Health Literacy Principles & Implementation Approach**
	For the attention of: **Māori Relationship Board, HB Clinical Council, HB Health Consumer Council**
Document Owner: Document Author:	Kate Coley, Executive Director of People & Quality Adam McDonald, Health Literacy Advisor
Reviewed by:	Health Literacy Steering Group, Executive Management Team
Month:	May 2017
Consideration:	For information

RECOMMENDATION

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

- Note the Health Literacy principles for the Hawke's Bay health sector
- Note the summary of the Quigley & Watts review report (Appendix 1 & 2). Full copy of report Appendix 3.
- Note the proposed action plan for the development of a set of health literacy products, tools and guidance/advisory to support the implementation of the health literacy principles

PURPOSE

The purpose of this paper is to provide a summary of the work that has been undertaken to date in regards to health literacy, a review of the report provided by Quigley & Watts (Q&W) and to outline the approach and programme of work to begin the implementation of the health literacy principles.

EXECUTIVE SUMMARY

The focus is to create a health literate Hawke's Bay health sector and an empowered and health literate population. This will be achieved through:

1. Reducing the health literacy demands and complexities that the health system places on people to obtain, understand and use health services and information.
2. Increasing the skills and abilities of people to access, navigate, understand and use the health system.

The ministry of health report Korero Marama (2010) found that 56% of New Zealanders have low levels of health literacy. Further to this, health literacy had a much greater impact on Māori contributing to greater health challenges and health inequities. Low levels of health literacy can impact negatively on the health of people and their whānau. International research has shown the relationship between a person's level of literacy and their health status[1] (Ministry of Health, 2010).

Phase 1 of the initial project was to undertake a stocktake of the HB health sector in regards to health literacy. A review was commissioned by Hawke's Bay District Health Board (HBDHB), on behalf of

[1] (Canadian Council of Learning 2008; Kickbusch et al 2005; Knight 2006; Korhonen 2006; Institute of Medicine 2004; Nutbeam 2008).

the sector. Quigley and Watts Ltd was commissioned to undertake a high-level strategic review of the health literacy strengths and weaknesses of the Hawke's Bay health sector. (A full copy of the report is provided in Appendix 3)

The report provided a good overview of where the HB health was at in regards to health literacy summarising our strengths, weaknesses and made a number of recommendations. (Appendix 1 & 2). These recommendations have been incorporated into the development of principles, the implementation approach and action plan detailed in this report.

The report identified the following key themes and opportunities:

- Strong leadership commitment at a strategic and senior level to health literacy
- Prioritise health literacy in a programme of work
- Focus now on the development of an overarching and co-ordinated wide action plan
- Linkages to creating a culture shift and link to the philosophy of person & whānau centred care
- Need to create an impetus to gain commitment across all levels of the sector

Since the report was finalised a number of related activities have been undertaken. The first, is the appointment of a Health Literacy Advisor who will be the Project lead for the implementation of health literacy across the sector. In addition to this appointment, the DHB has also been developing and designing training for all staff (aligned to that being offered in GP Practices) to support the improvement of health literacy. This model of Relationship Centred Practice incorporates Māori principles and frameworks including the Hui Process and is being made available to all Central region DHBs and potentially will be utilised at a national level through HQSC. Workshops and education sessions to support the building of awareness have also been taking place alongside the development of tools and guidance material for all teams across the sector. Ongoing advice and support has been provided to individuals and teams on an ad hoc basis and there has been an increase in these requests over the last few months.

The intent of the first phase of the project was to undertake a stocktake and develop a HB Health Literacy Framework. In completing this work, it is clear that health literacy is complex and it was felt that if we were going to be able to achieve the outcomes then we needed to ensure that we were not increasing the complexity with the introduction of another framework. To that end it is recommended that the HB utilises a simple model of creating a health literate organisation/system and sets out its commitment to health literacy in the form of a set of core principles. These would be easily understood by staff, patients, and the community, and will inform the programme of work.

The action plan outlines core work streams and the development of a set of products to support the roll-out of the health literacy programme of work. The work streams aim to build awareness and understanding of health literacy and develop guidelines with resources for organisations across Hawke's Bay to use to ensure a systematic approach to improving health literacy. Throughout the action plan, there is a focus on ensuring there is adequate consumer input, ensures that we build capacity across the health sector to improve health literacy and develops skills for organisations to be able to sustain the health literacy programme of work.

BACKGROUND

SUMMARY OF QUIGLEY & WATTS REPORT

A review was commissioned by Hawke's Bay District Health Board (HBDHB), on behalf of the sector. Quigley and Watts Ltd was commissioned to undertake a high-level strategic review of the health literacy strengths and weaknesses of the Hawke's Bay health sector and to provide findings and recommendations to inform the development of a framework and plan for health literacy within Hawke's Bay.

Information for this review was collected via face to face group discussions, telephone interviews, a literature scan and document review.

In assessing the health sector strengths and weaknesses Q&W utilised the MOH Six Dimensions framework for creating a health literate organisation and the findings are summarised below. A more detailed summary of the findings can be found in Appendix 1 & 2.

- Need for a clear and better understanding of health literacy. Health literacy often referred to as a confusing topic that contributes to the lack of clear understanding of the concept.
- Good intentions at a leadership and strategic level and some good pockets of practice, however overall there is poor and inconsistent practice across the HBDHB.
- Need for the culture within the health system to change, with re-organisation towards a more person and whānau centred system.
- Critically in the local context, this requires a health literacy framework to be underpinned by mātauranga Māori (Māori knowledge) in order to reflect the basis of New Zealand's founding relationships and to ensure the framework addresses health inequities.
- The need for the DHB to support change to make health literacy business as usual, this includes embedding health literacy into expected practice and behaviour and creating accountability.
- Workforce development and resourcing for better health literate practice for health professionals.
- Increase the Māori and Pacific health workforce.
- Effective communication from a systems to an operational level.
- Linked up clinical pathways and a health system that ensures easy access and navigation.
- More joined up and co-ordinated way of working within the health system.

Overall, whilst there is room for improvement across the six dimensions, it was Q&W's view that the HB health sector should feel optimistic about the future for health literacy as there was an absolute commitment to creating a health literat environment and it was felt that thei approach to health literacy identified in Transform & Sustain was a platform for real transformation.

CREATING A HEALTH LITERATE SECTOR

A health literate sector makes health literacy a priority. It makes health literacy part of all aspects of service planning, design, delivery and performance evaluation to reduce the health literacy demands on consumers.

A health literate sector:

- Makes health literacy everyone's business – leaders, managers, clinical and non-clinical staff
- Designs systems, processes and services that allow consumers to access services easily
- Supports operational staff to use health literacy approaches and strategies
- Eliminates confusing communication that could prevent consumers from accessing treatment easily
- Actively builds health literacy in consumers to help them to manage their health
- Makes operational staff understand that no matter how high a consumers level of health literacy is, stress and anxiety affect their ability to understand and remember new information

Q&W recommended that the concept of health literacy should embrace:

- A dual focus - on creating both a health literate sector and an empowered and health literate population.
- A partnership approach—where individuals/whānau are partners alongside the health system and health professionals. Within the local context this includes ensuring that the principles are underpinned by mātauranga Māori (Māori knowledge).
- A population health approach—a definition of health that encompasses wellness, recognises the social determinants of health, and addresses current inequities.

Drawing on international best practice, the following six dimensions have been developed in New Zealand and describe the attributes of a health literate organisation that make it easier for people to navigate, understand and use health information and services to take care of their health. These six dimensions exemplify a health literate organisation/system and an organisation/system that embodies these dimensions creates an environment that enables people to benefit optimally from

healthcare services and information. Each dimension highlights ways in which health literacy can be embedded.

These dimensions have informed the development of a set of guiding principles and an action plan for health literacy, rather than create a framework which could potentially add greater complexity to an already complex area.

New Zealand's Six Dimensions		Rationale
1.	**Leadership and management.** How is health literacy an organisational value, part of the culture and core business of an organisation? How is it reflected in strategic and operational plans?	Leaders and managers have a critical role in developing a health-literate organisation. They drive an organisation's health literacy culture by articulating and reinforcing goals and expectations, and by modelling expected behaviours. Leaders and managers in a health-literate health care organisation ensure that health literacy is built into all aspects of the organisation, explicitly measured and monitored, and continuously improved.
2.	**Consumer involvement.** How are consumers involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery?	A commitment to patient-centred care, consumer safety and quality improvement involves more than the activities of managers, clinical leaders and other staff. A health-literate health care organisation involves consumers and their families in all aspects of service delivery – not just the evaluation of consumer experience.
3.	**Workforce.** How does the organisation encourage and support the health workforce to develop effective health literacy practices? Has it identified the workforce's needs for health literacy development and capacity? Has the organisation's health literacy performance been evaluated?	The health workforce plays a crucial role in communicating oral and written information to consumers and families and ensuring they understand that information. A health-literate health care organisation provides health literacy training and coaching to its entire workforce to improve communication and build health literacy.
4.	**Meeting the needs of the population.** How does the delivery of services make sure consumers with low health literacy are able to participate effectively and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy)? How is meeting the needs of the population monitored?	Because health literacy is diverse and ongoing, health care organisations will find it difficult to identify who in their consumer population has low health literacy. A health-literate health care organisation adopts a universal precautions approach so that staff do not make assumptions about who might or might not need assistance.
5.	**Access and navigation.** How easy is it for consumers to find and engage with appropriate and timely health and related services? How are consumers helped to find and engage with these services? How well are services coordinated and are services streamlined where possible?	Health care organisations develop and use systems that place demands on consumers and families. A health-literate health care organisation reduces the demands its systems place on consumers and families and helps them to access and navigate systems.
6.	**Communication.** How are information needs identified? How is information shared with consumers in ways that improve health literacy? How is information developed with consumers and evaluated?	Health care organisations communicate with consumers and families orally, in writing and increasingly using technology. A health-literate health care organisation ensures that all communication, in all formats, is clear, easy to understand and easy for consumers and families to act on.

HEALTH LITERACY PRINCIPLES

Rather than utilise the MOH framework, a set of core principles (aligned to the framework) have been developed so that staff, consumers, our whānau/families and our community can easily understand them. The below outlines those principles and links to the sector wide values.

Six Dimensions	Health Literacy Principles	HB Values
Leadership and management	Leadership is needed to champion a culture change to ensure that Hawkes Bay becomes a health-literate sector	He Kauanuanu Ākina Tauwhiro
Consumer involvement	Creating a health literate sector happens in partnership, where consumers and whānau are viewed as important and equal partners with health professionals.	He Kauanuanu Raranga te tira
Meeting the needs of the population	Reducing complexities and demands of the health system is the most practical way to achieve a health literate sector	He Kauanuanu Raranga te tira Tauwhiro
Workforce	We need to invest in building skills and knowledge of our health professionals so that they with consumers build positive relationships, communicate effectively and understand one another	He Kauanuanu Ākina Tauwhiro
Communication	Communication is a critical component to ensure that health services and information is delivered so that it is understood by the consumer and can be used to make informed decisions	He Kauanuanu Ākina Raranga te tira Tauwhiro
Access and navigation	Our aim is to ensure that health services and information can be easily accessed and navigated, understood and then used to improve the health and wellness of our consumers	He Kauanuanu Ākina Raranga te tira Tauwhiro

HEALTH LITERACY ACTION PLAN

The action plan outlines core work streams and the development of a set of products to support the roll-out of the health literacy programme of work. The work streams aim to build awareness and understanding of health literacy and develop guidelines with resources for organisations across Hawke's Bay to use to ensure a systematic approach to improving health literacy. Throughout the action plan, there is a focus on ensuring there is adequate consumer input, ensures that we build capacity across the health sector to improve health literacy and develops skills for organisations to be able to sustain the health literacy programme of work.

	Work streams	Proposed timeframes Start	 End
1.	**Change management** Position the health literacy programme of work within the People strategy, with the aim of shifting the culture across the HBDHB. Collaborate and co-ordinate the health literacy programme of work with the following activities; o Person and whānau centred care o Workforce engagement o Health equity o Cultural competency	**December 2016**	**July 2018**

	o HBDHB values o Quality improvement and patient safety o Consumer and community engagement o Relationship centred practice o Long term conditions strategy o Community and primary healthcare strategy		
2.	**Establish a Project Advisory Roopu** The advisory roopu is to model a partnership approach towards improving health literacy across the health sector. Given that health literacy has a greater impact on Māori and contributes towards health inequities, the group will ensure there is adequate representation from Māori consumers, workers and the community. See Appendix 4 for the draft terms of reference and Appendix 5 for the project structure	**March 2017**	
3.	**Raise awareness for health literacy** *(Process to be developed in partnership with staff and consumers)* Develop marketing material (that is delivered through effective channels) that can effectively reach people working in the health sector and within the community to raise awareness and improve understanding of health literacy. The marketing material may require the use of alternative titles or terminology for health literacy, given the lack of association between health literacy and what it truly means. For example – understanding healthcare (for consumers), making healthcare easy to understand (for clinicians).	**January 2017**	**May 2017**
4.	**Health literacy leadership (across sector)** Ensure that leadership and management training programmes include creating a health literate sector. Advise on the approach to improving organisational health literacy that contributes to the change in health sector culture.	**March 2017**	**September 2017**

5.	**Creating a health literate environment** Develop guidelines with a set of resources for organisations (or large services) across the health sector to use to create a health literate environment*. (Potentially an e-book).* The guidelines may include the following steps; Step 1: Complete a health literacy assessment for the six dimension of a health literate organisation. This assessment will be based on the following; ▪ ENLIVEN: Health literacy self-assessment tool ▪ Harvard University: The health literacy environment of hospitals and health centres ▪ Ministry of Health: Staff survey for health literacy Step 2: Develop a health literacy action plan based on the findings from the assessment across the six dimensions of health literacy. Step 3: Implementing toolkits and resources that improve health literacy in your service or organisation. ▪ Health literacy promotion / marketing ▪ Hawke's Bay health literacy toolkit – based on the universal precautions health literacy toolkit. ▪ Developing health literate communications and resources - rauemi atahwhai (in video format) ▪ Links to other resources including three steps to better health literacy, P.L.A.N, safe to ask (increase consumer confidence to ask questions). Step 4: Continually improving health literacy. ▪ Repeat steps 1 – 3 annually	**November 2016**	**June 2017**
6.	**Workforce development (across sector)** Develop a health literacy workforce education programme that is positioned within the HBDHB peoples and work force development strategy*. (Linkage to current RCP programme)* The programme requires coaching in effective health literacy communication methods with an emphasis on improving quality relationships with consumers	**March 2017**	**February 2018**
7.	**Consumer and community health literacy** Create a consumer and community strategy that adopts a co-design methodology to improve consumer and community health literacy. *(Working with PHO, Staff and Consumers)*	**September 2017**	**February 2018**
8.	**Address health literacy priority areas within the HBDHB** Health literacy innovation: Investment in projects that aim to improve health literacy across the health sector Particular areas of interest, such as hospital discharge / readmission, consumer and community health literacy, Māori and Pacifica health.	**March 2017**	**July 2018**

9.	**Monitor, evaluate and continual improve health literacy** Review, evaluate and continually improve health literacy across the Hawke's Bay region ▪ Ministry of health – health literacy review framework ▪ QIPS measures ▪ Health outcome and output measures ▪ Workforce knowledge survey ▪ Consumer knowledge survey ▪ Health literacy self-assessment	**June 2017**	**July 2018**

APPENDIX 1 – SUMMARY OF FINDINGS

Dimension	Findings
Leadership	The leadership and management dimension assesses whether health literacy is an organisational value, part of the culture and core business of an organisation or service, and whether health literacy is reflected in strategic and operational plans. Health literacy is a clear strategic priority for HBDHB with support from leadership and it is consistent with the values of HBDHB. Findings indicate a coordinated and thoughtful approach to developing health literacy at the strategic level thus far. As the emphasis has been on developing a strategic focus, health literacy is yet to flow into operational plans or coordinated organisational action. With the exception of Health Hawke's Bay where health literacy workforce development and initiatives for consumers have been developed action has yet to filter out to the wider health workforce. As expected at this stage of development, there is significant work required before health literacy is part of the core business of the sector but it is clear that HBDHB has, and should continue to have, a strong leadership role in this area. Considerations for the framework include: ensuring HBDHB continues to lead health literacy work in collaboration with the rest of the sector; underpinning the framework by Māori principles; and, ensuring there is a multi-faceted, long-term approach to this work
Consumer Involvement	The consumer involvement dimension assesses how consumers are involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery. Overall, there is a currently limited consumer involvement in health literacy work or in the strategic direction of the Hawke's Bay health system more broadly. The Consumer Council is an important step in the right direction however it is just one facet of the collaboration with consumers required for health literacy improvement. Internationally, health literacy experts acknowledge that real progress in health literacy will be limited without true collaboration with consumers, which to date has been lacking. Considerations for the framework include: partnering with consumers in the development of the framework; importance of a patient/whānau-centred approach and the opportunities of co-design as a framework for involving consumers in service design and delivery.
Workforce	The workforce dimension assesses how the organisation encourages and supports the health workforce to develop effective health literacy practices, whether it has identified the workforce's needs for health literacy development and capacity, and whether the organisation's health literacy performance has been evaluated. There has been no coordinated approach to workforce development in health literacy. The focus of HBDHB has been at the strategic level thus far. There are significant workforce development needs a notable exception is Health Hawke's Bay which is in the process of undertaking workforce development for staff in primary care. While there is generally the will to up skill in this area, a key challenge will be getting all staff to see it as a priority. Considerations for the framework include: making workforce development a priority; making health literacy as much of a priority as clinical work; creating an enabling system to support workforce change and, increasing the Māori and Pasifika workforce.

Meeting the needs of the population	Meeting the needs of the population dimension assesses how service delivery ensures that consumers with low health literacy are able to participate effectively in their care and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy). This dimension also assesses how meeting the needs of the population is monitored. There is a strategic intent to address inequities however the health system is currently unlikely to be meeting the needs of consumers with low health literacy. There is no coordinated approach to identifying health literacy need, addressing it and then monitoring whether those needs are being met. One of the biggest challenges is that the system is set up to meet the needs of those working within it and not those accessing it. Less than 50% of adult New Zealanders have adequate health literacy. Low health literacy contributes significantly to health disparities for Māori and Pacific peoples. Four out of five Māori males and three out of four Māori females have poor health literacy skills (Ministry of Health, 2010). The health system is complex and everyone struggles with it at some point even those with good health literacy. Considerations for the framework include: a Universal Precautions approach to build the health literacy of the whole population without stigmatising those with low health literacy; a strong focus on reducing inequities particularly for Māori; monitoring mechanisms to measure whether needs are being met; and, reorienting the health system to meet the needs of the population.
Access & Navigation	The access and navigation dimension assesses how easy it is for consumers to find and engage with appropriate and timely health-related services, and how well these services are coordinated and streamlined. There was not as much discussion about this dimension as there was about the others but the findings indicate there is a lack of coordinated and streamlined services and impacting on access and navigation for consumers. Considerations for the framework include having more discussion about what this dimension means and how aspects of access and navigation are addressed across the other dimensions particularly leadership and management, and communication.
Communication	The communication dimension assesses how information needs are identified, how information is shared with consumers in ways that improve health literacy, and how information is developed with consumers and evaluated. As with other dimensions there are pockets of good things happening but there is no coordinated approach to identifying information needs or sharing information in a way that improves health literacy. Most of the health information is written by health professionals, there is no systematic approach for assessing the readability of resources, and health practitioners have no specific tools or training to build communication skills. Considerations for the framework include: having a coordinated approach to improving communication between health professionals and consumers with an emphasis on quality relationships; involve consumers in the development of health resources; and, think about how to improve the communication skills of both health professionals and consumers.

APPENDIX 2 - SUMMARY OF POTENTIAL OPPORTUNITIES

Domain	***Opportunity***	***Commentary***
Leadership	HBDHB needs to lead the work on health literacy	Findings from interviews and groups supported a leadership role for HBDHB in collaboration with the wider sector. HBDHB also needs to lead by example and embed health literacy into the DHB first ensuring that health practitioners understand their role in improving health literacy (more about this under the 'workforce' dimension).
	Underpin the framework with Māori principles	The Māori Relationship Board and some interviewees felt strongly that in order for the framework to be successful, it needs to be underpinned and driven by Māori principles – tikanga and kawa – rather than Māori perspectives being reflected in the strategy.
	A multi-faceted, long-term approach is needed	Health literacy will not be 'fixed' quickly and the long-term nature of this work needs to be highlighted. This work should not be viewed as another project but a long term approach that is sustainable over time. The approach needs to be multi-faceted addressing information, systems, processes and relationships relating to health literacy.
	Consider health literacy within the bigger issue of reorienting the health system	Creating the necessary system-wide culture change focused on wellness and patient/whānau centred care was thought to be essential but a key challenge. A key finding is that currently 'the system is set up for the system' and works for health practitioners but not necessarily for consumers. Sector culture change is required turning services around to meet customers' needs. Health literacy is only one component of this bigger issue. *Health literacy is a part of a bigger culture change – the move to patient/whānau centred care. A whole raft of things needs to change to make that shift from how the sector has delivered services for years…… health literacy is only one part of the puzzle, working out how to piece it together is critical* (EMT). *Health literacy issues will continue to exist until the structure changes. We have to invest money in changing the structure and supporting patient centred care. We're focused on sickness and not on wellness. Culture change is needed to create a joined up system with a wellness focus* (Staff Discussion Group).

		Health literacy is a fundamental challenge to how we deliver services as we are very clinic based. There are power imbalances in the system. Approach needs to come from the top, be visible and observable, and align with organisational values (Staff Discussion Group).
Consumer Involvement	Partner with consumers in the development of the framework	Many of the issues identified by participants about what is not currently working in the system will not be solved without genuine partnerships and collaboration with consumers. In a partnership approach for the development of the framework, the needs of both the service and the user can be explored, joint solutions (that a service may never think of) can be suggested, and ownership, empowerment and improving health literacy on both sides can occur. Aside from the Māori Relationship Board and the Consumer Council, there was limited discussion about involving consumers in the design of the sector or the framework.
	Importance of a patient/whānau-centred approach	The Māori Relationship Board emphasised that a patient/whānau-centred approach needs to be used in creating the framework and that approach should be driven by whānau to increase ownership of the process and the outcome. *The system should be designed around whānau taking ownership around this initiative* (Māori Relationship Board).
	Co-design a useful framework for involving consumers in service design and delivery	Within a health context, co-design (also known as experience-based design or co-production) is a method of designing better experiences for patients, carers and staff. It involves patients and staff exploring the care pathway and the emotional journey patients experience along it, capturing experiences then working together to understand these experiences and improve them (Boyd, McKernon, Mullin and Old, 2012).
Workforce	Workforce development needs to be a priority within the framework/plan for health literacy	Workforce development is required to ensure understanding of the concept of health literacy and the benefits of engaging with health literacy. The staff group discussions highlighted that workforce development needs to focus on empathy, communication, understanding consumer experiences, cultural competency and feedback processes. *It is hard to change practice as health professional until you are given feedback. We need an environment of feedback that allows people to change* (Staff member). Staff identified the following areas as important for workforce development: • the meaning of health literacy to create a shared understanding • the consumer/whānau and health practitioner relationship

		• how to communicate more effectively with consumers (including culturally appropriate communication) • resources/pathways that are available for consumers
	Getting all staff on board could be challenging	While there is a way to go in terms of up skilling staff about health literacy, staff involved in this review were very positive about health literacy, this review and the framework. They supported the DHB's role in workforce development, taking the onus off educating patients and whānau. Many of those working 'on the ground' were keen to increase their health literacy knowledge and were passionate about helping increase their patients' understanding of their own health and wellbeing. They did note though that it would be more challenging to engage some of their colleagues who may not see it as a priority.
	Make health literacy as much of a priority as other aspects of clinical work	Increased knowledge and skills in health literacy will assist staff in their work and could help them to see it as a priority. However, it also needs to be given priority by HBDHB. To ensure effective workforce development, changes need to be made to give health literacy and cultural competency equal value to clinical training. *Health professionals' training does not support health literacy related issues or cultural practice the same way it does clinical practice. Both need to be on same level and given same priority as you can't have one without the other* (Staff member).
	Support workforce development with a system that values and enables change	A consistent theme at both staff groups was that health literacy workforce development cannot happen in isolation and needs to be supported by system changes that allow better communication with patients e.g. more time for appointments, health literacy champions, and access to appropriate resources, information, services and support. Adequate funding for all the components was mentioned as being important.
	Increase the Māori and Pasifika workforce	Several participants talked about the need to increase the Māori and Pasifika workforce to fully meet the needs of the population (more about this under the 'meeting the needs of the population' dimension).
Meeting the needs of the population	Build health literacy using a Universal Precautions approach	Rather than assessing individual patient's health literacy, many experts recommend that health professionals assume that all patients experience some degree of difficulty when in health environments and therefore apply the principle of Universal Precautions to health literacy (similar to the approach for preventing blood-borne diseases). Taking a Universal Precautions approach to health literacy involves finding out what patients already know, sharing clear

		information with patients and helping patients build their understanding of how their body works, their health issues and associated treatment (DeWalt, Callahan, Hawk, Broucksou et al, 2010). This type of approach does not label or stigmatise those with low health literacy as it assumes everyone may have difficulty understanding. This dimension links strongly to the workforce dimension.
	Focus on reducing inequities particularly for Māori	Low health literacy contributes significantly to health disparities for Māori and Pacific peoples. Four out of five Māori males and three out of four Māori females have poor health literacy skills (Ministry of Health, 2010). The literature indicates health literacy is a key strategy to reduce inequities. Culturally appropriate approaches such as whānau ora need to be used, and systems and services need to be accessible and appropriate for specific communities.
	Create monitoring to measure whether needs are being met	It is clear that there needs to be a strong monitoring component in the framework. Levels of 'do not attends' and consumer complaints were suggested as potential measures. While useful these indicators may not specifically measure health literacy. There is also the wider question of meeting the needs of those not currently accessing health services.
	Reorient the health system so it is consumer focused	This would be a fundamental change to the health system however many participants mentioned the Nuka model of care in Alaska that is designed around and owned by the 'customer'. Given that HBDHB has already invested in up skilling some staff about this model, there are opportunities to further develop knowledge in this area.
Communication	A coordinated approach to improving communication between health professionals and consumers with an emphasis on quality relationships	Communication comes in all forms and while written resources are an important component, relationships are critical. Face-to-face communication was emphasised by the Māori Relationship Board especially for Māori, and communicating in ways the consumer will identify with and understand. *Come down to whānau level and talk the basics…it's a snotty nose…how hard is it to say that he's got a 'snotty nose'* (Staff member). Components of effective communication to consider are: • use clear, plain language that reflects the audience's own common language • use a range of mediums e.g. face-to-face discussions, DVDs or online video • use visual prompts to explain complex issues

		Rauemi Atawhai: A guide to developing health education resources in New Zealand has some good advice for developing written resources (Ministry of Health, 2012).
	Involve consumers in the development of health resources	It is important to involve a range of consumers in the development of health resources to ensure they are being communicated with in ways that are understandable and resonate with them. This links to the 'consumer involvement' dimension above.
	Skills to improve communication are needed on both sides for consumers and health professionals	Communication is a two-way thing and consumers need to communicate in ways health professionals can understand as well. Ultimately though, the responsibility to ensure patient understands information should lie with the health professional. Health professionals need access to appropriate tools to aid their communication with consumers. On a practical level the Health Quality and Safety Commission's *Three Steps to Better Health Literacy* – is a useful tool. The three steps are to find out what people know, build people's health literacy knowledge and skills to meet their needs, and then check for understanding and clarity. The Health Quality and Safety Commission's *Let's PLAN for better care* health literacy tool encourages people to plan ahead for visits to their GP or other health care professional and to ask questions when there so they fully understand their diagnosis and treatment. *Let's PLAN* is being used by the Ministry of Social Development's Work and Income case managers in Hawke's Bay to help their clients make the most of their visits to their GP and other health services.

APPENDIX 3 – HEALTH LITERACY STRATEGIC REVIEW

Health Literacy Strategic Review

April 2016

Prepared for the Hawke's Bay District Health Board

By Quigley and Watts

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Acknowledgments

Improving health literacy is central to improving the health of people living in the Hawke's Bay. This work to support health literacy was funded by the Hawke's Bay District Health Board (HBDHB) on behalf of the sector.

Our deep appreciation goes out to all the people who participated in interviews and discussion groups, including staff members, the Consumer Council, the Executive Management Team, the Māori Relationship Board and the Clinical Council. Your knowledge and experience is at the heart of this review.

The Health Literacy Leadership Group was central to the direction of this project. It was a pleasure to work with a professional and passionate group of people committed to equitable health outcomes for Hawke's Bay. Particular thanks to Jeanette Rendle, Consumer Engagement Manager and Kate Coley, Director, Quality Improvement and Patient Safety, for their support and assistance. Finally thanks to Ken Foote who led this work on behalf of the HBDHB.

Nāu te rourou, nāku te rourou ka ora ai te iwi

With your basket and my basket the people will thrive

Contents

Executive Summary

This review was commissioned by Hawke's Bay District Health Board (HBDHB), on behalf of the sector. Quigley and Watts Ltd was commissioned to undertake a high-level strategic review of the health literacy strengths and weaknesses of the Hawke's Bay health sector and to provide findings and recommendations to inform the development of a framework and plan for health literacy within Hawke's Bay.

Information for this review was collected via six face to face group discussions, and eighteen telephone interviews with staff, a literature scan and document review. Group discussions included two groups open to all staff which were attended by 22 people, and discussions with the Executive Management Team, Māori Relationships Board, Consumer Council and Clinical Council.

The intention of the review was to focus on health literacy however it is clear from the literature, interviews and discussion groups that health literacy is one factor in a complex suite of things that need to change within the health system.

The first section of this report is a discussion of overarching considerations which have arisen through the review process and can usefully inform the health literacy framework. This section includes discussion of critical conceptual and process issues to be considered in developing the framework.

There is debate among health literacy experts internationally and confusion generally about the boundaries of health literacy. Contributing to this is a realisation that a focus on health literacy while necessary, on its own will not be sufficient to create an equitable and sustainable health system.

The relevant question is how consumer literate is the health sector. How well does the sector know its consumers? The definition is around the wrong way and needs to be turned on its head – what is the capacity to communicate so consumers can use information and health services to make effective decisions (Consumer Council).

The initial steps in development of the framework are to clarify what the Hawke's Bay health sector means by health literacy and to determine the positioning of the framework in relation to other systems change intentions.

Developing a health literacy framework provides an opportunity to 'walk the talk.' The process of developing the framework is as critical as the content.

> *We believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting* (HBDHB, 2014).

As the Māori Relationship Board suggested:

> *A patient/whānau centred approach should be in creating the framework – it should be whānau driven* (Māori Relationships Board).

A core component of framework development is grappling with how to measure success. A mix of tangible targets is needed at the intervention level alongside an overarching evaluation approach that recognises the complexity of health literacy.

The second section focuses on issues raised in the literature, interviews and group discussions in relation to each of the six dimensions outlined in the Ministry of Health's *Health Literacy Review – A Guide* (Ministry of Health, 2015):

Leadership and management

Health literacy is a clear strategic priority for HBDHB with support from leadership and it is consistent with the values of HBDHB. Findings indicate a coordinated and thoughtful approach to developing health literacy at the strategic level thus far. As the emphasis has been on developing a strategic focus, health literacy is yet to flow into operational plans or coordinated organisational action. With the exception of Health Hawke's Bay where health literacy workforce development and initiatives for consumers have been developed action has yet to filter out to the wider health workforce. As expected at this stage of

development, there is significant work required before health literacy is part of the core business of the sector but it is clear that HBDHB has, and should continue to have, a strong leadership role in this area.

Considerations for the framework include: ensuring HBDHB continues to lead health literacy work in collaboration with the rest of the sector; underpinning the framework by Māori principles; and, ensuring there is a multi-faceted, long-term approach to this work.

Consumer involvement

Overall, there is a currently limited consumer involvement in health literacy work or in the strategic direction of the Hawke's Bay health system more broadly. The Consumer Council is an important step in the right direction however it is just one facet of the collaboration with consumers required for health literacy improvement. Internationally, health literacy experts acknowledge that real progress in health literacy will be limited without true collaboration with consumers, which to date has been lacking.

Considerations for the framework include: partnering with consumers in the development of the framework; importance of a patient/whānau-centred approach and the opportunities of co-design as a framework for involving consumers in service design and delivery.

Workforce

There has been no coordinated approach to workforce development in health literacy. The focus of HBDHB has been at the strategic level thus far. There are significant workforce development needs a notable exception is Health Hawke's Bay which is in the process of undertaking workforce development for staff in primary care. While there is generally the will to upskill in this area, a key challenge will be getting all staff to see it as a priority.

Considerations for the framework include: making workforce development a priority; making health literacy as much of a priority as clinical work; creating an enabling system to support workforce change and, increasing the Māori and Pasifika workforce.

Meeting the needs of the population

There is a strategic intent to address inequities however the health system is currently unlikely to be meeting the needs of consumers with low health literacy. There is no coordinated approach to identifying health literacy need, addressing it and then monitoring whether those needs are being met. One of the biggest challenges is that the system is set up to meet the needs of those working within it and not those accessing it.

Considerations for the framework include: a Universal Precautions approach to build the health literacy of the whole population without stigmatising those with low health literacy; a strong focus on reducing inequities particularly for Māori; monitoring mechanisms to measure whether needs are being met; and, reorienting the health system to meet the needs of the population.

Communication

As with other dimensions there are pockets of good things happening but there is no coordinated approach to identifying information needs or sharing information in a way that improves health literacy. Most health information is written by health professionals, there is no systematic approach for assessing the readability of resources, and health practitioners have no specific tools or training to build communication skills.

Considerations for the framework include: having a coordinated approach to improving communication between health professionals and consumers with an emphasis on quality relationships; involving consumers in the development of health resources; and, think about how to improve the communication skills of both health professionals and consumers.

Access and navigation

There was not as much discussion about this dimension as there was about the others but the findings indicate there is a lack of coordinated and streamlined services and impacting on access and navigation for consumers.

Considerations for the framework include having more discussion about what this dimension means and how aspects of access and navigation are addressed across the other dimensions particularly leadership and management, and communication.

Overall, while there is considerable room for improvement across the six dimensions, HBDHB should feel optimistic about the future for health literacy as the commitment and approach to health literacy is a platform for real transformation.

Next steps

To become health literate requires a system-wide culture change to creating a joined up system, focused on wellness and patient/whānau centred care. This requires this work to be valued, planned for and resourced. The approach needs to be long-term and sustainable. Cultural safety and consumer feedback/voices are critical aspects of health literacy (Staff discussion group).

1. **Clarity on meaning**

The review found a great deal of confusion about the meaning of health literacy. This was evident in the international literature, national documents and the interviews and discussions with staff in the Hawke's Bay region. The first step in developing the framework for health literacy is to develop an agreed understanding of health literacy, including an agreed definition, scope and focus.

Based on the findings of this review we recommend the concept of health literacy should embrace:

- **A dual focus** - on creating both a health literate sector and an empowered and health literate population. The framework should consider both sides of the health literacy equation – the capacity of individuals and the demands placed on them (NAS, 2015). Health literacy goes beyond being able to read information and navigate to appointments it includes empowerment of individuals and whānau to improve their own health (WHO, 2013).
- **A partnership approach**—where individuals/whānau are partners alongside the health system and health professionals. Within the local context this includes ensuring that the framework is underpinned by mātauranga Māori (Māori knowledge). While the onus for improving health literacy should not be placed on the individual it is important that patients and whānau are partners in any changes to improve health literacy (WHO, 2013). Engagement with consumers and their families/whānau will be pivotal to understanding where the health system is creating health literacy barriers (HQSC, 2015).
- **A population health approach**—a definition of health that encompasses wellness, recognises the social determinants of health, and addresses current inequities. The framework for health literacy at the regional level needs to be consistent with the population health approach in Transform and Sustain (Health Hawke's Bay, 2014).

2. **Clarity on purpose**

Clarifying how health literacy is conceptualised will impact on the aligning and positioning of the 'health literacy' framework. A multi-faceted approach is needed which addresses information, systems, processes and relationships. In order to achieve health literacy as an outcome, other intended transformations outlined in Transform and Sustain need to occur, likewise achieving health literacy will support the achievement of the other intended transformations.

The second step is to decide how to position health literacy in relation to other overlapping but distinct areas in Transform and Sustain (the principles, goals, strategies and intentions).

A key theme from the interviews was the importance of embedding health literacy in a cross cutting way, as part of the shift to patient/whānau centred care. Aligning health literacy with the focus on creating a culture of patient/whānau centred care was seen as means of creating an enabling environment in which current communications and access barriers may be addressed. Health literacy needs to be integrated with other quality improvement initiatives such as patient engagement, patient experience and cultural competence (NAS, 2015).

3. Clarity on action

While there are considerable gaps in the evidence reviewed concerning which interventions are most effective in improving health literacy (D'Eath, Barry & Sixsmith, 2012) and a need to evaluate interventions for their effectiveness (Batterham, Buchbinder, Beauchamp et al, 2014) this review has identified areas that clearly need to be addressed under each of the six dimensions.

There are specific actions that could begin immediately for which there are tools/programmes available. These include workforce development, giving staff the skills to build health literacy using a universal precautions approach outlined in the HQSC resource *Three Steps to Health Literacy*. Another area is written resources, providing comprehensive policy and support for the development of health literate resources/material for patients.

Alongside these specific actions is the deeper issue of system and culture change. Of reorienting a sector and the professionals within it to develop and provide services based on the needs of the people they serve. And to do this in an integrated way empowering individuals and whānau make effective decisions for health and wellbeing. This level of transformation requires strong leadership, clear vision and accountability mechanisms at all levels. A systems based approach is needed, yet individuals within the system must be accountable in order to create change.

Introduction

Purpose of this review

This review was commissioned by Hawke's Bay District Health Board (HBDHB), on behalf of the sector. Quigley and Watts Ltd was commissioned to undertake a high-level strategic review of the health literacy strengths and weaknesses of the Hawke's Bay health sector and to provide findings and recommendations to inform the development of a framework and plan for health literacy within Hawke's Bay.

This review supports the key intention of transforming health promotion and health literacy as identified in the Hawke's Bay strategic direction for the health system, *Transform and Sustain* (2014-2017) (HBDHB, 2014).

Report content and structure

Information for this review was collected via six face to face group discussions, and eighteen telephone interviews with staff, a literature scan and document review. Group discussions included two groups open to all staff which were attended by 22 people, and discussions with the Executive Management Team, Māori Relationships Board, Consumer Council and Clinical Council.

Details of the data collection methodology are included in Appendix 1. The literature review to understand New Zealand and international frameworks for health literacy is included in Appendix 2.

The first section of this report is a discussion of overarching considerations which have arisen through the review process and can usefully inform the health literacy framework. This section includes discussion of critical conceptual and process issues to be considered in developing the framework. The second section focuses on issues raised in the literature, interviews and group discussions in relation to each of the six dimensions outlined in the Ministry of Health's *Health Literacy Review – A Guide* (Ministry of Health, 2015). Considerations to inform the development of an appropriate framework for improving the health literacy of the Hawke's Bay health sector and community are included under each dimension.

Limitations

The intention of the review was to focus on health literacy however it is clear from the literature, interviews and discussion groups that health literacy is one factor in a complex suite of things that need to change within the health system.

There is debate among health literacy experts internationally and confusion generally about the boundaries of health literacy. Contributing to this is a realisation that a focus on health literacy while necessary on its own will not be sufficient to create an equitable and sustainable health system.

Overarching considerations

Clarifying understandings of health literacy

A shared responsibility

As the concept of health literacy has evolved, it has shifted from poor health literacy being seen as an individual deficit to acknowledging the health system as a key enabler or barrier to health literacy (NAS, 2015). Rather than an either/or focus on health systems or individuals, health literacy is situated as the intersection between an individual's skills and abilities and the demands and complexity of the information and what is being asked of the individual. As illustrated by Parker (2009):

Source: Parker R. Measuring health literacy: what? So what? Now what? In Hernandez L, ed. *Measures of health literacy: workshop summary, Round-table on Health Literacy.* Washington, DC, National Academies Press, 2009:91–98.

A 2015 US National Academy of Science roundtable on the future of health literacy identified creating both a health-literate population and health-literate organisations as the opportunity the field should seize going forward (NAS, 2015). The final discussion of the National Academy of Science Roundtable on Health Literacy concluded, '*patients are the experts and the field must figure out how to partner with them'* (NAS, 2015).

Similarly, the Australian Commission on Safety and Quality in Health Care (2013) identifies that for consumers to contribute to a safe and high-quality health system, by making effective decisions and taking appropriate actions in relation to their health and health care, they need to have an adequate level of individual health literacy and the health literacy environment needs to support and empower them.

The shift in focus from health literacy being an individual responsibility to being one that is shared with the healthcare system is critical. While the onus for improving health literacy should not be placed on the individual it is important that consumers/whānau are partners in systems changes to improve health literacy (WHO, 2013). This requires dramatic change within the system as a whole and amongst those who make up the system.

> *Health literacy is about creating partnerships between clinicians and patients. Currently the balance is not right, the focus is on information giving not on engagement. The power imbalance is engrained, it will be a hard slog to get the systems and processes right and to change clinician behaviours* (Executive Management Team).

In moving to an understanding of health literacy as a shared responsibility, power imbalances between consumers and health professionals need to be understood and addressed. Critically in the local context, this requires a health literacy framework to be underpinned by mātauranga Māori (Māori knowledge) in order to reflect the basis of New Zealand's founding relationships and to ensure the framework addresses health inequities.

Situating health literacy in a population health context

The information gathered from all sources for this review highlights inconsistency in definitions and understandings of health literacy. Central to this is the definition and framing of health. Health can be viewed through the lens of health care which focuses primarily on the treatment and management of illness involving the interaction of individuals with the health system. Health can also be understood more broadly from a population health perspective as wellbeing (physical, emotional, mental and spiritual health) determined by many societal factors, mostly outside of the health system. A population health approach recognises the social determinants of health, and focuses on addressing inequities, building strong community/whānau connections, and empowering people to take control of, and improve, their own health. Central to this is understanding that many determinants of health are situated beyond the health sector (e.g. education, housing, income etc.) and responding to this by fostering collaborative cross-sectoral approaches to address social inequities which impact on health.

Importantly, the Hawke's Bay health sector, in its key strategic documents, recognises that the responsibility for health includes but extends beyond treatment to one of improving population health.

> *We need to work on better ways to support the community to stay well ….. this will mean all organisations need to work together with a focus on prevention, recognising that good health begins in the places where we live, learn, work and play, long before medical assistance is required* (Health Hawke's Bay, 2014).

The challenge, as identified in the sector's key strategic documents and the interviews, is to transform a system which is currently structured on understandings of health as healthcare and in which health literacy is in the main, understood to be a consumer deficit.

Defining health literacy

In addition to issues relating to the broader understanding of health literacy, the interviews highlighted that the specific term is problematic and contributes to misunderstanding. Many interviewees considered the term to be confusing jargon which leads to most health professionals focusing on the health literacy of consumers rather than the role they play as of health professionals in supporting health literacy. The word 'literacy' can also lead to a narrow focus on the reading and numeracy skills of individuals.

> *Health literacy goes beyond being able to read information and navigate to appointments it includes empowerment of individuals and whānau to improve their own health* (WHO, 2013).

Clearly defining health literacy was seen by interviewees as critical, along with ensuring the concept is understood sector-wide.

> *We are at the stage of defining the problem. All too often it is defined as 'How do we empower people out there to understand what's going on in here.' Rather than how do we empower people in here to understand what is going on out there. That is as big an issue* (Staff member).

At a framework level, a critical dimension of defining the concept of health literacy is an understanding of the systems barriers and broader transformation required. Health literacy needs to be understood in the context of not only of inequities in the determinants of health—the impacts of income, education, social capital, and living conditions on health literacy—but also the wider determinants of the health system which include: clinical expertise being valued over cultural competence, health literacy and EQ in health professionals training; the funding distribution within Vote Health (prioritisation of treatment over prevention); and, the relative value placed on health vs economic prosperity. Given this complexity, undertaking a structural analysis exercise[2] in order to aid understanding of this complex issue and support a strategic approach to systemic change could be a useful step for those involved in developing the health literacy framework.

Embedding health literacy

Clarifying how health literacy is conceptualised will impact on the aligning and positioning of the 'health literacy' framework. In order to achieve health literacy as an outcome, other intended transformations outlined in Transform and Sustain need to occur, likewise achieving health literacy will support the achievement of the other intended transformations.

A key theme from the interviews was the importance of embedding health literacy in a cross cutting way, as part of the shift to patient/whānau centred care. Aligning health literacy with the focus on creating a culture of patient/whānau centred care was seen as means of creating an enabling environment in which current communications and access barriers may be addressed. Health literacy needs to be integrated with other quality improvement initiatives such as patient engagement, patient experience and cultural competence (NAS, 2015). The alignment of health literacy with organisational values and existing strategies is discussed in more detail below under the dimension of leadership and management.

Developing the framework

Process

Developing a health literacy framework provides an opportunity to 'walk the talk.' The process of developing the framework is as critical as the content. As the Māori Relationship Board suggested:

> *A patient/whānau centred approach should be in creating the framework – it should be whānau drive* (Māori Relationships Board).

[2] See http://awea.org.nz/spaghetti-junction for an example of a structural analysis exercise which aids problem definition.

In addition, the framework itself should be an example of a health literate document – it needs to be simple, focused and accessible. This in itself is a challenge, as the discussion in this section illustrates, health literacy is complex yet by definition demands simplicity.

Measuring success

One of the challenges in developing a health literacy framework is determining how to measure success. While interviewees mentioned the importance of tangible targets as a driver for change, there was recognition that multiple factors that will contribute to any particular change; some of which may be able to be attributed to the health literacy initiative and others not.

There are considerable gaps in the evidence reviewed concerning which interventions are most effective in improving health literacy (D'Eath, Barry & Sixsmith, 2012). Interventions should be evaluated for their effectiveness and used to establish a community of learning for future work (Batterham, Buchbinder, Beauchamp et al, 2014). Creativity and innovation are central to health literacy initiatives and therefore evaluation needs to encourage rather than stifle innovation.

This suggests that a mix of tangible targets is needed at the intervention level alongside an overarching evaluation approach that recognises the complexity of health literacy, for example developmental evaluation.3

Based on the findings of the review there are a number of interventions that could be undertaken as building blocks for wider transformative change for example, workforce development using the HQSC *Three Steps to Health Literacy* and a policy and process for the development of health literate resources.

Framework structure

As outlined above, the framework for health literacy at the regional level needs to be consistent with the population health approach in Transform and Sustain (Health Hawke's Bay, 2014). Current New Zealand frameworks and tools designed specifically for health literacy are of limited usefulness to developing a sector-wide health literacy framework for the Hawke's Bay in that they do not fully reflect a population health approach or the shared responsibility for improving health literacy. For example, a key tool, the Ministry of Health's (2015) *Framework for Health Literacy* discusses how each part of the health system can contribute to building health literacy so individuals and whānau can obtain, process and understand health materials and access and navigate appropriate, quality and timely health services. While useful to the process of organisational change, this framework does not adequately reflect a transformative agenda in which individuals, whānau and communities are seen as central and are empowered to take control of, and improve their own health, through being active in the design and delivery of health systems, organisations and initiatives.

It is beyond the scope of this review to suggest a particular model for the framework, however the following two framework examples are provided as relevant examples to stimulate thinking.

He Korowai Oranga: The Māori Health Strategy

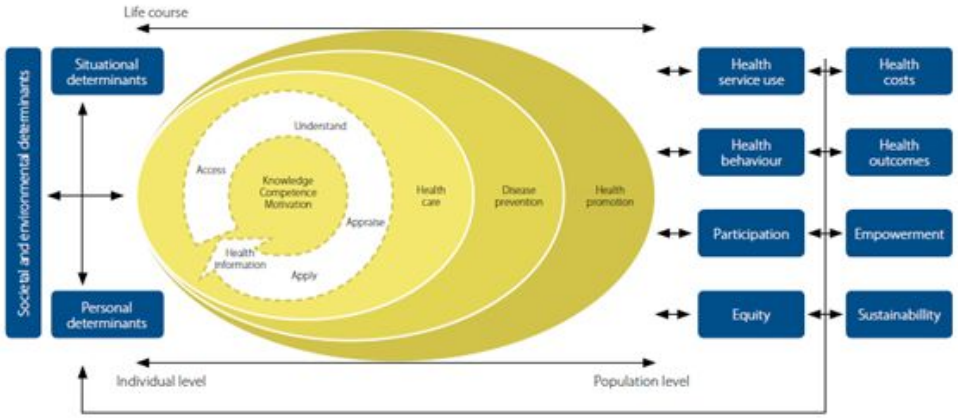
The overarching aim and three key elements of He Korowai Oranga: Māori Health Strategy (2014) provide a local, population health approach which aligns with the central tenets of health literacy and could usefully inform a health literacy framework for the Hawke's Bay.

Pae ora [healthy futures] is a holistic concept and includes three interconnected elements: mauri ora – healthy individuals; whānau ora – healthy families; and wai ora – healthy environments. All three elements of pae ora are interconnected and mutually reinforcing. (Ministry of Health, 2014)

Sorensen et al's integrated model

This international model from Sorensen et al (2012) depicts the continuum of population health from health care to health promotion. This model also recognises the personal and broader social determinants of health literacy and the situational determinants (barriers and enablers of health systems).

[3] See http://whatworks.org.nz/frameworks-approaches/developmental-evaluation/ for background.



Source: adapted from: Sørensen K et al. Health literacy and public health: a systematic review and integration of definitions and models. *BMC Public Health*, 2012, 12:80.

Summary

The discussion above suggests that the initial steps in development the framework are to clarify what the Hawke's Bay health sector means by health literacy and to determine the positioning of the framework in relation to other systems change intentions.

Within this work it is necessary to ensure the concept of health literacy embraces:

- A focus on creating both a health literate sector and an empowered and health literate population.
- A partnership approach—where individuals/whānau are partners alongside the health system and health professionals. Within the local context this includes ensuring that the framework is underpinned by mātauranga Māori (Māori knowledge).
- A population health approach—a definition of health that encompasses wellness, recognises the social determinants of health, and addresses current inequities.

Given the complexity of the task of creating a sector-wide health literacy framework, using existing models from related contexts to stimulate thinking and undertaking a structural analysis exercise in order to aid understanding of this complex issue and support a strategic approach to systemic change may be useful early steps for those involved in developing the health literacy framework.

Developing a health literacy framework provides an opportunity to 'walk the talk.' The process of developing the framework is as critical as the content.

> *We believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting* (HBDHB, 2014).

As the Māori Relationship Board suggested:

> *A patient/whānau centred approach should be in creating the framework – it should be whānau driven* (Māori Relationships Board).

A core component of framework development is grappling with how to measure success. A mix of tangible targets is needed at the intervention level alongside an overarching evaluation approach that recognises the complexity of health literacy.

Overall assessment - the six dimensions

The six dimensions of a health-literate organisation developed as part of *Health Literacy Review: A Guide* draw on international best practice. They were designed as a New Zealand framework for a health literacy review (Ministry of Health, 2015). The dimensions overlap in content and potential solutions and should be considered as an interdependent whole.

Leadership and management

Summary:

The leadership and management dimension assesses whether health literacy is an organisational value, part of the culture and core business of an organisation or service, and whether health literacy is reflected in strategic and operational plans.

Health literacy is a clear strategic priority for HBDHB with support from leadership and it is consistent with the values of HBDHB. Findings indicate a coordinated and thoughtful approach to developing health literacy at the strategic level thus far. As the emphasis has been on developing a strategic focus, health literacy is yet to flow into operational plans or coordinated organisational action. With the exception of Health Hawke's Bay where health literacy workforce development and initiatives for consumers have been developed action has yet to filter out to the wider health workforce. As expected at this stage of development, there is significant work required before health literacy is part of the core business of the sector but it is clear that HBDHB has, and should continue to have, a strong leadership role in this area.

Considerations for the framework include: ensuring HBDHB continues to lead health literacy work in collaboration with the rest of the sector; underpinning the framework by Māori principles; and, ensuring there is a multi-faceted, long-term approach to this work.

Sector strengths and weaknesses

Strategic health literacy focus evident in key documents

The findings highlight HBDHB's evolving interest in, and commitment towards, building health literacy and becoming a more health literate sector. A strategic focus on health literacy for the Hawke's Bay health system is signalled in Transform and Sustain (HBDHB, 2014) and in Mai: Māori Health Strategy 2014-2019 (2014).

The Māori Health Action Plan 2014/15 (HBDHB, Health Hawke's Bay and Ngati Kahungunu Iwi, 2014b) and the Pasifika Health Action Plan 2014-2018 (HBDHB and Health Hawke's Bay, 2014) both build on Transform and Sustain (HBDHB, 2014) and embed the sectors commitment to health literacy.

Health literacy was identified as one of three key strategic objectives for the sector at a strategic planning workshop of the HBDHB Board, Health Hawke's Bay Ltd Board and the Māori Relationship Board, and is to be an area of focus within the 2015/16 Annual Plan (Terms of Reference Health Literacy - Framework Establishment, HBDHB, 2015).

Health literacy is consistent with the values and key strategic documents of HBDHB

Health literacy is consistent with the values of HBDHB.

> *Health literacy is values in action e.g. he kauanuanu (showing respect), ākina (continuous improvement)* (Executive Management Team).

Findings indicate that health literacy needs to be tied to existing frameworks, strategies and concepts e.g. Triple Aim, patient-centred care, whānau ora.

A strong strategic platform developed to build other work off

Findings show that health literacy is supported at a leadership level and there have been some practical steps, at the strategic level, towards addressing it. The document review revealed that the Alliance Leadership Team established the Health Literacy Leadership Group in July 2015 to develop a coordinated and collaborative approach, structure, framework, principles and communications strategy for addressing health literacy issues in Hawke's Bay. The Health Literacy Leadership Group put forward a detailed business case for this work on health literacy and funds were secured at the end of September 2015 (Health Hawke's Bay, 2015). A number of strategic development projects have been undertaken including a review of health literacy and health promotion capability (Quigley and Watts, 2014) and a health literacy information paper (Foote, 2015).

As the emphasis has been on developing a strategic focus, health literacy is yet to flow into operational plans or coordinated organisational action and filter out to the wider health workforce, with the exception of Health Hawke's Bay where health literacy workforce development and initiatives for consumers have been developed.

Barriers and opportunities for improvement

HBDHB needs to lead the work on health literacy

Findings from interviews and groups supported a leadership role for HBDHB in collaboration with the wider sector. HBDHB also needs to lead by example and embed health literacy into the DHB first ensuring that health practitioners understand their role in improving health literacy (more about this under the 'workforce' dimension).

Underpin the framework with Māori principles

The Māori Relationship Board and some interviewees felt strongly that in order for the framework to be successful, it needs to be underpinned and driven by Māori principles – tikanga and kawa – rather than Māori perspectives being reflected in the strategy.

A multi-faceted, long-term approach is needed

Health literacy will not be 'fixed' quickly and the long-term nature of this work needs to be highlighted. This work should not be viewed as another project but a long term approach that is sustainable over time.

The approach needs to be multi-faceted addressing information, systems, processes and relationships relating to health literacy.

Consider health literacy within the bigger issue of reorienting the health system

Creating the necessary system-wide culture change focused on wellness and patient/whānau centred care was thought to be essential but a key challenge. A key finding is that currently 'the system is set up for the system' and works for health practitioners but not necessarily for consumers. Sector culture change is required turning services around to meet customers' needs. Health literacy is only one component of this bigger issue.

> *Health literacy is a part of a bigger culture change – the move to patient/whānau centred care. A whole raft of things needs to change to make that shift from how the sector has delivered services for years…… health literacy is only one part of the puzzle, working out how to piece it together is critical* (EMT).
>
> *Health literacy issues will continue to exist until the structure changes. We have to invest money in changing the structure and supporting patient centred care. We're focused on sickness and not on wellness. Culture change is needed to create a joined up system with a wellness focus* (Staff Discussion Group).
>
> *Health literacy is a fundamental challenge to how we deliver services as we are very clinic based. There are power imbalances in the system. Approach needs to come from the top, be visible and observable, and align with organisational values* (Staff Discussion Group).

Consumer Involvement

Summary:

The consumer involvement dimension assesses how consumers are involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery.

Overall, there is a currently limited consumer involvement in health literacy work or in the strategic direction of the Hawke's Bay health system more broadly. The Consumer Council is an important step in the right direction however it is just one facet of the collaboration with consumers required for health literacy improvement. Internationally, health literacy experts acknowledge that real progress in health literacy will be limited without true collaboration with consumers, which to date has been lacking.

Considerations for the framework include: partnering with consumers in the development of the framework; importance of a patient/whānau-centred approach and the opportunities of co-design as a framework for involving consumers in service design and delivery.

Sector strengths and weaknesses

There is limited consumer involvement in designing, developing and evaluating the organisation's values, vision, structure and service delivery

The findings indicate there is limited consumer involvement in the Hawke's Bay health system at present. Most of the discussion around consumer involvement centred on consumers interactions with the health system and health professionals. Much of this discussion was focused on what is currently not working well e.g. lack of communication with consumers (this is discussed in more detail below under the 'communications' dimension). The Consumer Council discussed the paradigm shift required suggesting the real change needed was consumer literate health professionals rather than health literate consumers.

> *We need focus on consumer experience of the system and the attributes of the people they are communicating with in the system. There are a lot of changes needed* (Consumer Council).

Internationally, health literacy experts acknowledge that real progress in health literacy will be limited without true collaboration with consumers, which to date has been lacking (NAS, 2015).

The Consumer Council is a positive step forwards

While there is still a way to go to really involve consumers, the Consumer Council is an important step in the right direction.

> *It is big step forward having the Consumers Council. I feel we've been listened to. The journey is well and truly underway. It is evolving* (Consumer Council).

The varying levels of consumer involvement were discussed as this quote from a staff member highlights:

> *Consumer involvement is so much more than the Consumer Council although that is a good start. We need to think about the community taking ownership of this framework* (Staff member).

Barriers and opportunities for improvement

Partner with consumers in the development of the framework

Many of the issues identified by participants about what is not currently working in the system will not be solved without genuine partnerships and collaboration with consumers. In a partnership approach for the development of the framework, the needs of both the service and the user can be explored, joint solutions (that a service may never think of) can be suggested, and ownership, empowerment and improving health literacy on both sides can occur. Aside from the Māori Relationship Board and the Consumer Council, there was limited discussion about involving consumers in the design of the sector or the framework.

Importance of a patient/whānau-centred approach

The Māori Relationship Board emphasised that a patient/whānau-centred approach needs to be used in creating the framework and that approach should be driven by whānau to increase ownership of the process and the outcome.

> *The system should be designed around whānau taking ownership around this initiative* (Māori Relationship Board).

Co-design a useful framework for involving consumers in service design and delivery

Within a health context, co-design (also known as experience-based design or co-production) is a method of designing better experiences for patients, carers and staff. It involves patients and staff exploring the care pathway and the emotional journey patients experience along it, capturing experiences then working together to understand these experiences and improve them (Boyd, McKernon, Mullin and Old, 2012).

Workforce

Summary:

The workforce dimension assesses how the organisation encourages and supports the health workforce to develop effective health literacy practices, whether it has identified the workforce's needs for health literacy development and capacity, and whether the organisation's health literacy performance has been evaluated.

There has been no coordinated approach to workforce development in health literacy. The focus of HBDHB has been at the strategic level thus far. There are significant workforce development needs a notable exception is Health Hawke's Bay which is in the process of undertaking workforce development for staff in primary care. While there is generally the will to upskill in this area, a key challenge will be getting all staff to see it as a priority.

Considerations for the framework include: making workforce development a priority; making health literacy as much of a priority as clinical work; creating an enabling system to support workforce change and, increasing the Māori and Pasifika workforce.

Sector strengths and weaknesses

No coordinated approach to improving the health literacy of HBDHB's health workforce yet

There has been no coordinated approach to improving the health literacy of the workforce yet which is no surprise given the focus of the HBDHB has been at the strategic level thus far. This means that overall, there has been little encouragement and support for the health workforce to develop effective health literacy practices, no identification of the workforces needs for health literacy development and capacity, and no evaluation of health literacy performance.

In the absence of a coordinated approach inconsistent understandings of health literacy exist. While some health professionals have a broad understanding of health literacy, many comments reflected a narrow understanding of health literacy e.g. the need to educate patients rather than looking at the systems in place that impact on a patient's ability to understand the information being imparted to them. Similarly, this has impacted health literacy practice; while there were pockets of good health literacy work happening, some of it was confused with health education i.e. focusing on distributing pamphlets to patients.

Health Hawke's Bay is taking a coordinated workforce development approach

Health Hawke's Bay is a notable exception in health literacy workforce development having undertaken a thorough review of health literacy workforce needs in 2015. A two-tier training programme for PHO staff has been developed based on the needs identified in the review. It was noted by an interviewee that the rest of the sector can learn a lot from the work of the PHO.

Barriers and opportunities for improvement

Workforce development needs to be a priority within the framework/plan for health literacy

Workforce development is required to ensure understanding of the concept of health literacy and the benefits of engaging with health literacy. The staff group discussions highlighted that workforce development needs to focus on empathy, communication, understanding consumer experiences, cultural competency and feedback processes.

> *It is hard to change practice as health professional until you are given feedback. We need an environment of feedback that allows people to change* (Staff member).

Staff identified the following areas as important for workforce development:

- the meaning of health literacy to create a shared understanding
- the consumer/whānau and health practitioner relationship

- how to communicate more effectively with consumers (including culturally appropriate communication)
- resources/pathways that are available for consumers

Getting all staff on board could be challenging

While there is a way to go in terms of upskilling staff about health literacy, staff involved in this review were very positive about health literacy, this review and the framework. They supported the DHB's role in workforce development, taking the onus off educating patients and whānau. Many of those working 'on the ground' were keen to increase their health literacy knowledge and were passionate about helping increase their patients' understanding of their own health and wellbeing. They did note though that it would be more challenging to engage some of their colleagues who may not see it as a priority.

Make health literacy as much of a priority as other aspects of clinical work

Increased knowledge and skills in health literacy will assist staff in their work and could help them to see it as a priority. However, it also needs to be given priority by HBDHB. To ensure effective workforce development, changes need to be made to give health literacy and cultural competency equal value to clinical training.

> *Health professionals' training does not support health literacy related issues or cultural practice the same way it does clinical practice. Both need to be on same level and given same priority as you can't have one without the other* (Staff member).

Support workforce development with a system that values and enables change

A consistent theme at both staff groups was that health literacy workforce development cannot happen in isolation and needs to be supported by system changes that allow better communication with patients e.g. more time for appointments, health literacy champions, and access to appropriate resources, information, services and support. Adequate funding for all the components was mentioned as being important.

Increase the Māori and Pasifika workforce

Several participants talked about the need to increase the Māori and Pasifika workforce to fully meet the needs of the population (more about this under the 'meeting the needs of the population' dimension).

Meeting the needs of the population

Summary:

Meeting the needs of the population dimension assesses how service delivery ensures that consumers with low health literacy are able to participate effectively in their care and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy). This dimension also assesses how meeting the needs of the population is monitored.

There is a strategic intent to address inequities however the health system is currently unlikely to be meeting the needs of consumers with low health literacy. There is no coordinated approach to identifying health literacy need, addressing it and then monitoring whether those needs are being met. One of the biggest challenges is that the system is set up to meet the needs of those working within it and not those accessing it.

Less than 50% of adult New Zealanders have adequate health literacy. Low health literacy contributes significantly to health disparities for Māori and Pacific peoples. Four out of five Māori males and three out of four Māori females have poor health literacy skills (Ministry of Health, 2010). The health system is complex and everyone struggles with it at some point even those with good health literacy.

Considerations for the framework include: a Universal Precautions approach to build the health literacy of the whole population without stigmatising those with low health literacy; a strong focus on reducing inequities particularly for Māori; monitoring mechanisms to measure whether needs are being met; and, reorienting the health system to meet the needs of the population.

Sector strengths and weaknesses

Strategic intent to address inequities but no coordinated approach across services

Findings show there is intent at the strategic level to address inequities - this is set out in key documents and was highlighted by many participants. However, there is no coordinated approach across services to identify needs, address them and monitor whether those needs are being met. This coupled with health literacy systems barriers means that, as the system currently stands overall, consumers with low health literacy are unlikely to bet able to participate effectively in their care. As noted above, there are pockets of good things happening and some services may meet needs better than others but there is no coordinated approach across services to meet these needs.

The system is currently set up to meet the needs of those working within it not those accessing it

One of the biggest challenges is that the health system is not consumer focused and is set up to meet the needs of those working within it rather than those accessing it e.g. appointments are based on a fixed length rather than on patients' needs. Time was a key barrier mentioned by both consumers and health professionals.

> *If a GP is explaining things adequately then they are the ones you end up waiting to see as they take more time with their patients. Time equals money – need time and money to improve health literacy* (Consumer Council).

Transform and Sustain (2014) acknowledges *the current systems do not effectively reward health providers for being responsive to patient needs or for delivering high-quality care. In addition, health organisations often appear to work around the needs of the organisation rather than the needs of the population.*

Everyone experiences poor health literacy at some point

Less than half of all adults in New Zealand have the basic health literacy skills to cope with everyday demands of life and work let alone understand complex medical conditions. This means not being able to do things like read labels on medicines or workout how much medicine to give a child. Eighty per cent of Māori males and 75 per cent of Māori females have poor health literacy skills (Ministry of Health, 2010).

People with low health literacy are more likely to have ongoing difficulties in making informed health decisions, but even people with good health literacy skills can also find it difficult to understand health care information. This is especially true when a person is first diagnosed with an illness or is unwell or stressed. The Institute of Medicine report (2004) concluded that even highly skilled individuals may find the systems too complicated to understand, especially when these individuals are made more vulnerable by poor health. This was supported by participants views, even health professionals that work in the system, can experience low health literacy not just those who are most at risk.

Barriers and opportunities for improvement

Build health literacy using a Universal Precautions approach

Rather than assessing individual patient's health literacy, many experts recommend that health professionals assume that all patients experience some degree of difficulty when in health environments and therefore apply the principle of Universal Precautions to health literacy (similar to the approach for preventing blood-borne diseases). Taking a Universal Precautions approach to health literacy involves finding out what patients already know, sharing clear information with patients and helping patients build their understanding of how their body works, their health issues and associated treatment (DeWalt, Callahan, Hawk, Broucksou et al, 2010).

This type of approach does not label or stigmatise those with low health literacy as it assumes everyone may have difficulty understanding. This dimension links strongly to the workforce dimension.

Focus on reducing inequities particularly for Māori

Low health literacy contributes significantly to health disparities for Māori and Pacific peoples. Four out of five Māori males and three out of four Māori females have poor health literacy skills (Ministry of Health, 2010). The literature indicates health literacy is a key strategy to reduce inequities. Culturally appropriate approaches such as whānau ora need to be used, and systems and services need to be accessible and appropriate for specific communities.

Create monitoring to measure whether needs are being met

It is clear that there needs to be a strong monitoring component in the framework. Levels of 'do not attends' and consumer complaints were suggested as potential measures. While useful these indicators may not specifically measure health literacy. There is also the wider question of meeting the needs of those not currently accessing health services.

Reorient the health system so it is consumer focused

This would be a fundamental change to the health system however many participants mentioned the Nuka model of care in Alaska that is designed around and owned by the 'customer'. Given that HBDHB has already invested in upskilling some staff about this model, there are opportunities to further develop knowledge in this area.

Access and navigation

Summary:

The access and navigation dimension assesses how easy it is for consumers to find and engage with appropriate and timely health-related services, and how well these services are coordinated and streamlined.

There was not as much discussion about this dimension as there was about the others but the findings indicate there is a lack of coordinated and streamlined services and impacting on access and navigation for consumers.

Considerations for the framework include having more discussion about what this dimension means and how aspects of access and navigation are addressed across the other dimensions particularly leadership and management, and communication.

Sector strengths and weaknesses

Integrated services for seamless service delivery

The need for better transitions between parts of the system was mentioned by many participants. Methods of communication with consumers and transitions between parts of the system were highlighted as areas for improvement. This included the relationship between the health professional and the patient, as well as getting into the system in the first place e.g. appointment letters can be difficult to understand. It was thought that pockets of the system have good communication processes but transitioning between parts of the system, with variable quality processes, meant that some patients 'dropped off'. This relates strongly to the communication dimension.

> *There is a lack of continuum of care for patients – no collaboration with other services. Services need to be connected to help with patient care* (Consumer Council).

Improve physical access

Interviewees discussed physical and coordination aspects that could be improved e.g. visible signage and prompts in different languages; consumers and whānau knowing where to park and what part of the hospital they need to visit to access services on time.

Barriers and opportunities for improvement

Allow for further discussion

This dimension relates strongly to all of the other dimensions and is somewhat difficult to separate out. For instance, the concepts of seamless service delivery and transitions between services need to be led at a management and leadership level as they relate to the structure of the organisation. The physical aspects of access do need to be addressed and these strongly relate to the communication dimension. More discussion is required around this dimension and what it means for the framework.

Communication

Summary:

The communication dimension assesses how information needs are identified, how information is shared with consumers in ways that improve health literacy, and how information is developed with consumers and evaluated.

As with other dimensions there are pockets of good things happening but there is no coordinated approach to identifying information needs or sharing information in a way that improves health literacy. Most of the health information is written by health professionals, there is no systematic approach for assessing the readability of resources, and health practitioners have no specific tools or training to build communication skills.

Considerations for the framework include: having a coordinated approach to improving communication between health professionals and consumers with an emphasis on quality relationships; involve consumers in the development of health resources; and, think about how to improve the communication skills of both health professionals and consumers.

Sector strengths and weaknesses

No coordinated approach to identifying information needs – for consumers and staff

The review found no coordinated approach to identifying consumer information needs or staff information needs. Some staff talked about the lack of resources in a range of formats for them to use with their patients, which they felt limited their ability to impart all of the information required. While some staff talked at length about education resources, few talked about the need to involve consumers in the resource development process or to ask consumers about their information needs. This reflects more of an education approach rather than a partnership approach, situating the health professional as the teacher and the consumer as the student.

> *Health literacy is about creating partnerships between clinicians and patients. Currently the balance is not right, the focus is on information giving not on engagement. The power imbalance is*

> *engrained, it will be a hard slog to get the systems and processes right and to change clinician behaviours* (Executive Management Team).

Most health information is written by health professionals with no consumer involvement

Most of the health information was reported to be written by health professionals. Currently there is no requirement for consumers to be involved in the design or evaluation of information or resources. Health professionals were reported to assume a level of understanding that some of their colleagues even found difficult to comprehend.

> *Health professionals use a lot of terminology and we don't ask patients what they understand* (Clinical Council).

No systematic approach for assessing the readability of resources

While some communication staff use an assessment tool to check the readability of some resources, there is no requirement for this to happen with all resources so it happens on an ad hoc basis with no coordination within or across services.

Health practitioners generally communicate poorly with consumers

The poor communication between health professionals and consumers was a common theme in the review and identified as a key barrier to improving health literacy. The review findings highlight a lack of training, skills and tools available to support health professionals to improve their communication.

> *'A lot of health professionals are not as literate as we think we are. We are very bad at communicating with patients and should be better'* (Clinical Council).

Barriers and opportunities for improvement

A coordinated approach to improving communication between health professionals and consumers with an emphasis on quality relationships

Communication comes in all forms and while written resources are an important component, relationships are critical. Face-to-face communication was emphasised by the Māori Relationship Board especially for Māori, and communicating in ways the consumer will identify with and understand.

> *Come down to whānau level and talk the basics…it's a snotty nose…how hard is it to say that he's got a 'snotty nose'* (Staff member).

Components of effective communication to consider are:

- use clear, plain language that reflects the audience's own common language
- use a range of mediums e.g. face-to-face discussions, DVDs or online video
- use visual prompts to explain complex issues

Rauemi Atawhai: A guide to developing health education resources in New Zealand has some good advice for developing written resources (Ministry of Health, 2012).

Involve consumers in the development of health resources

It is important to involve a range of consumers in the development of health resources to ensure they are being communicated with in ways that are understandable and resonate with them. This links to the 'consumer involvement' dimension above.

Skills to improve communication are needed on both sides for consumers and health professionals

Communication is a two-way thing and consumers need to communicate in ways health professionals can understand as well. Ultimately though, the responsibility to ensure patient understands information should lie with the health professional. Health professionals need access to appropriate tools to aid their communication with consumers. On a practical level the Health Quality and Safety Commission's *Three Steps to Better Health Literacy* – is a useful tool. The three steps are to find out what people know, build people's health literacy knowledge and skills to meet their needs, and then check for understanding and clarity.

The Health Quality and Safety Commission's *Let's PLAN for better care* health literacy tool encourages people to plan ahead for visits to their GP or other health care professional and to ask questions when there so they fully understand their diagnosis and treatment. *Let's PLAN* is being used by the Ministry of Social Development's Work and Income case managers in Hawke's Bay to help their clients make the most of their visits to their GP and other health services.

Next Steps

To become health literate requires a system-wide culture change to creating a joined up system, focused on wellness and patient/whānau centred care. This requires this work to be valued, planned for and resourced. The approach needs to be long-term and sustainable. Cultural safety and consumer feedback/voices are critical aspects of health literacy (Staff discussion group).

1. Clarity on meaning

The review found a great deal of confusion about the meaning of health literacy. This was evident in the international literature, national documents and the interviews and discussions with staff in the Hawke's Bay region. The first step in developing the framework for health literacy is to develop an agreed understanding of health literacy, including an agreed definition, scope and focus.

Based on the findings of this review we recommend the concept of health literacy should embrace:

- **A dual focus** - on creating both a health literate sector and an empowered and health literate population. The framework should consider both sides of the health literacy equation – the capacity of individuals and the demands placed on them (NAS, 2015). Health literacy goes beyond being able to read information and navigate to appointments it includes empowerment of individuals and whānau to improve their own health (WHO, 2013).
- **A partnership approach**—where individuals/whānau are partners alongside the health system and health professionals. Within the local context this includes ensuring that the framework is underpinned by mātauranga Māori (Māori knowledge). While the onus for improving health literacy should not be placed on the individual it is important that patients and whānau are partners in any changes to improve health literacy (WHO, 2013). Engagement with consumers and their families/whānau will be pivotal to understanding where the health system is creating health literacy barriers (HQSC, 2015).
- **A population health approach**—a definition of health that encompasses wellness, recognises the social determinants of health, and addresses current inequities. The framework for health literacy at the regional level needs to be consistent with the population health approach in Transform and Sustain (Health Hawke's Bay, 2014).

2. Clarity on purpose

Clarifying how health literacy is conceptualised will impact on the aligning and positioning of the 'health literacy' framework. A multi-faceted approach is needed which addresses information, systems, processes and relationships. In order to achieve health literacy as an outcome, other intended transformations outlined in Transform and Sustain need to occur, likewise achieving health literacy will support the achievement of the other intended transformations.

The second step is to decide how to position health literacy in relation to other overlapping but distinct areas in Transform and Sustain (the principles, goals, strategies and intentions).

A key theme from the interviews was the importance of embedding health literacy in a cross cutting way, as part of the shift to patient/whānau centred care. Aligning health literacy with the focus on creating a culture of patient/whānau centred care was seen as means of creating an enabling environment in which current communications and access barriers may be addressed. Health literacy needs to be integrated with other quality improvement initiatives such as patient engagement, patient experience and cultural competence (NAS, 2015).

3. Clarity on action

While there are considerable gaps in the evidence reviewed concerning which interventions are most effective in improving health literacy (D'Eath, Barry & Sixsmith, 2012) and a need to evaluate interventions for their effectiveness (Batterham, Buchbinder, Beauchamp et al, 2014) this review has identified areas that clearly need to be addressed under each of the six dimensions.

There are specific actions that could begin immediately for which there are tools/programmes available. These include workforce development, giving staff the skills to build health literacy using a universal precautions approach outlined in the HQSC resource *Three Steps to Health Literacy*. Another area is written resources, providing comprehensive policy and support for the development of health literate resources/material for patients.

Alongside these specific actions is the deeper issue of system and culture change. Of reorienting a sector and the professionals within it to develop and provide services based on the needs of the people they serve. And to do this in an integrated way empowering individuals and whānau make effective decisions for health and wellbeing. This level of transformation requires strong leadership, clear vision and accountability mechanisms at all levels. A systems based approach is needed, yet individuals within the system must be accountable in order to create change.

Appendix 1: Data collection methods

Literature Review
A brief literature review was undertaken to inform the development of a regional framework for health literacy for the Hawke's Bay region. The review focuses on identifying and assessing key tools and frameworks for health literacy.

The review is not systematic or comprehensive it is intended to be practical and help guide the next phases of the work for the framework. The selection of literature was based on seminal documents and reviews in health literacy along with the reviewer's knowledge of the literature.

The key research questions for the review were:

1. What health literacy frameworks exist that inform a strategic approach to improving health literacy at a regional level?
2. What tools are currently available to assess and build organisational health literacy particularly from a regional perspective?

Document Review
Documents are an important source of information about how an organisation positions and delivers on health literacy in terms of its infrastructure, policies, systems, processes, information and communications. The purpose of this high-level document review was to identify the DHB's commitment to health literacy and look at whether health literacy has been operationalised throughout the DHB and the processes through which that has happened. This was not an audit of all DHB documents, instead, the focus was on mapping out the DHB's approach to addressing health literacy through reviewing documents that explicitly referred to health literacy. This was an information gathering exercise to look at how all of the documents/information linked up rather than an assessment as such.

The document review aimed to answer the following questions:

1. How is health literacy guided and operationalised within the DHB? E.g. Is there any direction that flows through the funding on HL? Is it coordinated or random? Anything in the area of workforce? Workforce training? Communication?
2. What documents around infrastructure, policies, systems, processes, information and communications are in place within the DHB that address and support health literacy? Is there a consumer panel that all the resources go through?

The documents were located through key contacts at the DHB as well as a Google search. Two types of documents were collected and analysed:

1. Key organisational documents, which explicitly referred to health literacy.
2. Specific consumer-facing documents HBDHB had redeveloped/redesigned to be more health literate.

Key documents:

- Transform and Sustain: the next five years (Hawke's Bay DHB, 2013)
- Mai: Māori Health Strategy 2014-2019 (HBDHB, 2014)
- Māori Health Action Plan 2014/15 (HBDHB, Health Hawke's Bay and Ngati Kahungunu Iwi, 2014)
- Improving the Health of Pacific People in Hawke's Bay: Pasifika Health Action Plan 2014-2018 (HBDHB and Health Hawke's Bay, 2014)
- Hawke's Bay Health Consumer Council Annual Plan 2014/15 (Consumer Council, 2014)
- Health Promotion and Health Literacy Capability Report (Quigley and Watts, 2014)
- Health Literacy Information Paper – what does it mean and what can be done? (Foote, 2015)
- Health Literacy Update (Foote, 2015)
- Bay DHB Position Profile: Health Literacy Advisor (HBDHB, 2015)
- Terms of Reference - Health Literacy Framework Establishment (Health Hawke's Bay, 2015)
- Health Literacy Needs Assessment (Quigley and Watts Ltd, 2015)
- Patient-Client Information and Education Policy (Hawke's Bay DHB, 2008)

Interviews

Interviewees were in a range of clinical and non-clinical roles throughout the DHB and the broader health sector. They included those in senior management, clinical team leaders, iwi executives, practice managers, practice nurses, midwife, general practitioners, cultural navigators and kaitakawaenga, public health physician, publications advisors, and coordinators in particular areas of health and wellbeing e.g. breastfeeding. Many interviewees had multiple roles. In total, 12 interviewees were directly employed by the DHB and 6 interviewees were employed by service providers.

The HBDHB sent out an email informing interviewees about the project and giving them advance notice that they may be contacted for an interview. Interviewees were then contacted by email and a follow up phone call if necessary where they were asked to participate in 30 minute phone interview. They were informed that:

- they could stop the interview at any time
- the interview would be recorded for note-taking purposes
- their name would not be used in the report but their role may be referred to so anonymity could not be guaranteed
- they would be provided with the interview questions prior to the interview
- they would have access to the final report

Group meetings

Half hour group meetings were undertaken with the following groups:

- Executive Management Team
- Clinical Council
- Māori Relationship Board
- Consumer Council

These groups were emailed the questions prior to the discussion and the groups were recorded for note-taking purposes. In order to capture the views of other DHB staff interested in health literacy, an email was sent out to all staff inviting them to attend one of two group meetings which were attended by 22 people in various roles throughout the hospital. Prior to the discussions, the project was introduced and participants were informed that the discussion would be recorded for note-taking purposes, their name would not be used in the report but their role may be referred to so anonymity could not be guaranteed, and they would have access to the final report.

Appendix 2: Literature review

LITERATURE REVIEW TO INFORM THE DEVELOPMENT OF A REGIONAL FRAMEWORK FOR HEALTH LITERACY

Introduction

This brief literature review was undertaken to inform the development of a regional framework for health literacy for the Hawke's Bay region. The review focuses on identifying and assessing key tools and frameworks for health literacy.

The review is not systematic or comprehensive it is intended to be practical and help guide the next phases of the work for the framework. The selection of literature was based on seminal documents and reviews in health literacy along with the reviewer's knowledge of the literature.

The key research questions for the review were:

3. What health literacy frameworks exist that inform a strategic approach to improving health literacy at a regional level?
4. What tools are currently available to assess and build organisational health literacy particularly from a regional perspective?

Background

In New Zealand, health literacy has been defined as 'the capacity to obtain, process and understand basic health information and services in order to make informed and appropriate health decisions' (Ministry of Health 2010). In this definition the focus is most obviously on consumer capability. However, internationally support is growing for a stronger focus on how health systems, health care providers and practitioners can support consumers to access and understand health services (Ministry of Health, 2015).

Definitions for health literacy vary internationally and there is no unanimously accepted definition of the concept or its constituent dimensions (Sorensen et al 2012). The World Health Organization definition of health literacy identifies *capacity* as 'the social and cognitive skills which determine motivation and ability' (ref).

Sorensen et al 2012 argue making informed and appropriate health decisions' requires the ability to put information into context, understanding which factors are influencing it, and knowing how to address them. This requires the simultaneous use of a complex and interconnected set of abilities, such as reading and acting upon written health information, communicating needs to health professionals, and understanding health instructions (Sorensen et al, 2012).

Health literacy is also dynamic requiring an individual to continuously learn new information and discard what is out of date or no longer relevant. An individual's health literacy may also change over their life course as their skills set becomes subject to different information processing demands. To reflect this, a recent Canadian Expert Panel adopted the following definition of health literacy:

The ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course (D'Eath, Barry & Sixsmith, 2012).

As the concept of health literacy has evolved it has shifted from seeing poor health literacy as an individual deficit to acknowledging the health system as key enabler or barrier to health literacy. Systemic issues exist across New Zealand's healthcare system. In many cases the system is primarily organised to meet the needs of the system not the user. For consumers to contribute to a safe and high-quality health system by making effective decisions and taking appropriate actions in relation to their health and health care, they need to have an adequate level of individual health literacy and the health literacy environment needs to support and empower them. This means that responsibility for addressing health literacy rests with policy makers, healthcare providers and consumers (Australian Commission on Safety and Quality in Health Care, 2013).

This fits with the concept of health literacy as a shared responsibility between consumers and health professionals (within the overarching system). Acknowledging the important role health professionals play in communicating effectively and supporting the development of patient's health literacy.

There is now a growing focus on the demands health services and systems place on people using them. A new understanding has emerged that patients and health professionals cannot address health literacy needs independently. Healthcare services and systems need to support health professionals to build patient health literacy by reducing the demands placed on patients and by supporting health professionals to communicate more effectively with patients (Lambert, Luke, Downey et al, 2014).

The relationship between people as citizens, consumers or as patients with the institutions that affect their health is significantly influenced by two interacting factors: their levels of health literacy and the willingness of such institutions to recognize diversity and share or give power for more equal, inclusive and accountable relationships. A high level of health literacy allows for an expansion of decisions and actions through control over resources and decisions that affect one's life (WHO, 2013).

Evidence internationally and in New Zealand shows:

1. Navigating increasingly complex health care systems is a major challenge for patients and their families.
2. Patients face multiple literacy requirements and increasingly difficult decisions.
3. Health information materials are often poorly written and literacy demands are excessive.
4. Health providers' written and spoken communication has insufficient clarity and quality.
5. New "business" models can create new obstacles.
6. Health literacy affects the use of health services (WHO, 2013).

Becoming a health-literate organisation is a long-term commitment. Leaders of health-literate organisations make health literacy a priority and integrate health literacy in all aspects of service planning, design, delivery and performance evaluation.

Health-literate organisations:

- redesign systems, processes and services to remove barriers to consumer access
- address communication problems that exist at all stages of the patient journey – such as confusing treatment pathways and jargon-filled discussions with health practitioners
- make health literacy everyone's business, including leaders, managers, clinical and non-clinical staff
- take an active role in building health literacy with consumers in order that consumers can better manage their health and achieve improved health outcomes
- take into account that consumers, who might usually have good health literacy, will have less health literacy knowledge and fewer health literacy skills when they are unwell or receive a new diagnosis
- support operational staff to use health literacy approaches and strategies.

Some definitions for health literacy have explicitly included a population health approach arguably widening the remit for health literacy. For example the definition developed by the European Health Literacy Consortium in 2012 (WHO, 2013):

Health literacy is linked to literacy and entails people's knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgements and take decisions in every-day life concerning health care, disease prevention and health promotion to maintain or improve quality of life during the life course.

Realising the goals in *Transform and Sustain* of keeping the general population well and healthy, enabling those with complex conditions to live well and supporting older people at the end of their lives will require a transformational change to the 'health system' (Watts, Murphy & Quigley, 2014).

Health literacy as a determinant of health is closely related to other social determinants of health such as general literacy, education, income and culture (WHO, 2013).

One of the challenges of this work will be the scope. At one end of the spectrum the DHBs role in health literacy can be seen as primarily as an access issue to treatment (access to information and access to services) at the other end of the spectrum is a population health approach, including treatment but extending to staying well and disease prevention. A population health approach to health literacy would place the DHB as a partner with individuals, whānau and communities to strengthen people's ability to take responsibility for their own health as well as their family health and community health.

Context

This work will support Hawke's Bay strategic direction for the health system *Transform and Sustain* (2014-2017) (Hawke's Bay District Health Board, 2013). *Transform and Sustain* guides service planning and development.

Transform and Sustain outlines three main challenges:

- *Responding to our population: We believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting, and we need to have a stronger engagement with consumers and their families/whānau.*
- *Delivering consistent high-quality health care: The best quality care is appropriate, convenient and precise – the patient gets exactly what they need, delivered as soon as possible without error or undue waiting.*
- *Being more efficient at what we do: Reducing waste in health will make us more efficient and ensure we get the best value from health care resources by delivering the right care to the right people in the right place, the first time.*

The strategy acknowledges "*the current systems do not effectively reward health providers for being responsive to patient needs or for delivering high-quality care. In addition, health organisations often appear to work around the needs of the organisation rather than the needs of the population.*"

The DHB's responsibility for health includes but extends beyond medical treatment to one of improving population health.

We need to work on better ways to support the community to stay well ….. this will mean all organisations need to work together with a focus on prevention, recognising that good health begins in the places where we live, learn, work and play, long before medical assistance is required (Health Hawke's Bay, 2014).

A population health approach to health literacy requires a partnership with the people of Hawke's Bay.

Transform and Sustain recognises the need for a broad definition and framework for health literacy*:*

Improved health literacy is needed so that people can actively participate in their welfare, support self-management of their care and use health services better (Hawke's Bay DHB, 2014).

Summary and recommendations

- There is no unanimously accepted definition of health literacy (Sorensen, 2012).
- The Ministry of Health defines health literacy as 'the capacity to obtain, process and understand basic health information and services in order to make informed and appropriate health decisions' (Ministry of Health, 2015).
- Making informed and appropriate health decisions' requires the ability to put information into context, understanding which factors are influencing it, and knowing how to address them (Sorensen et al 2012).
- Health literacy is dynamic requiring an individual to continuously learn new information and discard what is out of date or no longer relevant (D'Eath, Barry & Sixsmith, 2012).
- As the concept of health literacy has evolved it has shifted from seeing poor health literacy as an individual deficit to acknowledging the health system as key enabler or barrier to health literacy (NAS, 2015).
- Health professionals play an important role in communicating effectively and supporting the development of patient's health literacy (Ministry of Health 2015a).

- For consumers to contribute to a safe and high-quality health system by making effective decisions and taking appropriate actions in relation to their health and health care, they need to have an adequate level of individual health literacy and the health literacy environment needs to support and empower them (Australian Commission on Safety and Quality in Health Care, 2013)
- Some definitions for health literacy have explicitly included a population health approach, including treatment but extending the concept of health to staying well and disease prevention (WHO, 2013)
- Transform and Sustain recognises the need for a broad population health definition and framework for health literacy*:*
  Improved health literacy is needed so that people can actively participate in their welfare, support self-management of their care and use health services better (Hawke's Bay DHB, 2014).

Recommendations

The framework for health literacy has a:

- Population health approach acknowledging health extends beyond treatment and the 'health system' and health organisations to include staying well and preventing disease.
- Partnership approach to health literacy seeing the health system and health professionals as partners with people and whānau.
- Equity approach to health literacy ensuring the needs of those currently not experiencing good health or accessing services are given priority.
- Partnership with Māori, Iwi and Hapu to accelerate the performance of Māori health.

Frameworks and tools

Internationally health literacy is moving from an either/or focus on health systems or individuals to seeing health literacy as the intersection between an individual's skills and abilities and the demands and complexity of the information and what is being asked of the individual. A 2015 US National Academy of Science round table on the future of health literacy identified creating both a health-literate population and health-literate organisations as the opportunity the field should seize going forward that (NAS, 2015).

Experts at the round table acknowledged that real progress in health literacy would be limited without true collaboration with consumers, which to date had been lacking in the USA. They also believed to get traction health literacy and cultural competence needed to be seen as an essential part of patient safety (NAS, 2015).

There is significant activity across New Zealand in the area of health literacy and also in areas directly related to health literacy. This is occurring at a national, regional and organisational level. In 2015 the Ministry of Health published two documents *A framework for health literacy* (Ministry of Health, 2015a) and *Health Literacy Review: A Guide* (Ministry of Health, 2015b).

A number of District Health Boards have also commenced programmes of work in health literacy. Counties Manukau DHB has a commitment to health literacy action within its Annual Plan for 2015/16 and Statement of Intent agreement with the Government (Counties Manukau Health, 2015) as does Hawke's Bay DHB (Hawke's Bay DHB, 2014). We found no integrated regional strategies for health literacy spanning sectors of health in New Zealand.

For health literacy initiatives to be of maximum effectiveness they need to be based on evidence, implemented in a coordinated and sustainable way and evaluated.

Addressing health literacy in a coordinated way has potential to increase the safety, quality and sustainability of the health system by building the capacity of consumers to make effective decisions and take appropriate action for health and health care, and building the capacity of the health system to support and allow this to occur (Australian Commission on Safety and Quality in Health Care, 2013).

Frameworks

Framework: the basic structure of something - a set of ideas or facts that provide support for something. Three broad levels of frameworks have been identified:

1. Population health level

These frameworks focus on improving health literacy in order to improve population health at all levels including health promotion, disease prevention, treatment of illness and end of life care. They acknowledge the important role of the health system and institutions within it and also that health occurs in everyday life and not in institutions or systems.

2. Health system level

These frameworks focus on health literacy at the level of the health system. The system is primarily viewed as the institutions and health professionals that diagnose and treat illness.

3. Health organisation level

These frameworks focus on health literacy at the level of institutions that diagnose and treat illness.

New Zealand frameworks

Population health level

No existing frameworks located.

Health system level

A Framework for health literacy

This framework reflects how each part of the health system can contribute to building health literacy so that all New Zealanders can make informed decisions about managing their health, or the health of those they care for (Ministry of Health, 2015b).

The framework was developed by the Te Kete Hauora with consultation from the health sector. The framework outlines expectations for the health system, health organisations and all of the health workforce to take action that:

- supports a 'culture shift' so that health literacy is core business at all levels of the health system
- reduces health literacy demands and recognises that good health literacy practice contributes to improved health outcomes and reduced health costs.

The framework sets out three key areas for action with outcomes and actions identified at the levels of the health system, health organisations and the health workforce:

Leadership and management

Championing health literacy and taking the lead on a 'culture shift' towards a health-literate health system.

Knowledge and skills

Improving our knowledge of how health literacy demands can be reduced and health equity achieved.

Health system change

Being committed to a 'culture shift' so that change occurs at all levels of the health system, leading to better health outcomes for individuals and whānau and reduced health costs.

Health organisation level

Health Literacy Review: A Guide

The Guide sets out an approach for reviewing a health service or organisation's current performance based on a framework identifying six key dimensions of health literacy in the New Zealand context. The framework was developed by the authors from an extensive review of national and international tools and frameworks. The New Zealand six dimensions framework is modelled on the US Ten Attributes framework (Brach et al 2012) which encompasses the seminal work of three earlier tools (Rudd and Anderson 2006; Jacobson et al 2007; Agency for Healthcare Research and Quality 2010).

From the Ten Attributes Framework, the following Six Dimensions were developed for the New Zealand context. These Dimensions form the framework for this Guide.

1. **Leadership and management.** How is health literacy an organisational value, part of the culture and the core business of an organisation? How is it reflected in strategic and operational plans?
2. **Consumer involvement.** How are consumers involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery?
3. **Workforce**. How does the organisation encourage and support the health workforce to develop effective health literacy practices? Has it identified the workforce's needs for health literacy development and capacity? Has the organisation's health literacy performance been evaluated?
4. **Meeting the needs of the population.** How does service delivery make sure that consumers with low health literacy are able to participate effectively and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy)? How is meeting the needs of the population monitored?
5. **Access and navigation**. How easy is it for consumers to find and engage with appropriate and timely health and related services? How are consumers helped to find and engage with these services? How well are services coordinated and are services streamlined where possible?
6. **Communication**. How are information needs identified? How is information shared with consumers in ways that improve health literacy? How is information developed with consumers and evaluated?

The Six Dimensions are applied to examine how staff, consumers and families interact, and to review relevant policies, processes, structures and culture in a particular health service or health care organisation. The aim of these activities is to identify the causes of health literacy barriers and opportunities for improvement.

The following table provides the rationale for each dimension.

New Zealand's Six Dimensions		Rationale
1.	**Leadership and management.** How is health literacy an organisational value, part of the culture and core business of an organisation? How is it reflected in strategic and operational plans?	Leaders and managers have a critical role in developing a health-literate organisation. They drive an organisation's health literacy culture by articulating and reinforcing goals and expectations, and by modelling expected behaviours. Leaders and managers in a health-literate health care organisation ensure that health literacy is built into all aspects of the organisation, explicitly measured and monitored, and continuously improved.
2.	**Consumer involvement.** How are consumers involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery?	A commitment to patient-centred care, consumer safety and quality improvement involves more than the activities of managers, clinical leaders and other staff. A health-literate health care organisation involves consumers and their families in all aspects of service delivery – not just the evaluation of consumer experience.
3.	**Workforce.** How does the organisation encourage and support the health workforce to develop effective health literacy practices? Has it identified the workforce's needs for health literacy development and capacity? Has the organisation's health literacy performance been evaluated?	The health workforce plays a crucial role in communicating oral and written information to consumers and families and ensuring they understand that information. A health-literate health care organisation provides health literacy training and coaching to its entire workforce to improve communication and build health literacy.
4.	**Meeting the needs of the population.** How does the delivery of services make sure consumers with low health literacy are able to participate effectively and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy)? How is meeting the needs of the population monitored?	Because health literacy is diverse and ongoing, health care organisations will find it difficult to identify who in their consumer population has low health literacy. A health-literate health care organisation adopts a universal precautions approach so that staff do not make assumptions about who might or might not need assistance.
5.	**Access and navigation.** How easy is it for consumers to find and engage with appropriate and timely health and related services? How are consumers helped to find and engage with these services? How well are services coordinated and are services streamlined where possible?	Health care organisations develop and use systems that place demands on consumers and families. A health-literate health care organisation reduces the demands its systems place on consumers and families and helps them to access and navigate systems.
6.	**Communication.** How are information needs identified? How is information shared with consumers in ways that improve health literacy? How is information developed with consumers and evaluated?	Health care organisations communicate with consumers and families orally, in writing and increasingly using technology. A health-literate health care organisation ensures that all communication, in all formats, is clear, easy to understand and easy for consumers and families to act on.

International frameworks

Population health level

WHO European Conceptual Model

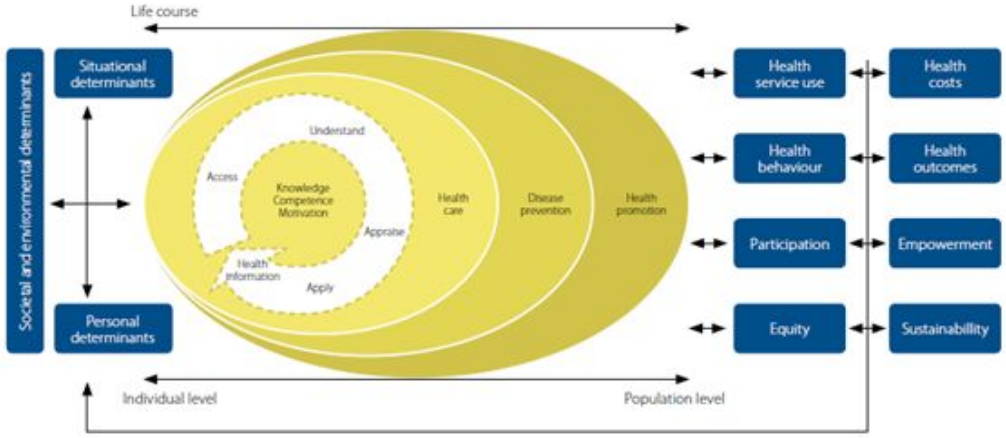
In 2013 the WHO Regional Office for Europe published Health Literacy: The Solid Facts (WHO, 2013). The publication presents a review of the evidence for interventions in health literacy. It supports a relational concept of health literacy that considers both an individual's level of health literacy and the complexities of the contexts within which people act (Figure 1). Both need to be measured and monitored (WHO, 2013).

Figure 1: Interactive Health Literacy Framework (WHO, 2013)

Source: Parker R. Measuring health literacy: what? So what? Now what? In Hernandez L, ed. *Measures of health literacy: workshop summary, Round-table on Health Literacy.* Washington, DC, National Academies Press, 2009:91–98.

The conceptual model seen as most comprehensive and based on evidence is shown below in figure 2. It is adapted from Sorensen et al 2012 and integrates medical and public health views of health literacy. The model was developed through a systematic literature review and content analysis of 17 peer-reviewed definitions and 12 conceptual models (frameworks) found in extensive literature reviews.

Figure 2: Conceptual Model of Health Literacy



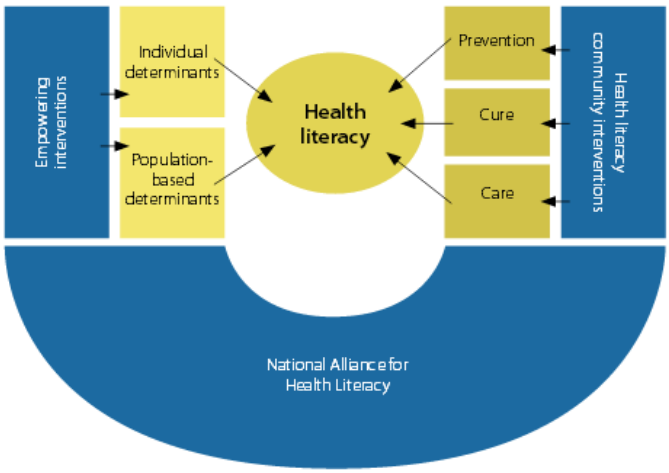
Source: adapted from: Sørensen K et al. Health literacy and public health: a systematic review and integration of definitions and models. *BMC Public Health*, 2012, 12:80.

This model is a population level model enabling a person to navigate three domains of the health continuum being ill or as a patient in the healthcare setting, as a person at risk of disease in the disease prevention system, and as a citizen in relation to the health promotion efforts in the community, where people live, play, work and learn (Sorensen et al, 2012).

Netherlands Model

In the Netherlands, the Alliance for Health Literacy found a combined effort of empowerment of individuals or communities with improvement of health sector communication yields the best results in improving health literacy. Tackling health literacy in the Netherlands is based on a strong lobby for patients' rights, which resulted in clear legislation as well as longstanding programmes for improved communication in the health care sector (WHO, 2013).

Figure 3: Netherlands Model



Source: Netherlands National Alliance for Health Literacy (WHO, 2013)

Health organisation level

ISLHD Health Literacy Framework: A Plan for Becoming a Health Literate Organisation 2012 – 2015

(Illawarra Shoalhaven Local Health District (ISLHD), (2014))

The Framework sets out the following five key goals to guide the ISLHD to becoming a health literate organisation:

1. Embed health literacy into high-level systems and organisational policies and practices
2. Integrate health literacy into planning and evaluation for clinical and quality improvement
3. Have plain English health information that is easy to access, read, understand and use
4. Partner with consumers in the evaluation of health information and access and navigation of services
5. Have effective and evidence based health literacy strategies in interpersonal communication

An Action Plan with specific strategies and monitoring was developed and continues to guide action in 2016. An example of the action plan strategies for goal 5 is shown below in Figure 4:

Figure 4: **GOAL 5: Have Effective and Evidence Based Health Literacy Strategies in Interpersonal Communication**

Strategies	Measurement	Timeframe	Progress
a) Develop and implement a consistent Teach-back training program in line with best practice for all ISLHD staff	i. Teach-back information presented to all new staff at Corporate Orientation ii. 100% of all new staff attending Corporate Orientation receive basic training in health literacy and the 'teach-back' communication	2013 Ongoing	Achieved, 2013 Achieved, 2013
	iii. ISLHD Teach-back training program developed (including audio-visual and written resources)	2013 ongoing	Video resources developed, 2013
	iv. Teach-back training calendar developed	2014/2015	

Optimising Health Literacy (Ophelia) Victoria, Australia

Ophelia is a partnership between two Universities, eight service organisations and the Victorian Government. The project is designed to assist agencies to identify and respond, in a planned way, to the varied health literacy needs of their clients. The project will assess the potential for targeted, locally developed health literacy interventions to improve access, equity and outcomes (Batterham, Buchbinder, Beauchamp et al, 2014).

The Ophelia project uses a methodological foundation of three systems:

1. Intervention Mapping (IM)

IM is a tool for the planning and development of health promotion interventions. It maps the path from recognition of a need or problem to the identification of a solution. Although Intervention Mapping is presented as a series of steps, Bartholomew and colleagues (2011) see the planning process as iterative rather than linear. Program planners move back and forth between tasks and steps. The process is also cumulative: Each step is based on previous steps, and inattention to a particular step may lead to mistakes and inadequate decisions.

The Ophelia project uses IM steps of:

a) Needs Assessment
   HLQ and semi-structured interviews, assess health literacy needs, and organisational assessment to determine contextual enablers and barriers.
b) Identify performance objectives, determinants and change objectives
   Structured workshop format to engage key stakeholders, consider data and needs and possible ideas to meet needs
c) Selection of interventions
   Each site generates program logic and selects appropriate interventions to test. Communities of practice formed.
d) Detailed design and planning of interventions
   Create, test and evaluate interventions using Plan-Do-Study-Act (PDSA) cycles
e) Adoption and implementation of interventions
   PDSA cycles are implemented and results considered
f) Implementation trial
   Conduct trials and evaluate those pilot interventions demonstrating potential to improve health literacy

2. Quality Improvement Collaboratives (QIC)

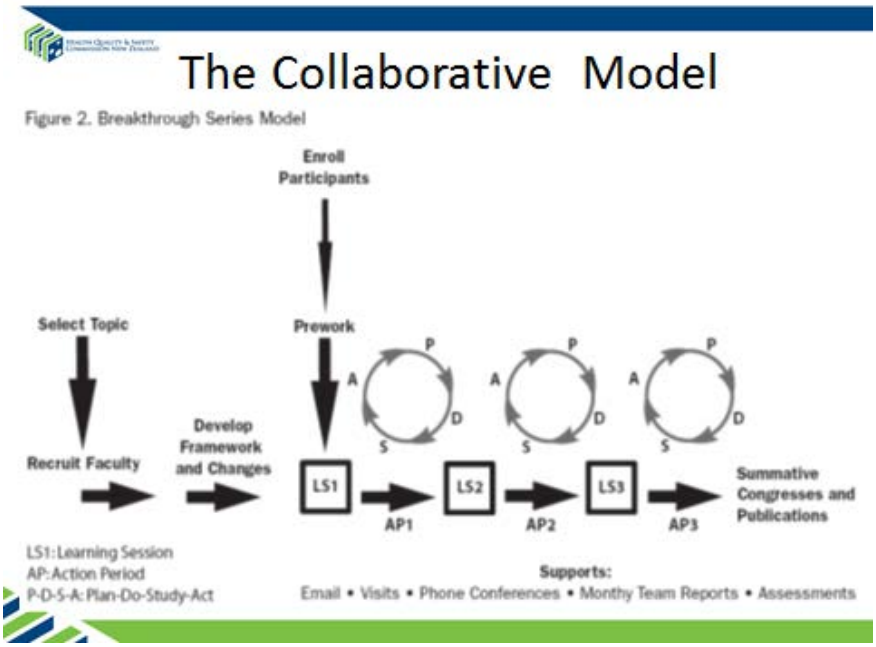
QIC (Figure 5) is a quality improvement methodology that "brings together groups of practitioners from different healthcare organisations to work in a structured way to improve one aspect of the quality of their service. It involves a series of meetings to learn about best practice in the area chosen, about quality methods and change ideas, and to share their experiences of making changes in their local settings" HQSC, 2012).

QIC have been shown to be effective in primary care delivering some real improvements in the systems of care for people with long-term conditions and a change in culture among participating practices in New Zealand (Palmer, Bycroft, Healey et al 2102). HQSC also advocates the use of QIC (HQSC, 2012) and has set these up to work on different issues, for example the safe use of opioids collaborative project (HQSC, 2014).

QIC essential components include:

- Ensuring leadership commitment
- Setting clear aims (including changes to be spread, target level of performance, target population, and time frame)
- Identifying and packaging proved ideas and practices
- Developing and executing a plan to communicate and implement the ideas
- Creating a system for measuring progress
- Establishing a process for refining the plan in response to learning during implementation (HQSC, 2012).

Figure 5: Quality Improvement Collaboratives



3. Realist synthesis

Realist synthesis is an increasingly popular approach to the review and *synthesis* of evidence, which focuses on understanding the mechanisms by which an intervention works (or not).The realist approach is particularly suited to the synthesis of evidence about complex implementation interventions (Rycroft-Malone, McCormack, Hutchinson et al, 2012).

Tools

Health Literacy Questionnaire

This is a validated tool containing 44 questions across nine domains:

1) Feeling understood and supported by healthcare providers
2) Having sufficient information to manage my health
3) Actively managing my health
4) Social support for health
5) Appraisal of health information
6) Ability to actively engage with healthcare providers
7) Navigating the healthcare system
8) Ability to find good health information
9) Understand health information well enough to know what to do

The HLQ domains cover a broad range of issues pertinent to an individual's life and can be interpreted as intrinsic and extrinsic dimensions of health literacy. Some domains more strongly reflect: a) the capability of an individual to understand, engage with, and use health information and health services; or b) more strongly reflect the capability of an organisation to provide services that enable a person to understand, engage with and use their health information or services. The latter is based on the users' lived experience of using health services (Osborne, Batterham, Elsworth et al, 2013).

There are considerable gaps in the evidence reviewed concerning which interventions are most effective in improving health literacy. Further research is needed on the impact of health literacy interventions in the public health field, paying particular attention to evaluating communication about communicable diseases, and determining the most effective strategies for meeting the needs of population groups with low literacy levels, and those who are vulnerable, disadvantaged and hard to reach (D'Eath, Barry & Sixsmith, 2012).

Health literacy tools for improving communication

A number of tools/resources have been developed to assist communication for health professionals and for consumers. These include:

Three Steps to Health Literacy

Developed by the Health Quality and Safety Commission in 2014 *Three steps to better health literacy* combines a range of practical tools including *Teach Back* and *Ask Me 3* for the New Zealand context.

http://www.hqsc.govt.nz/assets/Consumer-Engagement/Resources/health-literacy-booklet-3-steps-Dec-2014.pdf

Let's PLAN

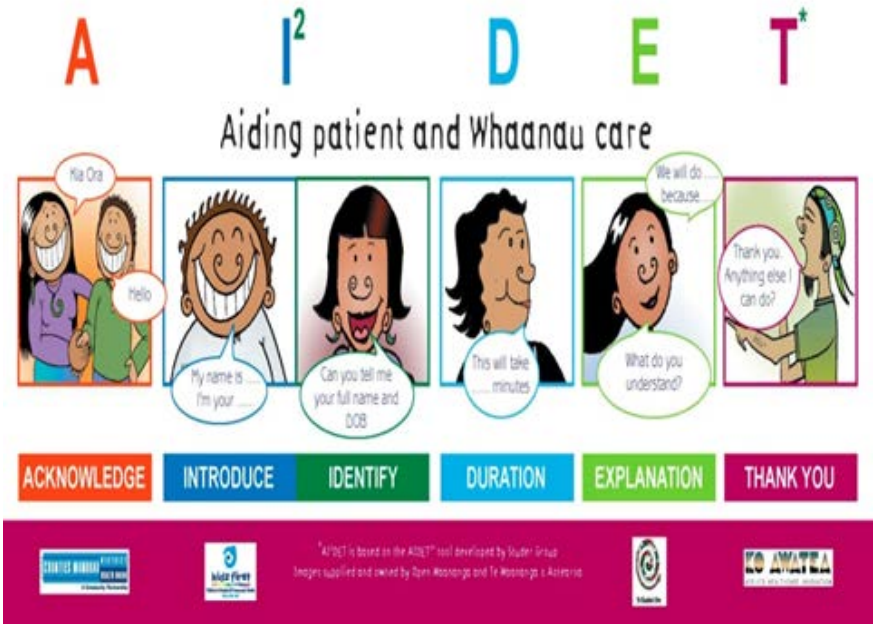
Let's PLAN is a health literacy initiative to help consumers prepare well for their visit to the GP or other primary care health professional.

The A4 flyer, with an accompanying promotional poster, encourages people to plan ahead for practice visits and to ask questions when there so they fully understand their diagnosis and treatment. It also suggests questions they can ask pharmacy staff when they pick up their medicine. Available for HQSC http://www.open.hqsc.govt.nz/patient-safety-week/publications-and-resources/publication/1826/.

Aiding Patient and Whānau Care (AI^{2}DET)

(Counties Manukau DHB, nd)

AI2DET is a communication tool adapted by Counties Manukau DHB to improve face-to-face engagement experiences for patients and whānau using services.



AI2DET emerged through the establishment of an Operational Group focusing on Patient and Family Centred Care. This led to the development of a number of workstreams, of which one was Face-to-Face Patient and Whānau Engagement.

Tools and frameworks from related areas

There are a number of quality improvement areas related to health literacy which are important to consider in a framework for health literacy. We have covered some of these below however recommend the DHB consider other work in the area of cultural competence, consumer experience and patient safety. Many of the frameworks or models sit under the area of consumer engagement. The Health Quality and Safety Commission has a stream of work dedicated to consumer engagement called *Partners in Care*. *Partners in Care* includes health literacy, co-design, patient and family centred care and shared decision making.

Cultural competence is a key area in health literacy, both at the system level and the level of health professionals. It overlaps with the several key dimensions of health literacy, particularly communication. Cultural competence is also central to addressing indigenous health inequalities.

Cultural Competence

The Indigenous Health Framework developed by the University of Otago translates the principles of cultural competency and safety into an approach that health practitioners can use in everyday practice. The framework consists of the *Hui Process* for enhancing the doctor-patient relationship and the *Meihana Model* to guide the interaction (Pitama, Huria & Lacey, 2014).

Framework for consumer engagement

Health literacy is fundamental to patient engagement. If people cannot obtain, process and understand basic health information, they will not be able to look after themselves well or make sound health-related decisions (HQSC, 2015).

Figure 6: A New Zealand framework for consumer engagement (HQSC, 2015)

Patient and family centred care (PFCC)

The core elements of patient and family centred care are:

- **Dignity and Respect.** Health care practitioners listen to and honour patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
- **Information Sharing.** Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- **Participation.** Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
- **Collaboration.** Patients, families, health care practitioners, and hospital leaders collaborate in policy and program development, implementation, and evaluation; in health care facility design; and in professional education, as well as in the delivery of care (Boon, 2012).

Patient and Family-Centred Care (PFCC) is a method of improving health care quality that changes the perspective of staff delivering care, and helps them reconnect with their values and motivation for working in health care. PFCC is a simple, low-technology health care quality improvement approach designed to tackle two parallel aspects of health care: processes of care and staff–patient interactions. Together, these have a profound effect on how patients and staff experience health care (Kings Fund, nd).

PFCC helps tackle issues in:

- the organisation of care (care 'transactions' – how care is delivered)
- 'relational' aspects of care (the human interactions that take place between patients and families, and their professional carers).

Rather than blaming staff when things go wrong, PFCC seeks to understand where care systems and processes prevent them from providing the kind of care they would wish for themselves or their families. This understanding helps staff to see where improvements are possible, and enables them to reconnect with their motivation for working in health care, promoting a new workforce culture (Kings Fund, nd).

Patient and whānau centred care is a key element of the Hawke's Bay health strategy:

We believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting, and we need to have a stronger engagement with consumers and their families/whānau (Hawke's Bay DHB, 2014).

Patient and family centred care toolkits

Bay of Plenty DHB

The Bay of Plenty DHB (Bay of Plenty DHB, nd) has an online toolkit for PFCC containing:

- Literature Review
- Facilitators Guide
- Organisation Leaders Self-Assessment
- Organisational Self-Assessment Templates
- Stakeholder & Communication Plan
- Getting Internal Stakeholders Involved 01
- Getting Internal Stakeholders Involved 02
- Volunteer Patient Advisor Information
- Volunteer Patient Advisor Application Form
- Orientation for Patient Advisors

Kings Fund

The Kings Fund (Kings Fund, nd) has an online toolkit, tools available in the PFCC toolkit:

- **Process mapping** – A process map is a visual representation of what happens to the patient at each stage of their care experience. It enables teams to identify which steps in the care process add value for patients and who is responsible for each step.
- **Shadowing** – This method forms the core part of the PFCC approach. It involves accompanying a patient throughout their care experience – for example, from arriving at reception to leaving at the end of the day – and taking notes and discussing experiences with patients. It is this aspect of the PFCC approach that has had the greatest impact on staff.
- **Patient stories** – This approach involves interviewing patients to gather their insights into the service they have received. It is a useful adjunct to shadowing.
- **Driver diagrams** – These are used to identify the 'drivers', or main influences, on patients' experiences. This then helps to identify the aspects of care that need to be influenced if improvements in patients' experiences are to be achieved. A driver diagram is a conceptual framework that helps teams to set an aim and then identify the key drivers (main areas of focus) and subsequent interventions they need to put in place that will align to support the achievement of the overall goal.
- **Measurement** – Measurement is an essential part of any quality improvement initiative. It must be carried out beforehand, to set the baseline, and then again at stages throughout and following the intervention. This enables you to demonstrate the impact and to identify any aspects that may need tweaking during the project.
- **The model for improvement** – This well-established approach to improvement incorporates Plan, Do, Study, Act (PDSA) cycles – also known as small tests of change, or rapid cycle improvement – which make it possible to test interventions on a small scale, and to tweak these, before rolling out more widely.
- **Snorkelling** – A group activity that enables a wide variety of health care staff to think creatively and develop their own ideas for changes that will improve patients' care experiences.

Co-design

Patient experience is positively associated with clinical effectiveness and patient safety which supports the inclusion of patient experience as one of the central pillars of quality in health care (Doyle, Lennox & Bell, 2013).

The HQSC has a co-design programme under *Partners in Care* which offers a co-design course based on the NHS Experience-based design approach (NHS, 2009). Further information about the course is available at http://www.hqsc.govt.nz/our-programmes/partners-in-care/work-streams/co-design-partners-in-care/.

Waitemata DHB has developed a toolkit and guide for co-design, *Health service co-design: working with patients to improve healthcare services* available on line at http://www.healthcodesign.org.nz/.

Many service improvement projects have patient involvement but co-design focuses on understanding and improving patients' experiences of services as well as the services themselves.

This toolkit includes a framework and tools for undertaking co-design:

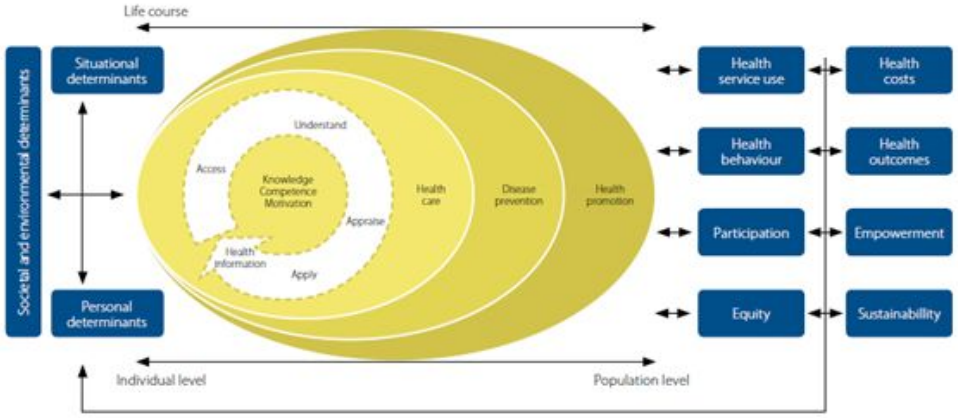
- Understanding the patient experience:
- Patient shadowing - identifying what happens during a patient visit to a service
- Patient journey mapping - summarising the service experiences patients have over time
- Experience-based surveys - learning about patients' reactions to services based on their journeys
- Patient stories - assessing patients' service experiences in their life context (Boyd, McKearnon & Old, 2010).

Summary and recommendations

- The framework should consider both sides of the health literacy equation – the capacity of individuals and the demands placed on them (NAS, 2015).
- While the onus for improving health literacy should not be placed on the individual it is important that patients and whānau are partners in any changes to improve health literacy (WHO, 2013).
- Engagement with consumers and their families/whānau will be pivotal to understanding where the health system is creating health literacy barriers (HQSC, 2015).

Source: Parker R. Measuring health literacy: what? So what? Now what? In Hernandez L, ed. *Measures of health literacy: workshop summary, Round-table on Health Literacy*. Washington, DC, National Academies Press, 2009:91–98.

- The framework for health literacy at the regional level needs to be consistent with the population health approach in Transform and Sustain (Health Hawke's Bay, 2014).
- A good starting point is the conceptual model adapted from Sorensen et al 2012. This model is based on evidence and integrates medical and public health views of health literacy.



Source: adapted from: Sørensen K et al. Health literacy and public health: a systematic review and integration of definitions and models. *BMC Public Health*, 2012, 12:80.

- Health literacy goes beyond being able to read information and navigate to appointments it includes empowerment of individuals and whānau to improve their own health (WHO, 2013).
- Health literacy needs to be integrated with other quality improvement initiatives such as patient engagement, patient experience and cultural competence (NAS, 2015).
- There are considerable gaps in the evidence reviewed concerning which interventions are most effective in improving health literacy (D'Eath, Barry & Sixsmith, 2012).
- Any interventions should be evaluated for their effectiveness and used to establish a community of learning for future work (Batterham, Buchbinder, Beauchamp et al, 2014)..
- The framework should drive the workstreams (actions) of the DHB to address health literacy. These could include:
  - ✓ Providing leadership/champions for health literacy.
  - ✓ Raising awareness and building the skills of the workforce about health literacy.
  - ✓ Raising awareness and building the skills of the consumers and their families/whānau about health literacy.
  - ✓ An internal commitment to build health literacy into all DHB decisions, processes and policies.

- ✓ A comprehensive policy and support for the development of health literate resources/material for patients.
- ✓ Training for health professionals using effective and evidence based health literacy strategies in interpersonal communication.
- ✓ Guidance and support for services and organisations within the region on how to assess the degree to which they are supporting health literacy (integrating the *Health Literacy Review: A guide* and the Ophelia model including the Health Literacy Questionnaire)
- Guidance and support for services and organisations on the co-design of new processes/interventions to address health literacy.
- Oversight and guidance on the evaluation of changes made to improve health literacy (possibly using the quality improvement collaboratives (QIC) model).

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APPENDIX 4 – PROJECT ADVISORY GROUP DRAFT TERMS OF REFERENCE

Health Literacy Project Advisory Roopu – Terms of Reference

Background

Health literacy is about health organisations ensuring health services and information are easy for people to find, understand and use to make effective decisions for their health. Health literacy has come into focus after the Ministry of health reported that 56% of New Zealander's and a majority of Māori have difficulties understanding the healthcare that the health system delivers.
HBDHB has taken action to improve health literacy. A review was commissioned that uncovered a number of areas that we need to address. With these recommendations in mind, the health literacy project team has adopted a number of health literacy principles that will help to guide the health literacy work (see appendix A). Furthermore, we are using these principles to help our local health organisations look at the health literacy environment, to assess where they need to make changes, so that healthcare is easy for whanau to understand and use.

Purpose

This roopu has been established to look at how we can advise organisations in Hawke's Bay to improve health literacy. This will involve a number of ways, including how organisations approach health literacy to find out where and what it is they need to do to make improvements. Then, how can we provide them with resources that make it easy for them to make the changes to deliver health information and services to whanau that is easy to find, access, understand and use.

Role and responsibilities

The people in this roopu will be expected to:

- Provide advice and expertise on how the health system can make it easier for people and whanau to find, access, understand and use healthcare
- Provide direction to the project manager to achieve the goals of the health literacy project
- Provide advice into the process and products needed to improve organisational health literacy and the overall health literacy environment
- Communicate progress to key stakeholders and other interested parties
- Provide final endorsement of the process and products developed to improve the health literacy environment

Scope

The project includes:

- Positioning health literacy within the HBDHB peoples strategy and overall objectives of 'changing the culture' within the DHB
- How we communicate health literacy across the health sector, which is easy to understand, provides some clarity and direction on how we go about improving health literacy
- Developing a process and a set of products that help organisations to review / audit their health literacy status (or current performance), how they go about improving health literacy performance with resources to assist them in this process.
- Educating the workforce about health literacy and the impact of poor health literate practice on whanau, utilising health literacy specific strategies including the Universal precautions approach, effective communication and building quality relationships with whanau
- Advising the health sector on innovative ways to increase consumer and community health literacy skills and knowledge
- Addressing particular health literacy problem areas
- Understanding how we evaluate the health literacy programme of work to ensure we achieve the objectives and goals of the project.

And excludes:

- Decisions regarding the distribution of financial or human resources
- implementing of products into organisational BAU

Each member will have:

- Knowledge and breadth of experience with or within the health system
- Connections with whanau and people living in Māori / Pacific communities or areas of high deprivation
- Demonstrated leadership capability

Members will be appointed from the following categories:

- The health workforce
- Māori health providers, experts, academics and kaimahi
- Consumers and whanau
- Key stakeholder groups

Responsibilities of members

Project manager:

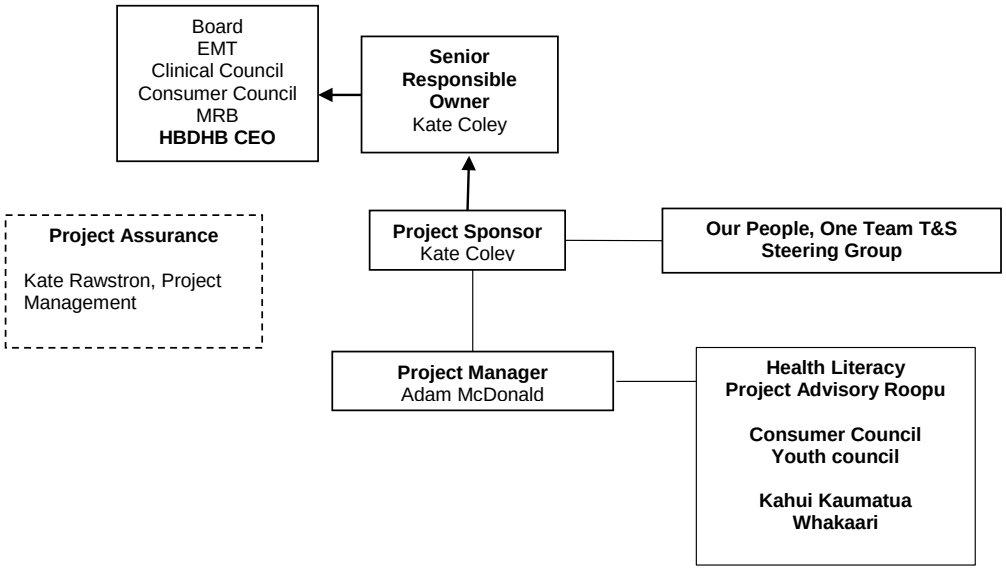
- Leads meetings effectively
- Sets and adheres to meeting protocols and ground rules
- Ensures that minutes properly reflect the input of members.
- Ensure meetings are organised and facilitated effectively
- Prepare and disseminate agenda and related papers, schedule of meetings
- Meeting records; documents required for approval
- Collate feedback from consultation

All advisory roopu members will:

- contribute positively and openly to the work of the group
- maintain regular attendance
- respond to communications
- be prepared and informed
- consult with and report to, as appropriate, the stakeholders they represent

Meetings will be held monthly until the project is completed.

APPENDIX 5 – PROJECT MANAGEMENT TEAM STRUCTURE



HAWKE'S BAY District Health Board Whakawāteatia	**Best Start: Healthy Eating and Activity Plan- Healthy Weight Strategy**
	For the attention of: **HB Clinical Council, HB Health Consumer Council and Māori Relationship Board**
Document Owner: Document Author(s):	Tracee Te Huia, ED Strategy, Health & Improvement Shari Tidswell, Team Leader/Population Health Advisor
Reviewed by:	Executive Management Team
Month:	May 2017
Consideration:	For information

RECOMMENDATION:

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

- **Note** progress in the implementation of this Plan.

OVERVIEW

In 2015 the Healthy Weight Strategy and in 2016 the Best Start: Healthy Eating and Activity Plan were endorsed by the HBDHB Board. These documents guide the HBDHB's work in increasing the number of healthy weight people, with a focus on children. Work is delivered across HBDHB and other sectors including primary care, councils, education, workplaces and Ngati Kahungunu Iwi Inc.

Childhood healthy weight is also being reported to the HBDHB Board via Te Ara Whakawairoa and the Raising Healthy Kids target. These reports share information and the Best Start Plan provides the direction and overview for all this work.

The Board requested six monthly progress reports. This report provides an overview of the progress and changes impacting the Plan's delivery.

REPORTING ON PROGRESS

Below is a summary of the highlights for each of the Plan's four objectives. Appendix One provides further detail of the progress on the Plan's activities to date.

1) Increasing healthy eating and activity environment

There has been progress in collecting data to provide benchmarks to measure change in healthy eating environments. Schools were contacted re 'water only policies' and the school environments mapped (part of Auckland University Informus Programme). This work was completed by the Public Health Nurses.

2) Develop and deliver prevention programmes

Prevention resources and staff training have been delivered. The breastfeeding resource is systematically provided to all whānau birthing at Hastings Hospital. This resource integrates key maternal messages (i.e. breastfeeding, smokefree, safe sleep) and is well received by whānau and staff supporting whānau. Healthy First Food resource and education sessions are business as usual for WellChild and Plunket. A new healthy food resource for 3-5 year olds and their whānau supports

conversations and co-creating a whānau healthy weight plan. This included training for B4 School Check nurses.

3) Intervention to support children to have healthy weight

Screening for gestational diabetes, WellChild Checks and B4 School Checks is supported. Tools are provided to support whānau with healthy weight messages and behaviours at these screening points. Maternal Green Prescription and Active Families continue to have high levels of referrals. These programmes show good outcomes with 80% of families completing Active Families programme increasing healthy eating and activity. All children with a BMI in the 98th percentile at the B4 School Check are receiving a healthy eating conversation and support to develop a whānau plan – whānau feedback is positive.

4) Provide leadership in healthy eating

HBDHB Board endorsed the reviewed Healthy Eating Policy and this now aligns with the MoH's guideline. Food Services have completed a review of food served in Zacs café and are leading the roll-out to comply with the 'traffic light' system in the policy. The Strategy has been shared widely and there has been support from a range of sectors. The work with the B4 School Check programme demonstrates an effective HBDHB-led collaboration with primary care.

CHANGING CONTEXT FOR CHILDHOOD HEALTHY WEIGHT

Since HBDHB endorsed the Plan, MoH have:

- Released a "Childhood Obesity Plan".
- Required HBDHB to review the recently approved Healthy Eating Policy to comply with the national guidelines.
- Set a Raising Healthy Kids target (1 July) reports on referrals to a health professional for children in the 98th weight percentile.

This MoH direction aligns with or was planned for in the Best Start Plan. However, has meant reprioritisation of the Best Start Plan's work and will now impact on planned work with the early childhood education sector, primary schools pilot programme and engagement with new settings.

HBDHB entered into a Memorandum of Understanding with the Hawke's Bay Community Fitness Centre Trust that was established in November 2016. This Trust sets out to establish a two stage development for a facility at the regional sports park to provide community and elite athlete programmes. Alongside this will be research projects that look at early childhood and school programmes, as well as a longitudinal study. HBDHB have been invited to attend the launch and workshops delivered by the Trust with HBDHB sharing their information and plans with the Trust.

Again this aligns with the Best Start Plan and will require that the activities are coordinated. To achieve this, we are working closely with Sir Graeme Avery and others engaged with the HB Community Fitness Trust. In the planning phase, we have contributed to the information and discussion forum. Moving forward we will be actively involved in the research projects and collaborating on the schools based programme by integrating programmes developed by the Trust with the primary schools programme.

CONCLUSION

Overall, we are on track with some adjustment made to respond to changes. There has been significant work completed and/or embedded as business as usual, i.e. Healthy First Food and breastfeeding support. New work has focused on MoH lead areas including; supporting the new Raising Healthy Kids target, water only policies in schools and the HBDHB Healthy Eating Policy.

New developments offer opportunities including new partnerships and potentially increased investment in healthy weight projects. MoH-led initiatives have increased the impact of this Plan's activities i.e. more schools with water only policies and a HBDHB policy with wider coverage.

NEXT STEPS

1. Address the identified need for a nutrition and physical activity advice/resource for early childhood education. This will reinforce key messages whānau receive via maternity services, WellChild/Plunket and B4 School Checks.

2. Continue the work to develop a primary schools programme – working with community partners, MoE East Coast, Health Promoting Schools, Hawke's Bay Community Fitness Centre Trust and schools.

3. Continue work with Councils to support healthy weight environments, investigate engagement with supermarkets to promote healthy eating choices, using the findings from the Auckland University healthy environment survey to support changes.

Appendix One

Objective 1: Increase healthy eating and activity environments

Indicator 1a: Increase the number of schools with healthy eating policies

Indicator 1b: Increase the number of settings including workplaces, churches and marae with healthy eating policy

What the data shows

The data we have is improving, there is now policy information recorded in HealthScape showing an increase in school policies and data for the school environments has been collected with Auckland University (Informas).

Activity to deliver objective one				
	What	**How**	**Progress**	**When**
Current activity	• Work with settings to increase healthy eating including education, schools, workplaces, events, Pasifika churches, marae • Support national messaging including sugar reduction i.e. Water Only • Advocate for changes in marketing and council planning	• Healthy eating policies which reduce sugar intake in 5 ECE centres, key community events increase healthy food choices, 4 Pasifika churches have a healthy eating approaches and guidelines for marae reviewed with Ngāti Kahungunu Iwi Incorporated • Communication plan implemented for national and regional messages • Supporting the implementation of programmes and plans i.e. i Way, Active Transport, Sport HB and Ngāti Kahungunu Iwi Incorporated plans	• School water only policies reviewed by PHNs, all primary schools have policies and two secondary schools. Support is being developed for ECEs with MoH licensing staff. Four churches engaged, two are working toward reducing sugar. Hasting District Council is going water only. • Water only messaging promoting in schools, under 5 Healthy Food messages • DHB rep on Active Transport group, supporting Ngāti Kahungunu Iwi Inc. event to provide health messages.	July 2017
New actions	• Support education settings to implement healthy eating and food literacy- early childhood, primary schools secondary schools,	• 50% increase in schools with “water only” policy annually • Decile 9/10 communities have a whānau co-designed programme delivered in primary schools, - trialled 2016, 5 new schools annually	• Exceeded with all primary schools having a water only policy • Project lead in place, workshop held • Presented Healthy Weight Strategy to Hastings and Napier Council. • Food Environment data collection complete	Reported annually to 2020

Activity to deliver objective one				
	• Establishing a base measure for monitoring • Engage cross-sector groups to gain support and influence to increase healthy eating environments • Investigate food security for children and their whānau identifying issues	• All schools surveyed for status in healthy eating/water only policies • Establish a group to influence changes in the environment across Hawke's Bay • Partner with Auckland University to establish a baseline for the Hawke's Bay food environment and monitor annually		

Objective 2: Develop and deliver prevention programmes

Indicator 2a: Rates of breastfeeding at 6 weeks increase

Indicator 2b: Number of healthy weight children at 4 years remain stable or improves

What the data shows

- Child fully or exclusively breastfeeding at 6 weeks rates as 72% (Dec 2015) for total population, 66% Māori and 78% Pasifka (December 2015 Ministry of Health), these sho slight increases
- 76.5% of Hawke's Bay four year olds are healthy weight, 65.2% Māori and 66.9% Pasifika (2014 Before School Check data, Health Hawke's Bay), this will be refreshed with 2016 data at the end of the year.

Actions and Stakeholders				
	What	**How**	**Progress**	**When**
Current activity	• Implementing Maternal Nutrition Programme activities- breastfeeding support, healthy first foods • Supporting settings to implement healthy eating/sugar reduction programmes/policies • Supporting health promoting schools	• Breastfeeding support resources provided via Hauora • All Well Child/Tamariki Ora providers trained in Healthy First Foods • All schools, ECE, Well Child/Tamariki Ora Providers with health eating policies are provided with information resources and advice • Health Promoting Schools health promoters are up-skilled to implement healthy eating approaches	• Complete • Complete • Information and resources shared • Meeting HPS coordinators, attended workshop with other providers	July 2017
Next actions	• Extend the Maternal Nutrition programme developing programmes in ECE and resources to support B4 School Check providers	• Deliver training to LMCs, Well Child providers and B4 School Check nurses to increase skills to promote healthy eating- Healthy Conversation, Healthy First Foods, B4 School Check resources	• Healthy Conversation workshops delivered for LMCs and others engaging with whānau and young children. Session delivered for B4 School Check nurses and GPs. • Active Families contracts in place and delivered by Iron Māori and Sport HB.	Reported annually until 2020

Actions and Stakeholders				
	• Supporting healthy pregnancies, via education and activity opportunities • Support the development of whānau programme (building on existing successful programme) • Develop food literacy resources including sugar reduction messages -deliver via programme and settings • Support healthy eating programmes and approaches in schools	• Contract and support local provider/s to deliver the maternal healthy eating activity programme • Contract and support local provider/s to deliver whānau based programmes i.e. Active Families • Deliver key messages for whānau with 2–3 year olds • Develop food literacy resources for B4 School Check provider, promote Healthy First Food and heart foundation school resources • Support the co-designed programme for deprivation 9/10 communities	• 3-5 year old messages developed – Healthy Food resource- food choices, portion size and promoting water. • Resources launched with B4 Schools Check nurses • Project manager appointed.	

Objective 3: Intervention to support children to have healthy weight

Indicator 3a: Increase referrals to programmes which support healthy lifestyles and whānau engagement for 4 year olds with a BMI over 21

Indicator 3b: Increase food literacy training to targeted workforce including midwives, Well Child/Tamariki Ora, education workforces, social services and Before School Check practitioners.

What the data shows

- 55 Hawke's Bay children were identified with BMI over 21, of these, 47 were referred to interventions including Pre-school Active Families and the remaining 8 were given advice. Of the referrals 55% were Māori, 29% other and 19% Pasifika. (2015 B4 School Check Clinical Data- Health Hawke's Bay)
- 57 participants attended breastfeeding support training, 23 Well Child staff attended First Foods Trainer Workshops, 83 health professionals attended Gestational Diabetes updates (2015 HBDHB Maternal Nutrition Report to MoH) and 45 practice nurses attended CNE session on Raising Healthy Kids Target and whānau conversation tool/plan.

Activities and Stakeholders				
	What	**How**	**Progress**	**When**
Current activity	• Screening including gestational diabetes, Well Child/Tamariki Ora and B4 School Checks • Whānau activity based programmes for under 5s • Paediatric dietetic referrals	• Monitor the screening and responding referrals • Fund Active Families under five and monitor implementation. Investigate extending to further providers • Monitor referrals and outcomes	• Monitoring provided via HBDHB Board and MoH. Raising Health Kids target is on track to reach target in quarter 4. • Active Families under 5 is funded and Health HB will support with additional funding • Majority of referrals are to Active Families which has 80% of children increasing healthy eating and activity.	July 2017 Māori Health Targets - 6 monthly to the Board
New actions	• Support screening in maternal programme, Well Child/Tamariki Ora and B4 School Checks	• Support training for health professionals completing screening - maternal, Well Child/Tamariki Ora and B4 School Checks.	• Completed WellChild/Plunket Health First Foods training, B4 School Check Conversation Tool training • Active Families – delivered by Iron Māori and Sport HB	Annually until 2020

Activities and Stakeholders				
	• Provide whānau based programmes to support lifestyle changes which support healthy weight i.e. Active Families • Support referrals to programmes via a range of pathways • Develop a clinical pathway from well child/primary care to secondary services • Support child health workforce, to deliver healthy conversations	• Contract community providers to take referrals for whānau with an overweight child (3-12 years) • Clinical pathway developed with key stakeholders- whānau, parents, children and health professionals • Healthy Conversation training delivered	• Reviewing pathway development – potentially included in Long Term Conditions pathway • Delivered the Health Food conversation tool. Investigating new training opportunities	

Objective 4: Provide leadership in healthy eating

Indicator 4a: Monitor the implementation of the HB DHB Healthy Eating policy

Indicator 4b: Engage support from key partners

What the data shows

Hawke's Bay District Health Board policy has been updated and aligns with MoH guidelines and an implementation plan is in place, endorsed by EMT June 2016. Healthy Weight Strategy have been presented to the Intersectorial Forum, Napier and Hastings Councils, MoE East Coast, Priority Population Committee (Health HB) and internally across the DHB.

Activities and Stakeholders				
	What	**How**	**Progress**	**When**
Current activity	• Share information, evidence and best practice and healthy weight data with key community partners • Show leadership by establish the HBDHB Healthy Eating Policy and implementing the Healthy @ Work work plan	• Regular updates provided via Maternal, Well Child/Tamariki Ora and B4 School Check forums. Regular meetings with community providers • Review and monitor the HBDHB Healthy Eating Policy and support the implementation of the Health @ Work work plan	• Strategy and Best Start Plan shared with - Sport HB, Mananui, Napier and Hastings Councils, HB Community Fitness Centre Trust, DHB staff and placed on DHB website • Policy has been replaced with one aligning with the national Food and Nutrition Policy and for implementation in place	July 2017
New actions	• Lead an equity focus by applying an equity lens to review this plan and delivered activity • Lead messaging and delivery to reduce sugar intake • Align HBDHB Healthy Eating Policy with national food and beverage guidelines	• Equity assessment written and finding used to refine this plan to improve response to equity • Cross-sector activity includes a sugar reduction focus • Reviewed policy reflects the healthy eating guidelines • Framework/process implemented for cross-sector approach and inter-agency activity reported	• All contracts have targets for Māori and Pasifika, resources are tested with Māori and Pasifika whānau and equity lens was applied to funding. • Water only and healthy food has been delivered in event planning, Pasifika churches, workplaces and education. • HBDHB policy review is complete and aligns to MoH Nutrition Guidelines.	Ongoing until 2020

Activities and Stakeholders				
	• Develop a process for a cross-sector approach to support healthy eating environments • Influence key service delivery stakeholders to maintain best practise and consistent messaging • Continue engagement with community particularly key influencers for Māori and Pasifika i.e. marae and church leaders	• Hauora, general practice, LMCs, contracted community providers provide national messages consistently to whānau, community and their workplace • Key activities Waitangi Day celebrations - policy/guidance document development Ngāti Kahungunu Iwi Incorporated and engagement with Pasifika church leaders	• Shared Healthy Eating Strategy with Intersectorial Forum • Messaging is "water only" and promoting the MoH Nutrition Guidelines • We have worked with the Te Matatini steering group and achieved promoting water and healthy food choices (with a reduction in high fat, sugar and salt foods). The Healthy Events – Food guide material has been reviewed by Ngāti Kahungunu Iwi (events and comms staff).	

DRAFT ANNUAL PLAN 2017/18

Verbal

11

ANNUAL MAORI PLAN Q3 DASHBOARD

Will be provided as soon as it is available

12

HB CLINICAL RESEARCH COMMITTEE

Verbal

(find attached the Research Committee's Annual Report for 2016/17)

Hawke's Bay Clinical Research Committee

Annual Report 2016

12.1

The Hawke's Bay Clinical Research Committee (HBCRC)

The role of the HBCRC is to help ensure appropriate governance of all health and disability research being undertaken within the public health sector in Hawke's Bay. It does this by maintaining an overview of all such research and providing strategic and operational advice to the Hawke's Bay Clinical Council.

The HBCRC also aims to promote good clinical and ethical practice in health and disability research across primary, community, hospital, educational and training services within the public health sector in Hawke's Bay.

The Committee membership in 2016 included representatives of the Hawke's Bay District Health Board (HBDHB), Health Hawke's Bay (the Primary Health Organisation), Eastern Institute of Technology (EIT), University of Otago and Hawke's Bay Medical Research Foundation (HBMRF).

 **John Gommans** Clinical Council & Chair	 **Andi Crawford** Allied Health	 **Bob Marshall** EIT	 **David Barry** HBMRF
 **Diana Schmid** Clinical Trials HBDHB	 **Graeme Norton** Consumer Council	 **Justin Nguma** Maori Health	 **Kerryn Lum** Primary Care Health Hawkes Bay
 **Ross Freebairn** University of Otago	 **Sally Houliston** HBDHB Clinical Research/Nursing	 **Sharon Mason** COO, HBDHB	

Annual Report: Published 20/04/2017 Contact details via the website or email research@hbdhb.govt.nz

Message from the Chair

Dr John Gommans. General Physician and Chief Medical & Dental Officer – Hawke's Bay Hospital

This is the third annual report of the Hawke's Bay Clinical Research Committee.

The primary aim of the HBCRC is to ensure appropriate governance of all health and disability research activity being undertaken within the public health sector in Hawke's Bay. It does this via its regular oversight of this activity and reports to the Hawke's Bay Clinical Council. HBCRC reports on research activity are available via the website;

http://www.hawkesbay.health.nz/page/pageid/2145884116/Hawkes_Bay_Clinical_Research_Committee

Research is fundamental to the practice of clinical medicine as we increasingly focus on both evidence-based practice and regular audit and review of practice standards. Skills in undertaking research and the critical appraisal of research findings are important for all clinicians and those who manage health services.

Therefore, the HBCRC also aims to promote local clinical research activity and the sharing of local expertise and experience within Hawke's Bay as participation in clinical research has benefits for researchers and the local community. In particular;

- Research, audit and associated external review activities help assure us regarding the quality of services delivered locally, adherence to best practice guidelines and dissemination of evidence based medicine, which enhances the care of all.
- Clinicians engaged in research gain skills, broaden their understanding, and develop links into regional, national and international clinical networks, which enhances the capability and morale of the individuals involved and the health workforce in general.
- The ability to participate in research helps attract clinicians with academic interests to Hawke's Bay.

I would like to acknowledge the willing contribution of all Committee members who freely gave of their time, energy and enthusiasm, reflecting their passion for clinical research.

Achievements in 2016

The Clinical Research Forum:
A particular highlight of the committee's work is the ongoing success of our Clinical Research Forum that was initially established in 2014. The Forum continues to be well supported by local researchers and provide an opportunity for researchers to discuss the results of their research and to share with their colleagues what they have learnt in the process. All presenters have freely and willingly given of their time and expertise. The degree of audience engagement in both the formal question and answer sessions and the informal conversations that follow is encouraging.

The Annual Report:
The Annual Reports of the HBCRC provide a summary of the breadth and depth of research activity undertaken in Hawke's Bay each year, and a summary of the Committee's.

Other activity:
The Committee helps link researchers with potential colleagues and like-minded peer groups, provides guidance regarding process and contacts for ethical approvals and links researchers to work reported separately via the various participating organisations e.g. EIT, HBMRF and University of Otago.

Looking Forward

The Committee's goals for 2017 include:

- Continuing to fulfil our obligations regarding governance of all health and disability research being undertaken within the public health sector in Hawke's Bay
- Build a strong relationship with the new Professional Standards & Performance Committee reporting to Clinical Council established under the Council's new Clinical Governance structure.
- Building on the successes of the past three years including continuation of the Clinical Research Forum and publication of an Annual Report.
- Investigating the feasibility of collating a list of all publications by Hawke's Bay Researchers to be included in the annual report

We welcome feedback from researchers and the local community – what do you expect of or want from the Committee and/or from the local clinical research community?

Events

Research Forum – April 2016

The August forum was "Research in Primary Care" with a focus on engaging effectively with Health Professionals from both the Primary and Secondary Care Sector and highlighting a couple of important pieces of research with Primary Care

Speakers:

- **Di Vicary –** Clinical Advisory Pharmacist at Health Hawke's Bay
  Community Pharmacists Educating to Reduce Risk of Acute Kidney Injury

- **Helen Francis –** Quality & Performance Manager, The Hastings Health Centre
  Title: Relationships and PhD Research in Primary care

Eastern Institute of Technology (EIT)

Professor Bob Marshall, EIT Research Director

Research highlights for the past year at EIT include Associate Professor Clare Harvey representing New Zealand on the 37 country, 4-year COST (European Co-operation in Science and Technology) RANCARE project "Rationed – missed nursing care: An international and multidimensional problem". Another highlight was the development of the EIT Centre for Health and Wellness Research (http://www.eit.ac.nz/subject-areas/research/centre-of-health-research/), with five focus areas: Community Health; Missed and Rationed Care; Sport Performance; History of Nursing; and Health and One Welfare. For more information on any of those areas, contact Associate Professors Rachel Forrest, Clare Harvey, Carl Paton, Pamela Wood or Professor Nat Waran respectively.

EIT's Master of Health Science and Master of Nursing programmes saw sixteen students commencing their Thesis/Independent Scholarly Project in 2016, while the graduation ceremony in March saw 18 Master of Nursing and two Master of Health Science students cross the stage to receive their degrees. Those students' theses (as well as those from previous years) are available on www.digitalnz.org – sort by 'thesis' and then by EIT as the content provider.

There were 19 refereed journal articles and 6 national/international conference presentations on health related topics by EIT staff in 2016. In addition, there are thirteen EIT-funded research and three externally funded projects underway.

EIT appreciates the interaction with and support of the wider Hawke's Bay research community. The HB Clinical Research Committee is an important part of that network.

University of Otago

Associate Professor Ross Freebairn – Associate Dean Undergraduate Studies

The University of Otago has several regional campuses – including Hawke's Bay. While the principal role of the Hawke's Bay campus is providing clinical experience and training for physiotherapy, dietetic and final year medical students, participation in research is another vital activity.

The University of Otago Wellington Associate Dean is working with the other Regional Associate Deans of the University of Otago to enhance its profile to support clinicians who have a research interest or project. A role of the Associate Dean is to facilitate research in the Hawke's Bay DHB. It is acknowledged that the challenges of undertaking research in the setting of the delivery of acute health services are many. The University can assist with process, grant applications as well as the detail of methodology, analysis and academic rigour. The University also has available summer studentship programs that can fund short research projects completed by medical students during the summer break.

Hawke's Bay Medical Research Foundation (HBMRF)

David Barry – QSO FRCP FRACP DCH, HBMRF

The HBMRF is a registered Charity founded in 1961 to "promote, initiate and support research in all health related fields including medical and health education, knowledge and understanding'.

The Foundation is particularly interested in promoting research relevant to, and carried out by, Hawkes Bay people.

One funding round occurs each year. Successful applicants are usually notified in February.

2016 saw the retirement of long serving secretary and Hasting District Council representative Judy Baxter. Her hard work and loyalty to the Foundation was acknowledged by all. She was replaced as HDC representative by Cr. Malcolm Dixon and as secretary by Lorraine Guillemot.

The Foundation's Annual report noted research funded but not yet completed;

- How do Patients with multiple long term conditions manage their health
- Characterisation of N.gonorrhoea resistant to Ceftriaxone
- Human Papilloma Virus and Oropharyngeal Carcinoma
- Persistent leptospirosis infection symptoms in NZ
- Fighting for Maori Health-The PATU initiative
- Pre-diabetes intervention package in primary care (PIP)
- Hypoglycaemia prevention in new-borns with oral Dextrose

Completed studies were:

- Lucy Zwimpfer: Talking to Babies in a Neonatal Intensive Care Unit: impact of verbal soothing on measures of infant stress during heel prick procedures.
- Emma Merry; What are the barriers and enabling factors affecting motivation to teach in the clinical environment of Intensive care in New Zealand

More detailed Information about the HBMRF can be found at www.hbmrf.org.nz

DHB CTRU Research

Diana Schmid, Coordinator – Research. RN and Manager Clinical Trials Research Unit

The Clinical Trials Research Unit (CTRU) was established within Hawke's Bay Hospital in 1998. The unit is based in Villa Two at Hawke's Bay Hospital and is responsible for the management and coordination of clinical trials conducted within the Medical Service. The unit also provides advice and support to clinicians in other hospital services who are interested in starting clinical trials research. The Chief Medical Officer (Hospital) is the Director of this unit, and the Research Coordinator manages the operational requirements and is supported by experienced research nurses.

Clinical trials conducted over the past 19 years have covered a wide range of clinical indications including acute coronary syndromes, stable & unstable angina, atrial fibrillation, heart failure, hypertension, hyperlipidaemia, stroke, diabetes, osteoporosis, ulcerative colitis, Crohn's disease,
C Difficile infection, irritable bowel syndrome, rheumatoid arthritis, obesity, respiratory syncytial virus and hypoglycaemia prevention in high risk newborn babies.

Staff within the CTRU are proud of their achievements in all areas of trial participation. Hawke's Bay Hospital has a reputation both nationally and internationally as a site which maintains high standards in protocol adherence, patient recruitment & retention and data quality. We have undergone three external audits and received very positive feedback on each occasion with no major findings.

Currently there are 11 trial investigators actively involved in the conduct of 8 ongoing clinical trials covering cardiology, endocrinology, gastroenterology, rheumatology and paediatrics.

The future of clinical trials in New Zealand and Hawke's Bay is reassuring, with many sponsors and clinical research organisations contacting us regularly to invite our physicians to participate in new trials. However, our capacity is limited by resources and increasing clinical demands.

DHB Nursing and Clinical (non CTRU) Research

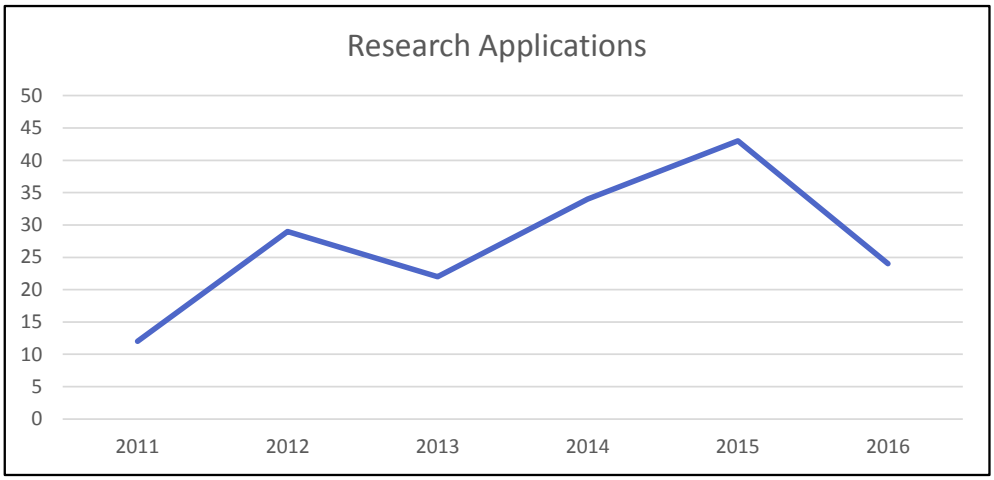
Sally Houliston, Nurse Consultant Workforce Development, HBDHB

The coordination of locality review and authorisation for research conducted within HBDHB (excluding clinical trials managed by the CTRU) continues to be managed by Sally Houliston, Nurse Consultant Workforce Development (as delegated by the CEO/CMO/CNO). Locality review is the process by which a locality (in this case HBDHB) assesses its suitability for the safe and effective conduct of a study. If a locality is satisfied that this is the case, it authorises the study. This relates to research which involves consumers of our health service and / or our employees.

There has been a diverse range of new research being commenced within HBDHB during 2016, involving either patient's as consumers of health care or DHB employees. The researchers are often conducting research as part of postgraduate (masters), PhD studies or as part of vocational training programmes. Research topics focus on areas such as chronic disease, improving Māori health, workforce development. Some examples include:

- Examining the factors influencing decision-making amongst End-Stage Renal Disease (ESRD) patients considering asking family & friends for a kidney
- Addressing adverse outcome suffered by Maori babies from SAMM events: SAMM Kids Burden
- The National Child Protection Alert System: a study of inter-rater reliability
- ESKD patient's perceptions of pre-dialysis information / resources
- The effect of a structured long term care management programme on hospital presentations
- Nurses recognition and action in response to unsafe practice by their peers
- What makes a good preceptor? Perspectives of recent new graduate nurses in NZ

- What are the experiences of dialysis nurses in NZ discussing advance care planning and death & dying with their patients?
- The role & benefit of accessing primary care records during unscheduled care
- Māori staff workplace wellbeing survey HBDHB



HAWKE'S BAY District Health Board Whakawāteatia	**Infection Prevention Control Committee Update**
	For the attention of: **HB Clinical Council**
Document Owner:	Chris McKenna, Chief Nursing Officer
Reviewed by:	N/a
Month:	May, 2017
Consideration:	For Information

RECOMMENDATION

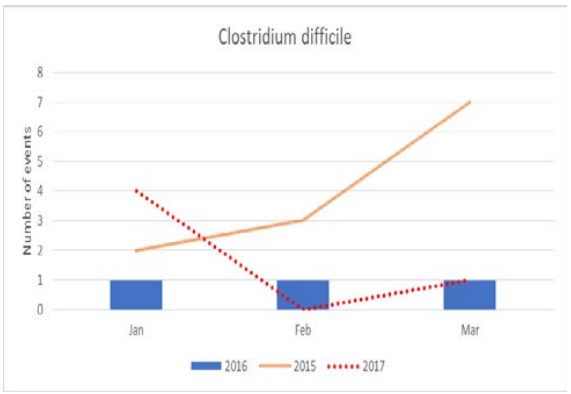
That Clinical Council:

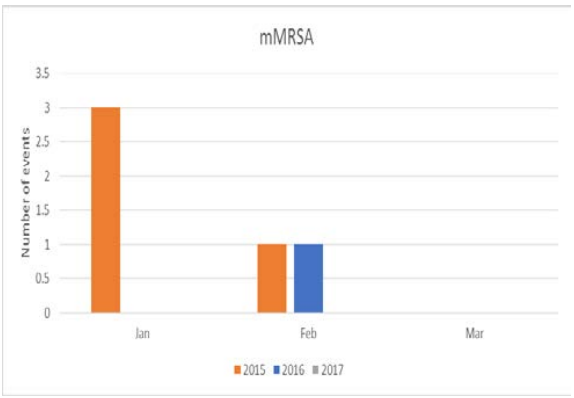
Note the contents of this report.

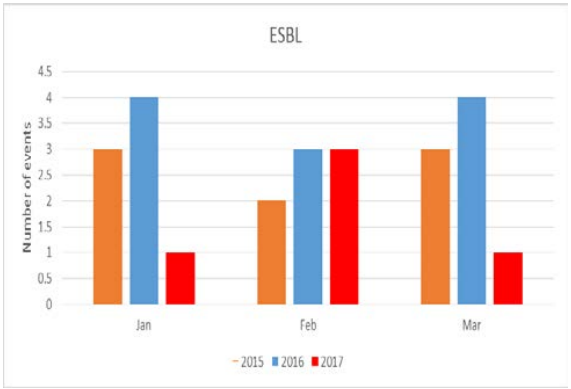
Surveillance

Below graphs show surveillance trends for the first quarters January – March 2015-2017. Surveillance is continuous, with monthly reporting to the Infection Control Committee (ICC).

All surveillance for the previous quarter remain within thresholds agreed by the ICC committee.







Health Quality Safety Commission (HQSC) Programmes

Hand Hygiene

HBDHB Hand Hygiene compliance rate for the quarter ending March 31 reported an overall compliance rate of 88.7%. HBDHB achieved the highest compliance rate in New Zealand. Nursing and Allied Health Staff are trained Gold Auditors which enables this achievement. Four new hand hygiene auditors were trained and validated March 2017.

National Orthopaedic Surgery Latest Quarterly Report (July to September 2016)

For this reporting period HBDHB has performed 90 procedures and no surgical site infections have been reported.

The report acknowledged and congratulated HBDHB, as one of seven DHB's which met and exceeded both QSM's (correct timing and dose of antibiotic prophylaxis).

Month	Event	Comment / action
February	Norovirus	One aged care facility reported a confirmed Norovirus outbreak. The Infection Prevention and Control Advisors (IPCA) provided advice and support to the facility as required, in conjunction with Health Protection.
March	Scabies	IPCA were contacted by two aged care facilities (Atawhai and Colwyn House). Both facilities requested advice regarding intermittent ongoing scabies like symptoms in their facilities. IPCA provided support, including an onsite visit, and continue to act in an advisory role. This is on the agenda for the April ICC meeting.
Ongoing	Hospital Isolation Management	The availability of single rooms continues to influence the management and isolation of multi drug-resistant organisms (MDRO). The risk management strategies undertaken by the IPCA's have minimised cross infection in this challenging environment.

HAWKE'S BAY District Health Board Whakawāteatia	**Legislative Compliance Programme Report**
	For the attention of: **Executive Management Team**
Document Owner: Document Author(s):	Kate Coley, Executive Director of People & Quality Kaye Lafferty, Patient Safety & Clinical Compliance Manager
Reviewed by:	Kate Coley, Executive Director of People & Quality Ken Foote, Company Secretary
Month:	May 2017
Consideration:	For Discussion / Information

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RECOMMENDATION

1. **Note** the contents of this report.
2. **Note** the action plan (Appendix 1)
3. **Note** that a review of the value of an annual legislative Compliance programme will be investigated, in light of all the other audits and reviews undertaken annually and a recommendation put forward to FRAC.

PURPOSE

The purpose of the Legislative Compliance Review is to inform the Executive Management Team & FRAC of the level of compliance with a range of relevant statutes and regulations within services and departments of the Hawke's Bay District Health Board (HBDHB).

OVERVIEW

Every District Health Board (DHB) is a Crown Agent for the purposes of the Crown Entities Act 2004 (CE Act). DHBs are established under the New Zealand Public Health and Disability Act 2000 (NZPHD Act). Other legislation which applies to DHBs includes:

- State Sector Act 1988;
- Public Finance Act 1989;
- Commerce Act 1986;
- Official Information Act 1982;
- Privacy Act 1993;
- Protected Disclosures Act 2009;
- Public Records Act 2005;
- Various pieces of employment legislation.

The NZPHD Act creates the main organisations of New Zealand's public health system, and sets out their relationships between each other and the Crown. The NZPHD Act contains detailed provisions applicable to DHBs, covering such issues as DHBs' objectives, powers, duties, governance arrangements, elections, and so on. Everything done by a DHB derives its validity or

otherwise from the NZPHD Act. The Crown Entities Act provides the mechanisms for ensuring accountability of senior management and Boards of DHBs.

The Health and Disability Services (Safety) Act 2001 sets out the process for approving service standards, certification and audit of health care service providers. Service providers compliance with Standards are audited by designated audit agencies. Service providers are required to apply to the Ministry of Health for certification under the Act. The core standards include the following areas.

- Consumer Rights
- Organisational Management
- Continuum of Service Delivery
- Safe & Appropriate Environment
- Restraint Minimisation and Safe Practice
- Infection Prevention and Control

A full certification audit was undertaken 12-15 April 2016. A total of 22 corrective action requests were applied, all of a low risk rating. The Health Cert division at the Ministry of Health issued HBDHB with Certification for a further 3 years expiring 6 August 2019. The next mid-point surveillance will be undertaken in October/November of 2017. A progress report has been provided to the MOH on improvements relating to our corrective actions in February 2017 and 10 of the corrective actions have been closed. A further progress report is to be supplied to the MOH in August 2017.

BACKGROUND

HBDHB uses the E-services programme offered by Chapman Tripp. The costs associated with this annual review equate to $8,000 - $10,000. (Cost of software, staff hours to undertake the assessment, ongoing monitoring and implementation of corrective actions).

This programme is divided into sections, these are currently:

- Certification
- Commercial Activity
- Consumer Care
- Health & Safety
- Information Management
- Employment

Appropriate managers are identified as having the prime delegated responsibility/accountability from the Chief Executive to ensure that HBDHB complies with the various legislative provisions within each of the above sections.

In addition to the annual review, legislative compliance at HBDHB is monitored through a number of other external audit processes including:

- Ministry of Health Certification audits
- IANZ Accreditation Audits (Radiology and Laboratory)
- National Radiation Laboratory Audits
- National Screening Unit – Breast Screening Programme Audit
- National Cervical Screening Programme (NSCP Colposcopy Audit)
- NZ Blood Service Audits
- ACC Partnership Audits

In addition HBDHB undertakes a number of internal activities with monitoring of clinical action or outcomes e.g. serious event investigation, Protected Quality Assurance Activities (PQAA) such as clinical audit, and morbidity and mortality meetings, Quarterly HR KPIs and Bi-Monthly OH&S reports.

For the most part compliance with HBDHB policies and other related documents are sufficient to maintain legislative compliance. These documents reflect the specific section of the Acts which apply to the DHB. In some instances, the DHB has not translated an Act into policy.

However other arrangements such as specific job descriptions are used to cover compliance activity.

HBDHB undertakes the following assurance measures to assist with compliance:

- Provision of training or seminars in the relevant legislation
- Ensuring job descriptions are appropriately updated to reflect responsibilities
- providing clear policy statements that assist staff to comply with legislation
- scheduling of internal audit and other compliance checks.

Having undertaken this review for a number of years, and in discussion with the other DHBs it is clear that only a small number of DHBs (5/20) complete this annual assessment, The majority of DHBs utilise the other audits, policy and certification audits to provide assurance to their Boards. A full investigation will be undertaken in regards to the DHBs requirements and a recommendation paper will be provided to FRAC in the future.

FINDINGS

Summary of Compliance (as at January 2017):

Subject	Compliant	Other mechanisms/audits to provide assurance
Accident and Rehabilitation	Yes	ACC Partnership
Accident recording and investigation, Facilities and Monitoring	Yes	Certification
Anti-competitive behaviour	Yes	
Certification	No	Certification
Codes of Practice, Stress, OOS, HPCA	Yes	Certification, ACCPP
Biosecurity	Yes	
Infection Control	Yes	Certification
Complaints Management	No	Certification
Employment Relationships	Yes	
General Health & Safety	No	Certification, ACCPP, Internal Audit, Bi-Monthly FRAC report
Hazardous Substances and New Organisms	No	Certification, ACCPP, Internal Audit, Bi-Monthly FRAC report
Health Act	Yes	Certification
Land Transport	Yes	
Misuse of Drugs	Yes	Certification
Informed Consent	No	Certification
Leave	Yes	Policy, HR KPI's
Medication Management	Yes	Certification
Mental Health Patients	No	Certification
Privacy and Confidentiality	No	Certification
Radiation Protection,	Yes	IANZ Accreditation
Smokefree Environments	Yes	Policy
Requests for Information	Yes	Certification, OIA Process, Privacy Act & Policy
Salary, Wages	Yes	
Service Quality	No	Certification
Vulnerable Persons	Yes	Certification, Vulnerable Children's Act requirements

Appendix 1 – Recommendations for Improvement

Checklist Item	Governing Statute	Checklist Reference	Finding as at November 2016	Update as at March 2017
Certification	Health & Disability Services (Safety) Act 2001 Health & Disability Services (Safety) Exemption Order 2002 Health & Disability Services (Safety) Standards Notice 2008	Does the hospital meet relevant service standards?	The DAA audit agency and MOH issued HBDHB with 22 low risk corrective action requests.	Good progress being made on all corrective actions. Results forwarded to MoH HealthCert at the end of February. 10 corrective acitons closed.. Work is in progress to address the remaining 12 coorective actions.
Complaints Management	Health & Disability Services (Safety) Act 2001 Code of Rights	Are complaints solved simply, quickly and fairly within the required timeframe of 20 working days?	Some complaints are complex and require in-depth review. Complainants advised regarding delays and reasons for same. Complainants are provided with expected date of resolution.	Process for consumer feedback currently being reviewed. Close monitoring and report regarding complaint resolution developed and shared with Health Services.
General Health & Safety	Section 38, Health and Safety at Work Act 2015	Have you ensured that all fixtures, fittings or plant at the workplace that you manage or control is, so far as is reasonably practicable, without risks to the health and safety of any person?	There have been improvements to guarding of some plant in facilities. Others are still underway and will continue to be updated. Due to the size of the site and number of pieces of plant to review across the site, this will be an ongoing item throughout 2017.	Facilities continue to review plant with the assistance of the H&S Advisor as required.

Checklist Item	Governing Statute	Checklist Reference	Finding as at November 2016	Update as at March 2017
General Health & Safety	Section 41 Health and Safety at Work Act 2015	Are all items of plant and equipment monitored for repairs and maintenance?	Limited planned maintenance system for non-clinical equipment. Equipment is repaired at break-down. Facilities advised that equipment is maintained to standard. Clinical equipment, however, does have a preventative maintenance system in place. Equipment is maintained as per manufacturer's instructions/NZS 3551 etc.	Ongoing.
General Health & Safety	Section 41 Health and Safety at Work Act 2015	Are all items of plant and equipment monitored for safe levels of usage?	Clinical equipment is monitored for safe levels of usage. There are specific intervals where it must be checked and Clinical Engineering advise that this takes place. Non-clinical equipment – facilities advise that they do not over-use their plant/equipment. They advised that they do not monitor plant/equipment that they do not have control over. Some plant e.g. cooling towers, have contractor involvement for testing levels etc.	A register of plant/ equipment is under development, which includes safe levels of usage.
General Health & Safety	Section 41 Health and Safety at Work Act 2015	Are all items of plant and equipment monitored for use in physically designated use areas only?	Clinical equipment is used in specific areas. Non-clinical equipment is used in areas as required, with the exception of static plant in facilities which remains in situ.	Ongoing

Checklist Item	Governing Statute	Checklist Reference	Finding as at November 2016	Update as at March 2017
General Health & Safety	Regulation 16, Health and Safety in Employment Regulations 1995 and Regulation 24, Health and Safety at Work (General Risk and Workplace Management) Regulations 2016	Raised and falling objects?	Further investigation required by H&S Advisor and Facilities.	Ongoing.
General Health & Safety	Regulation 17, Health and Safety in Employment Regulations 1995	Machinery cleaning and repair work?	Clinical. Clinical equipment is not cleaned by Clinical Engineering, it is cleaned by the Departments. Some written safe operating procedures (SOP's) for cleaning equipment e.g. laboratory centrifuge. Non-clinical. There are no SOP's for cleaning equipment. SOP's will be required to link to Lock Out/Tag Out (LOTO). There is currently no LOTO policy in place. An informal system is in place, however, it requires review and a more robust system.	SOP's to be completed. Due to the large number of plant/equipment this will be progressively completed throughout the year. H&S Advisor has met with Facilities to discuss LOTO. More equipment required. A policy/procedure to be implemented. To be completed by Facilities/ H&S Advisor by end June 2017.
General Health & Safety	Regulation 18, Health and Safety in Employment Regulations 1995)	Woodworking and abrasive grinding machinery?	Guarding has been significantly improved. When re-visited by H&S Advisor, there were still a few gaps that need to be closed up on woodworking machinery.	Completed
General Health & Safety	Regulation 20, Health and Safety in	Self-propelled mobile mechanical plant?	The tractor guarding has been attached. However, there is a gap	Complete

Checklist Item	Governing Statute	Checklist Reference	Finding as at November 2016	Update as at March 2017
	Employment Regulations 1995)		where a small hand could enter the belt drive area. This would be a deliberate act. There is a forklift located at the store which is regularly maintained and operators are trained and have been recently re-certified.	
General Health & Safety		Workplace stress/excessive hours?	While there have been minimal incident reports for stress/excessive hours, these are investigated and acted upon. The Occupational Physician becomes involved in the event. It is positive to see workers using the notification process. A fatigue questionnaire was sent out to two busy areas of the DHB, which focussed on out of work issues that can affect fatigue at work. Rostering guidelines are in place.	People Strategy to look at the issue of fatigue and stress management.
General Health & Safety	Section 44, Health and Safety at Work Act 2015	Have you ensured that officers have complied with their obligation of due diligence?	Initial gap analysis undertaken.	Assessment through use of Safe365 tool and paper to FRAC / Board in relation to H&S Progress and action to reduce any residual gaps.
Hazardous Substances and New Organisms	Section 2, Hazardous Substances and New Organisms Act 1996)	• Are any hazardous substances with one or more of the following intrinsic properties located on site: explosiveness; • toxicity (including chronic toxicity);	WorkSafe HSNO Audit undertaken 20 September 2016. No issues raised.	Ongoing

Checklist Item	Governing Statute	Checklist Reference	Finding as at November 2016	Update as at March 2017
		• ecotoxicity; • or substances which on contact with air or water generate a substance with any one or more of the properties specified above.	We do have ecotoxics and toxics on site. We have a membership with Responsible Care where we can call 24/7 if there is a hazardous substance emergency and all workers have been advised.	
Informed Consent	Code of Rights	Do consumers' health records record that official documents appointing welfare guardians or enduring power of attorney have been sighted by the facility manager?	Prompts are available in Health Records to remind staff to obtain confirmation and verification of EPOA. EPOA legal documentation to be held on ECA. A recent snapshot audit undertaken evidences poor compliance	Snapshot audit undertaken evidencing poor compliance. This matter has been raised with Health Service directorate teams. In-service education undertaken in February 2017. Buddle Findlay will provide further guidance material on an ongoing basis.
Informed Consent	Code of Rights	If consumers have an advance directive, is a record of that directive kept in their health record?	Records of Advance Directives to be kept in health records. HQSC is leading a major quality initiative regarding advanced directives.	Advance Directives discussed at Clinical Council meeting in November 2016. Further work ongoing to embed across all clinical areas.
Informed Consent	Code of Rights	Do care plans record if consumers agree to be involved in student teaching	Formal consent is obtained for consumers regarding students being involved in care. Health record documentation to be revised to incorporate this information.	Ongoing

Checklist Item	Governing Statute	Checklist Reference	Finding as at November 2016	Update as at March 2017
Informed Consent	Code of Rights	Does the consent form contain the presence of staff not directly involved in the treatment (e.g. students)?	The presence of students not directly involved in the patient's treatment to be included in the next re-print of Consent form.	Ongoing
Informed Consent	Code of Rights	Does the consent form contain the name, signature and language of an interpreter	The name, signature and language of the interpreter will be included in the next reprint of the consent form.	Name of Interpreter now included on form.
Mental Health Patients	Mental Health (Compulsory Assessment and Treatment) Act 1992	Do all patients detained under the Mental Health Act have correctly completed documentation?	Mistakes are made on completion of some paperwork due to human error. Mechanisms are in place to check, identify and correct	Ongoing
Privacy and Confidentiality	Health Information Privacy Code 1993	Is a record kept of who has and has not received training and updates?	The Learning & Development Service keep a record of staff attending in-service privacy training. There is a need to implement a record of training for contractors, trainees and volunteers who have attended training in Privacy & HIPC.	Now incorporated in Learning & Development records – Complete.
Service Quality	Code of Health and Disability Services Consumers' Rights Regulations 1996	Are care/treatment plans reviewed regularly by both medical and nursing staff to ensure the plan is geared to meet the consumers' changing needs?	More coordination is required for Care Plans. Audit to be undertaken to ensure all Care Plans meet the Health Records standard.	Audit scheduled in Clinical Nurse Manager audit programme.

OURHEALTH
HAWKE'S BAY
Whakawateatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

16. Minutes of Previous Meeting (Public Excluded)

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

18. Member Topics of Interest – Member issues / updates

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

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