Hawke's Bay Clinical Council Meeting

Date: **Wednesday, 13 September 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:

Dr Andy Phillips (Co-Chair)
Chris McKenna (Acting Co-Chair)
Dr Mark Peterson
David Warrington
Dr Robin Whyman
Lee-Ora Lusis
Dr Nicholas Jones
Jules Arthur
Dr Tae Richardson
Dr David Rodgers
Dr Russell Wills
Debs Higgins
Anne McLeod
Dr Kiri Bird

Apology: Dr John Gommans (Co-Chair)

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

PUBLIC MEETING

Item	Section 1 – Routine	Time (pm)
1.	Apologies / Welcome / Meeting Rules New Format	3.00
2.	Interests Register	
3.	**Recommendation to Exclude the Public**	

PUBLIC EXCLUDED

Item	Section 2 – Workshop	Time (pm)
4.	After Hours Concept Wayne Woolrich / Mark Peterson and David Rodgers	
5.	Minutes of Previous Meeting (public excluded)	
6.	Matters Arising - Review Actions (public excluded	
7.	**Recommendation to move into the Public section of the meeting**	

PUBLIC MEETING

Item	Section 3 – Focus on providing quality acute hospital care 24/7	
8.	Consumer Story of Acute Care	3.40
9.	Staff Story of providing Acute Care	3.45
10.	When Patients Deteriorate - David Warrington and Mike Park	3.50
11.	Trauma Service – Sharon Mason / Albert Lo and Susan Hawken	4.05
12.	Acute Flow – Sharon Mason / Colin Hutchinson / Paula Jones and David Warrington	4.20
13.	"Health Roundtable view of a patient journey through Hawke's Bay Hospital" Gail Prileszky	4.35
	Section 4 – For Decision	
14.	Quality Dashboard Concept Paper – Kate Coley	5.00
15.	Quality Improvement & Patient Safety / Quality Annual Plan 2017/18 – Kate Coley	5.10
16.	Implementing the Consumer Engagement Strategy – Kate Coley / Jeanette Rendle	5.15
17.	Position on Reducing Alcohol Related Harm – Tracee TeHuia / Rachel Eyre	5.20
	Section 5 – Monitoring and Information only	
18.	Te Ara Whakawaiora / Healthy Weight (national indicator)	-
19.	Clinical Advisory & Governance Group Report (monthly)	-
20.	Falls Minimisation Committee (6 monthly)	-
21.	Maternity Clinical Governance Group Update (6 monthly)	-
	Section 1 – Routine continued	
22.	Minutes of Previous Meeting Minutes of Annual General Meeting	5.30
23.	Matters Arising – Review Actions	
24.	Clinical Council Workplan	

NEXT MEETING - Wednesday, 11 October 2017

Hawke's Bay Clinical Council Meeting

Dear Colleagues

At the August meeting of council we agreed to change the content and format of future meetings. For the September meeting we have designed the agenda to focus attention on a small number of significant issues. We have also intentionally moved the procedural business to the end of the meeting so we can give our best attention to the most important matters at the start. The programme is quite full, so we are asking council members to read the material carefully prior to the meeting. We have scheduled five minutes only for a number of papers so we would ask council members to contact either of the co-chairs if you would like a longer discussion of these short items.

You will see from the agenda that this month we will be focussing on acute services in both primary and hospital care.

For the primary care paper in the public excluded section we would like to be able to make a recommendation from Council to the Board.

For the public part of the meeting we have a number of items related to acute care in hospital. The purpose of this section is :

- ✓ To provide information to Clinical Council to support members to understand quality and safety of care provided in hospital to discharge our duty to provide assurance
- ✓ To inform members in respect of contributing to development of the clinical services plan
- ✓ To start to inform development of the workplans of some of the Sub-committees and Advisory Groups within our agreed Clinical Governance structure.

The agenda has been constructed to allow members to raise questions and comment on the items. The chairs will be seeking to ensure that members have their say, but that the meeting concludes on time and that there is an accurate summary of reflections and agreed actions for the minutes.

Chris McKenna has kindly agreed to co-chair for this meeting in the unavoidable absence of one of the newly elected co-chairs.

We're looking forward to a lively discussion

Andy Phillips and John Gommans
Co-chairs

Interests Register
9 August 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
Jules Arthur (Midwifery Director)	National Midwifery Leaders Group	Chair	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	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
Dr Tae Richardson (GP and Chair of Clinical 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	
	Dr Bryn Jones employee of MoH	Husband	Deputy Chief Strategy & Policy Officer (Acting)	No	
	Pacific Chapter of Royal NZ College of GPs	Secretary			
	Ministry of Health - First Specialist Assessment Oversight Group	Member		No	

Name **Clinical Council Member**	**Interest** **eg Organisation / Close Family Member**	Nature of Interest **eg Role / Relationship**	Core Business **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
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	
	Totara Health / Youth Contract with Directions	Employee of Totara Health		No	
Dr Nicholas Jones (Clinical Director - Population Health)	NZ College of Public Health Medicine	Fellow	Professional network	No	
	Association of Salaried Medical Specialists	Member	Professional network	No	
	HBDHB Strategy & Health Improvement Directorate	Employee	Employee	No	
	National Information Clinical Leadership Group	Member	Professional network	No	
Maurice King (Community Pharmacist)	Napier Balmoral Pharmacist	Shareholder and Director	Community Pharmacy	Yes	Has various contracts with HBDHB to provide pharmacy based services. Low. Ensure position declared when discussing issues in this area.
	Pharmacy Guild of NZ	Member	Representative and negotiating organisation for Pharmacy	Yes	Negotiations on behalf of Napier Phamacy with HBDHB. Low. Ensure position declared when discussing issues in this area.
	Phamaceutical Society of NZ	Member	Pharmacy advocacy, profressional standards and training.	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Independent Advisor	No	

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:

4. After Hours Concept

5. Minutes of Previous Meeting (Public Excluded)

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

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).

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Recommendation to move into the Public Section of the meeting.

CONSUMER STORY – ACUTE CARE

STAFF STORY – PROVIDING ACUTE CARE

10

WHEN PATIENTS DETERIORATE

Presentation

11

TRAUMA SERVICE

Presentation

12

ACUTE FLOW

Presentation

HEALTH ROUNDTABLE – VIEW OF A PATIENT JOURNEY THROUGH HBDHB

Presentation

HAWKE'S BAY District Health Board Whakawāteatia	**Quality Dashboard**
	For the attention of: **HB Clinical Council and HB Health Consumer Council**
Document Owners/Authors:	John Gommans (CMDO), Chris McKenna (CNO), Andrew Phillips (CAHPO); Russell Wills (MD QIPS); and Kate Coley, Executive Director of People & Quality
Reviewed by:	Executive Management Team
Month:	September 2017
Consideration:	For Endorsement

RECOMMENDATION

That Clinical and Consumer Council

- **Endorse** the establishment of a Quality Dashboard.
- **Note** that the dashboard will be reported on a quarterly basis and shared across the sector from December 2017

OVERVIEW

The governance of clinical quality and patient safety occurs within the context of the broader governance roles of boards, which includes financial governance, health & safety, managing risk, setting strategic direction and ensuring compliance with statutory requirements. Clinical Governance is defined as

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

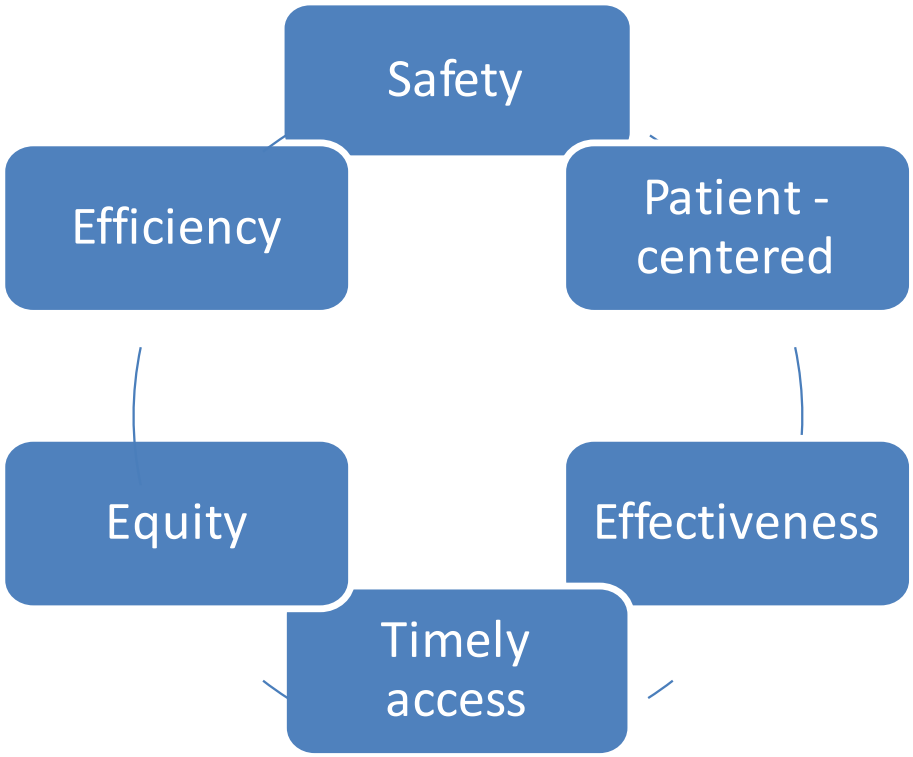
An effective system of clinical governance at all levels of the health system is essential to ensure continuous improvement in the safety and quality of care, Good clinical governance makes certain that there is accountability and creates a 'just' culture that is able to embrace reporting and support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

The DHB has both a stated commitment to quality and safety and a well-established patient safety and quality management system in place. With the establishment of the new clinical governance committee structure, there is now an opportunity to give more prominence to this commitment and establish a quality dashboard.

The purpose of this report is to seek approval for the establishment of a quality dashboard to provide assurance to the Board, EMT, and Clinical Council in regards to the core dimensions of quality.

OVERVIEW OF THE DASHBOARD

As identified the dashboard will be built around the core domains of quality as defined by the Institute of Medicine (IOM) detailed below.



The timing of the development of this dashboard aligns to a piece of work currently being undertaken by Health Quality & Safety Commission (HQSC) and DHBs to establish a national quality dashboard. HBDHB clinical leaders are providing input into the development of the plan influencing the type and number of measures and indicators. It is envisaged that the dashboard will be available in December 2017 and will include around 170 published data items including a newly established primary care dataset. The dashboard will allow understanding of movement over time and valid comparison between other DHBs, both nationally and regionally, with commentary focussing on areas where the DHB is below target performance and the identification mitigation and quality improvement activities to get the indicator back on track.

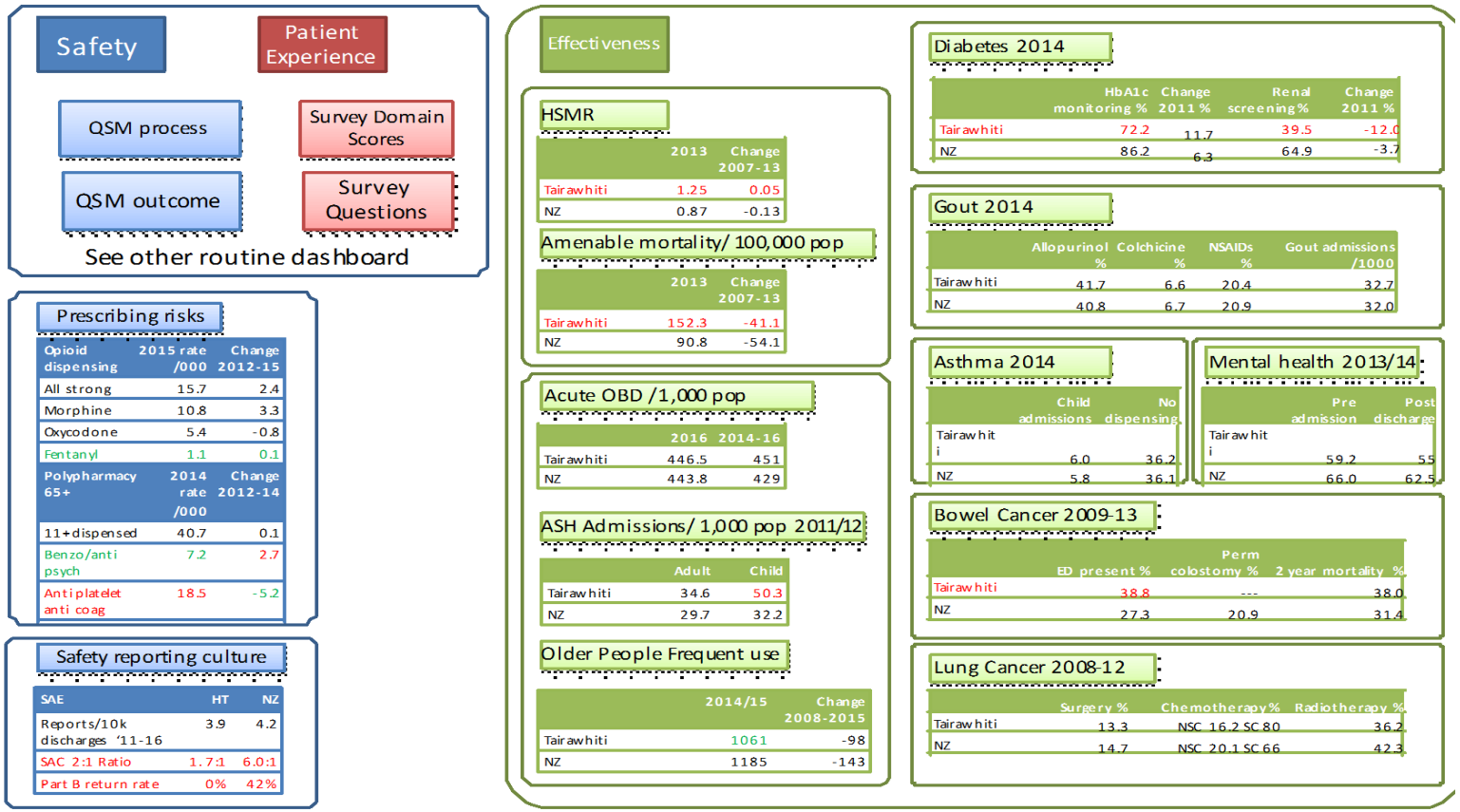
Depending on the final design of the HQSC dashboard it may be necessary to supplement the indicators with those safety issues that are pertinent to the DHB as follows:

- Number of Patient at Risk Calls/Rapid responses,
- Unplanned readmission rates
- Stranded patients/long stay patients (unexpected LOS over 10 days).
- Serious Adverse events (SAC1 & 2)
- Number of days where acute demand is greater than capacity

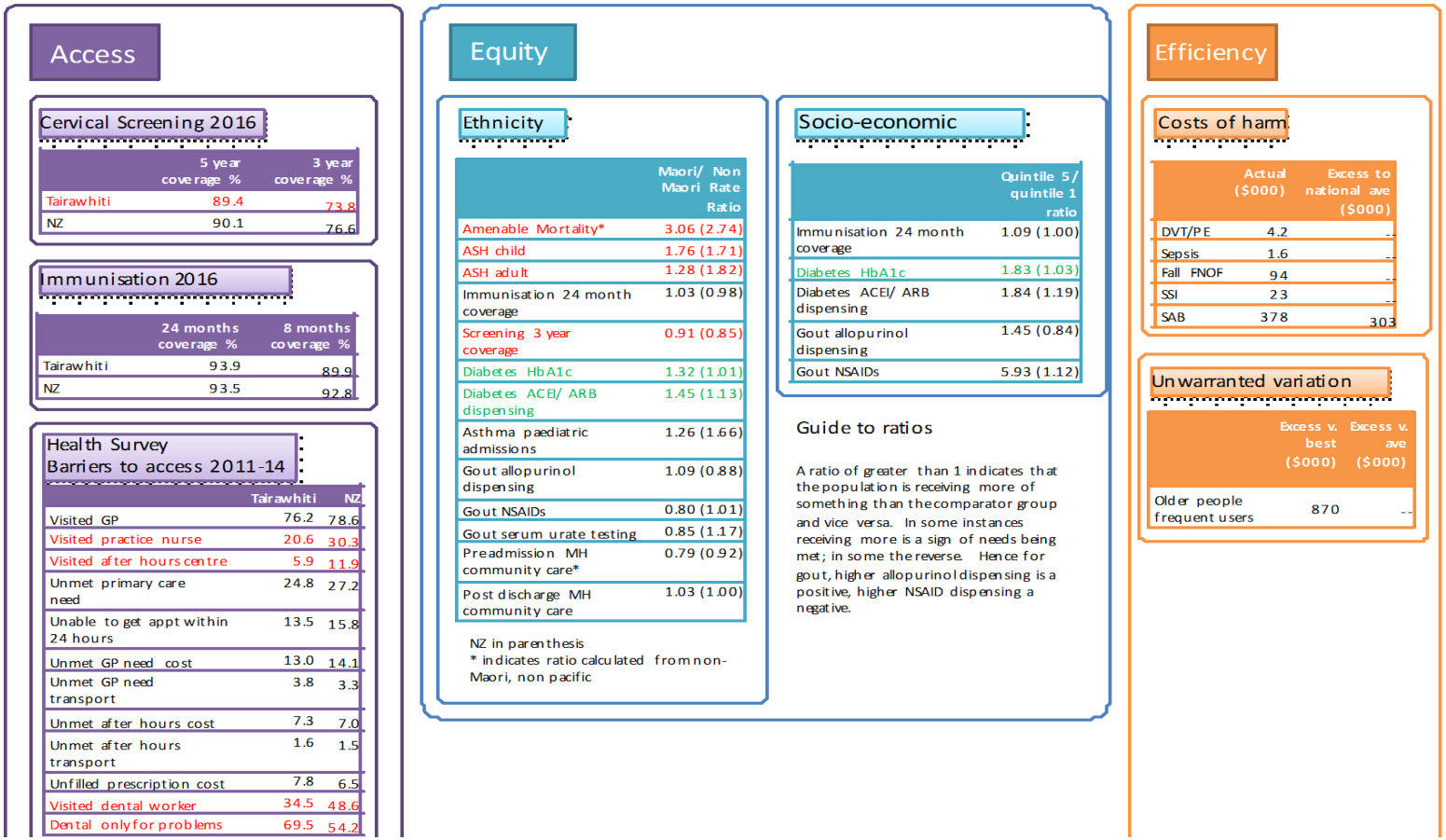
The following shows an example of the dashboard indicators and the proposed format of presentation of those results for comparison against other DHBs.

Appendix 1 - Example of Dashboard Indicators – Still to be finalised

Dashboard – example of Hauora Tairawhiti



Dashboard – example of Hauora Tairawhiti



Access

Cervical Screening 2016

	5 year coverage %	3 year coverage %
Tairawhiti	89.4	73.8
NZ	90.1	76.6

Immunisation 2016

	24 months coverage %	8 months coverage %
Tairawhiti	93.9	89.9
NZ	93.5	92.8

Health Survey Barriers to access 2011-14

	Tairawhiti	NZ
Visited GP	76.2	78.6
Visited practice nurse	20.6	30.3
Visited after hours centre	5.9	11.9
Unmet primary care need	24.8	27.2
Unable to get appt within 24 hours	13.5	15.8
Unmet GP need cost	13.0	14.1
Unmet GP need transport	3.8	3.3
Unmet after hours cost	7.3	7.0
Unmet after hours transport	1.6	1.5
Unfilled prescription cost	7.8	6.5
Visited dental worker	34.5	48.6
Dental only for problems	69.5	54.2

Equity

Ethnicity

	Maori/ Non Maori Rate Ratio
Amenable Mortality*	3.06 (2.74)
ASH child	1.76 (1.71)
ASH adult	1.28 (1.82)
Immunisation 24 month coverage	1.03 (0.98)
Screening 3 year coverage	0.91 (0.85)
Diabetes HbA1c	1.32 (1.01)
Diabetes ACEI/ ARB dispensing	1.45 (1.13)
Asthma paediatric admissions	1.26 (1.66)
Gout allopurinol dispensing	1.09 (0.88)
Gout NSAIDs	0.80 (1.01)
Gout serum urate testing	0.85 (1.17)
Preadmission MH community care*	0.79 (0.92)
Post discharge MH community care	1.03 (1.00)

NZ in parenthesis
* indicates ratio calculated from non-Maori, non pacific

Socio-economic

	Quintile 5/ quintile 1 ratio
Immunisation 24 month coverage	1.09 (1.00)
Diabetes HbA1c	1.83 (1.03)
Diabetes ACEI/ ARB dispensing	1.84 (1.19)
Gout allopurinol dispensing	1.45 (0.84)
Gout NSAIDs	5.93 (1.12)

Guide to ratios

A ratio of greater than 1 indicates that the population is receiving more of something than the comparator group and vice versa. In some instances receiving more is a sign of needs being met; in some the reverse. Hence for gout, higher allopurinol dispensing is a positive, higher NSAID dispensing a negative.

Efficiency

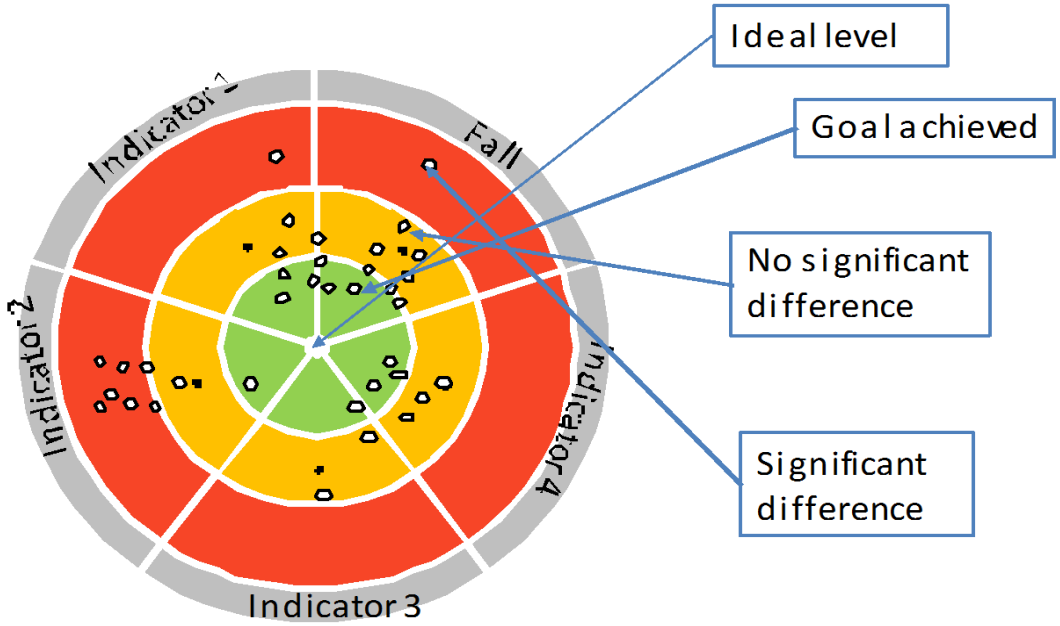
Costs of harm

	Actual ($000)	Excess to national ave ($000)
DVT/PE	4.2	-
Sepsis	1.6	-
Fall FNOF	94	-
SSI	23	-
SAB	378	303

Unwarranted variation

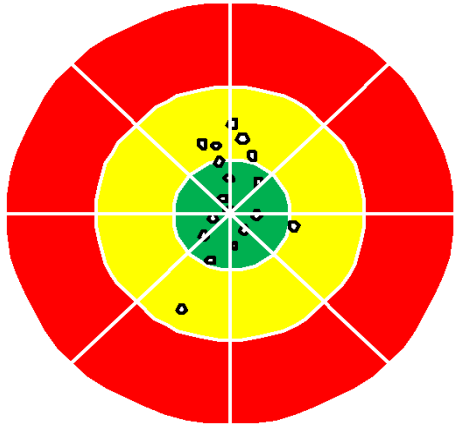
	Excess v. best ($000)	Excess v. ave ($000)
Older people frequent users	870	--

Dashboard future format : dartboard

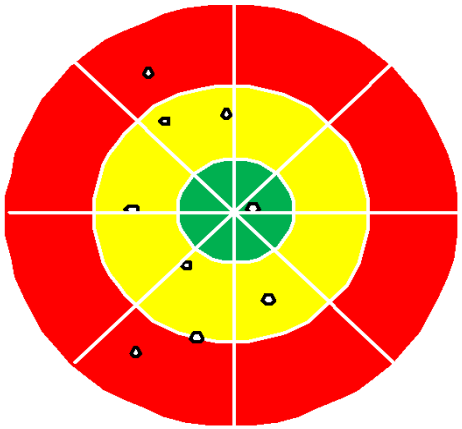


Dashboard future format

Dartboard, DHB picture



Domain 1



Domain 2

HAWKE'S BAY District Health Board Whakawāteatia	**Quality Improvement & Patient Safety Plan**
	For the attention of: **HB Clinical Council**
Document Owner & Author:	Kate Coley, Executive Director People and Quality
Reviewed by:	Executive Management Team
Month:	September, 2017
Consideration:	For Feedback/Discussion

RECOMMENDATION

That HB Clinical COuncil:

- Provide feedback and endorse in principle the Quality Annual Plan 2017 /18.

EXECUTIVE SUMMARY

With the embedding of the Working in Partnership for Quality Framework an annual quality plan is developed to ensure that the priorities and objectives identified in the framework are implemented. In addition to this, a number of other priorities including HQSC programmes, the Regional Services Plan and other local drivers have been identified.

The intention is that progress against the objectives detailed within will be reported every six months and progress will be identified as below.

Progress	Progress Indicator
●	Completed
●	On track
●	Behind, some risk
●	Behind plan, significant risk
Reporting Schedule	
6 month report	February 2018
Annual review	August 2018

Quality Improvement & Patient Safety

Annual Plan 2017 - 18

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Contents

Introduction & Context

The Quality Improvement and Safety Framework developed in 2013 outlines a framework to support integrated quality improvement and performance across the Hawke's Bay health sector by providing direction and priorities. Its aim is to ensure that the entire health sector has a shared sense of direction in provision of quality care for the Hawke's Bay people.

The Working in Partnership for Quality framework breaks quality improvement and safety into four dimensions to provide a focus for our work and help us identify more readily opportunities for improvement.

WELLNESS: Improving the health of our communities.

PEOPLE'S EXPERIENCE OF HEALTH CARE: Continuously improving the safety of our services, underpinned by a culture of care and compassion.

WORKING WITH THE PEOPLE OF HAWKE'S BAY: The patient, family/whānau and carer voice as an essential component of clinical quality improvement and patient safety.

LEADERSHIP AND WORKFORCE DEVELOPMENT: Clinical quality improvement and safety is embedded within the Hawke's Bay health sector workforce and leaders.

The Framework aligns to the NZ Triple Aim focussing on the three core components.

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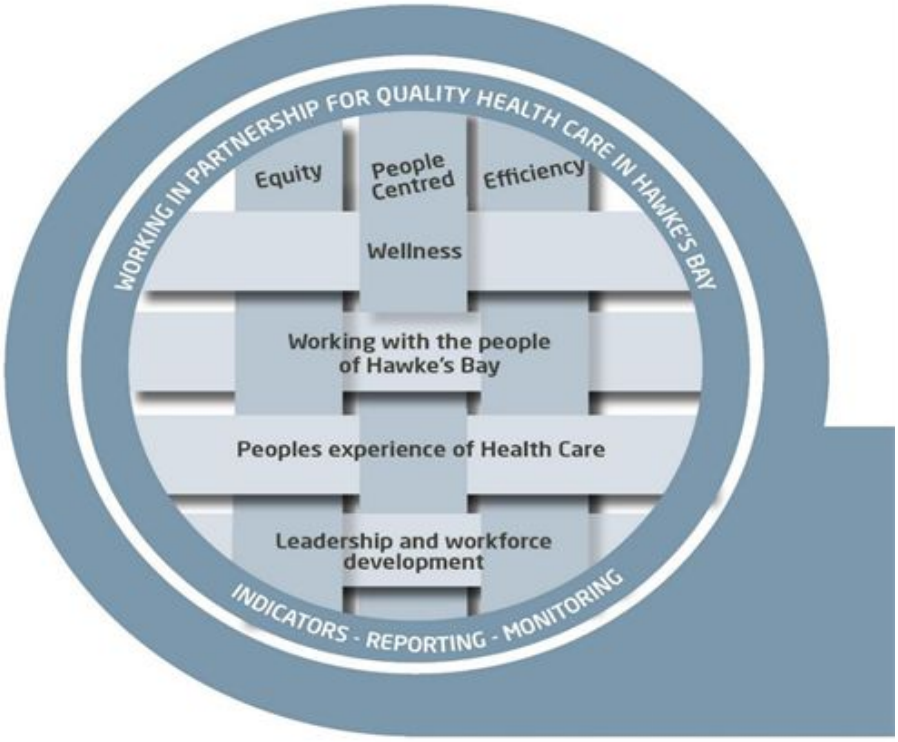
What does success look like?

- Every person that works in the Hawke's Bay Health sector will be aware of their responsibility for quality improvement and patient safety.
- Consumers are active participants in determining their wellness and their voice is valued in decision making.
- Clinical participation in management and governance of health services is essential in creating the culture needed for effective quality improvement and patient safety.
- Clinicians are not only responsible for the provision of high quality patient care, but their leadership is also important at all levels of the system.

Working in Partnership for Quality Framework



HEALTH CARE MUST BE:

- SAFE: Avoiding harm to patients from care that is intended to help them.
- EFFECTIVE: Providing services based on evidence and which produce a clear benefit, with neither underuse nor overuse of the best available techniques.
- PEOPLE CENTERED: Establishing a partnership between clinicians and patients, inclusive of family and whānau, to ensure care respects patient's needs and preferences; and the person should play an active role in making decisions about their own care.

- TIME: Reducing waits and sometimes harmful delays.
- EFFICIENT: Constantly seeking to reduce waste.
- EQUITABLE: Providing care that does not vary in quality because of a person's characteristics

WELLNESS

Population health and prevention programmes ensure that people are better protected from accidents, ill health and disability. The programmes support people to maintain healthy lifestyles.

As part of this annual plan we acknowledge the importance of making sure that health information about conditions and services, are easily accessible and easy to understand. This will reduce barriers for access to services as well as improve equity in health services and outcomes.

PEOPLE'S EXPERIENCE OF HEALTHCARE

The health experience Hawke's Bay people have is of utmost importance. We understand that some people may be vulnerable and may be going through life changing diagnoses and treatments. It is our goal that we make this experience the best that it can possibly be.

This means we will support a culture of care and compassion, sustain an open, transparent system that will ensure those people that use the health service come first at all times.

We will ensure all those who provide care for these people, both individuals and organisations, are aware of their role in ensuring a high quality and safe service, and are accountable for what they do.

WORKING WITH THE PEOPLE OF HAWKE'S BAY

We acknowledge the people who use our services have a unique perspective of health services and are able to provide us with important information about how we design, deliver and monitor health services.

Working together with the people of Hawke's Bay includes developing and maintaining stronger partnerships to share information between all those involved to ensure that the right care, is given to the right person, at the right time and by the right person.

LEADERSHIP AND WORKFORCE DEVELOPMENT

Ultimately we want a health system that focuses on system wide improvements and not on individuals. We want to examine underlying contributing factors and root causes to identify changes that could be made to improve systems and process to improve quality of care.

Ultimately we want a culture of open reporting where staff are empowered to make decisions relating to quality improvement and patient safety as close as possible to the person receiving care.

Annual Quality Improvement & Patient Safety Programme of Activities

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Timeframe
Wellness	Ensure that our systems of communication are responsive to the people of Hawke's Bay	Implementation of Health Literacy Framework	Action plan developed and monitored on a monthly basis through Transform & Sustain programme report	Q4
	Improving the Communication between health professionals and the consumer	Implementation of HL Training programmes to support clinicians to understand how to best engage with consumers	Training programmes developed and utilised	Q2
	Presentation of quality health information	Review of information provided to patients on admission and on discharge, with a view to making improvements.	Plan developed and implemented with improved patient responses to national patient experience survey	Q3
Monitoring & Measuring	Ensuring that quality improvement and safety reporting and monitoring is provided and communicated effectively	Ensure reporting of Serious Adverse Events and ACC Treatment Injury information is completed with learnings identified and recommendations implemented.	SAE Report provided annually	Q2
		Implementation and completion of work in Primary Care relating to misdirected results.	Action plan developed and implemented leading to reduction in number of issues relating to mis-directed results to GP Practices	Q2
		Align to new national event reporting policy and review of new investigation process	New investigation process in place with all staff having received training	Q4

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Timeframe
		Implementation of an Adverse Events reporting framework for Primary Care	Framework developed and implementation of training and tools to support Primary Care.	Q3
		Development of a quarterly sector wide quality dashboard focussed on IOM core dimensions of quality	KPI's developed	Q2
		Implementation of new clinical governance committee's structure to ensure effective reporting	Committees established, with TOR, cross sector representation	Q2
		Implementation of all HQSC Quality safety marker programmes	Maintain and improve DHB positions against all markers	O1 – Q4
		Ensure implementation of an effective morbidity and mortality monitoring framework and audit process	Process and reporting framework established Ongoing monitoring of HSMR	Q1
		Facilitate and lead the implementation of a new Integrated Risk Management System in DHB & Primary Care.	Project plan developed and implemented	Q2 – Q4
Working With HB Community & Patient Experience	Improving clinical oversight in all provider contracts	Consider the development of a mechanism to collect information to monitor quality and safety within our contracted providers	Ensure appropriate reporting processes in place	Q4
	Improving the process of gathering patient experience data and stories, sharing them widely across the sector.	Continue to participate in the National Patient Experience Survey	Communication & Awareness building strategy implemented	Q1
		Support the implementation of System Level Measures relating to Patient Experience	Effective implementation of National Patient Experience survey in Primary Care and the effective sharing of results	Q3
		Development and implementation of a local patient experience survey aligned to	New local experience survey in place Results shared on a quarterly basis	Q3

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Timeframe
		the values of the sector ensuring survey reflects our population.		
		Implementation of new complaints management process	New processes in place with reporting/monitoring implemented	Q3
		Identify a variety of mechanisms to engage effectively with our Community around health matters to gather their feedback and ideas	Identify provider to support effective community engagement and implement programme	Q4
		Implementation of a Consumer Engagement framework and guideline for all staff.	Guidelines, tools and training completed	Q2
Leadership & Workforce	Improving workforce engagement	Implementation of GEMBA Walks	Agree approach and purpose & implementation plan	Q3
		Clinical Documentation Improvement Programme	Reduction in patient complaints Improvement in Certification report	Q2 & Q4
		Certification – Midpoint surveillance audit	Audit completed with reduction of corrective actions	Q2
		Choosing Wisely Campaign	TBD	Q4

HAWKE'S BAY District Health Board Whakawāteatia	**Implementing the Consumer Engagement Strategy**
	For the attention of: **HB Clinical Council (in September), Maori Relationship Board (MRB) and HBDHB Board (in October)**
Document Owner/Author:	Kate Coley, Executive Director People & Quality
Document Author	Jeanette Rendle, Consumer Engagement Manager
Reviewed by:	Executive Management Team
Month:	September 2017
Consideration:	For Endorsement

RECOMMENDATION

That HB Clinical Council and MRB

1. Note the contents of this paper and the Consumer Engagement Strategy endorsed by HB Health Consumer Council
2. Note the matters yet to be resolved and proposed action plan
3. Endorse this Strategy to go to Board via Clinical Council and MRB.

PURPOSE

The purpose of this paper is to present the final draft of the Consumer Engagement Strategy, to highlight the matters yet to be resolved and to outline the proposed action plan which will support effective implementation of the strategy. The Strategy was endorsed by HB Health Consumer Council in May 2017 and has since incorporated feedback received from EMT.

OVERVIEW

It is our ultimate aim to create a culture which puts people at the centre of everything that we do, and one that is respectful of, and responsive to the needs, preferences, and values of our community. Consumer engagement is one enabler of a people centred culture.

The attached consumer engagement strategy has been developed as a key piece of work alongside others to:

- Achieve culture change.
- Strengthen and embed consumer participation at all levels in the health sector
- Ensure consumers are active partners in how we design, deliver and improve services
- Drive improvements - experience of care, quality and safety of care, health outcomes and best value
- Build knowledge and educate health sector staff about the value of consumer engagement.

This is not a standalone strategy. To be effective, consumer engagement should be seen as a "way of working" and part of our 'culture'. It should be linked to other organisational plans and build on

existing skills and the work we are already doing. The strategy supports the Hawke's Bay Health Sector vision of *"Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community".*

MATTERS TO BE RESOLVED

To ensure a systematic approach to working with the people of Hawke's Bay is developed and implemented the following questions will need thorough consideration and to be practically worked through:

- How will we develop success measures?

The collection of consumer feedback over time is in itself a measure of increasing engagement. At a systems level measuring success will mean looking at all areas in which consumers have been involved. To measure how well engagement is being embedded we could consider building it in to performance reviews, regularly review the diversity of consumer representatives and publicly report quality initiatives that have involved consumers.

- How will we recognise consumer participation and engagement?
- Will there be a budget for consumer engagement and where does it sit?

Based on the assumption that we value and wish to encourage consumer, whānau and community input and participation in our work, a discussion paper has been written to work through how we might recognise consumer participation and the budget required to do so. This is being considered by consumers and management.

A review of our current narrow policy ('Payment of Fees and Expenses' (HBDHB/OPM/108) and/or the establishment of an organisation wide policy that incentivises and acknowledges the desired level of engagement and balances the expectations of both consumers and the organisation is required. This needs to be mindful of the financial constraints within the system, be realistic, sustainable and easy to understand and apply.

This should include tangible and intangible recognition of participation as well as investment in training and support. Tangible recognition may include koha/gifts, refreshments, reimbursements, payments and fees. Intangible recognition my include consideration of timing/place of meeting, sincere and valued acknowledgment of contribution. Processes need to be developed to support the implementation of this.

- What information systems are required to support this work?

Currently there is not one electronic source of the truth when it comes to understanding the depth of existing engagement initiatives and information, communications and databases to support engagement work. This will need to be linked up to reduce duplication and waste.

- Based on the assumption that everyone has a part to play in consumer engagement, who will be specifically responsible for what?

For consumer engagement to be effective, clear roles and responsibilities need to be clearly defined. Partnership roles should be well thought through and support will be required from leaders and champions within the system. Consideration will need to be given to how we resource and support administration and coordination of consumer representatives and engagement activities.

WHAT IS REQUIRED?

We recognise that across the Hawke's Bay health sector there are a number of examples where consumer engagement is already occurring however there is also a lack of guidance, practical resources and tools to support effective engagement. A systematic approach needs to be developed and implemented to support engagement being effortless and part of business as usual. Consistent processes, policies and guidelines for engagement need to be developed.

Six key work stream themes have been identified. The following proposed action plan provides more detail around the streams of work that need to be developed and considered to embed and practically support the implementation of the consumer engagement strategy.

1. Culture change
2. Roles and responsibilities
3. Consumer Engagement Framework
4. Consumer Leadership
5. Consumer Feedback
6. Working in Partnership

A Consumer Engagement Strategy Implementation project has been confirmed as part of the Our People, One Team work stream under the Transform and Sustain programme. A project initiation meeting took place on 29 May to set the scope and direction at a high level. This has since informed some changes to the proposed action plan below (in red).

CONSUMER ENGAGEMENT ACTION PLAN (draft)

	Work streams	Proposed timeframes Start	End
1.	**Culture Change** Position the consumer engagement strategy within the people strategy, with the aim of shifting culture.		
2.	**Roles and Responsibilities** • Identify leaders, champions and partners in the system • Clearly define roles and responsibilities for everyone that plays a part in consumer engagement • Consider how we resource and support administration and coordination of consumer representative and engagement activities	ongoing	
3.	**Consumer Engagement Framework** Support the consumer voice to be a formal part of any planning or redesign process through developing guidelines and resources to embed consumer engagement activities into current and future work. This may include: • Consumer Engagement toolkit including processes, policies, decision tree and flowchart • Guidelines for engagement within projects • Training and education to support staff and build capability in co-design	May 2017	

	• Recognition of consumer participation (out of project but a dependency) • Coordination with Māori Health Service to ensure greater representation of Māori consumers • Development of service and system success measures		
4.	**Consumer Leadership** Empower consumer leadership through developing consumer representative selection, orientation and training guidelines for staff Build and strengthen existing relationships and structures within the sector, such as clinical committees and cross sector quality forums. For example: • Guidelines for engaging with consumer council • Clinical governance committee structure (i.e.: patient experience committee) • Develop subgroups of consumer council • Database of available consumer representatives and community groups	May 2017	June 2018
5.	**Consumer Feedback** Improve the process of gathering and monitoring consumer feedback (Limitations and challenges around capturing, measuring and reporting on patient experience will be addressed in a separate project and linked to System Level Measures) • Ensure clear ownership and accountability • Share stories, outcomes and recommendations for improvement purposes. • Reporting calendar – from Services through to Board • Consumer Feedback process redesign • Implementation of new feedback system • Further develop patient experience survey to include outpatient areas • Online community engagement platform (post project – phase 2)	ongoing	
6.	**Working in Partnership** (BAU, out of scope of project) • Work with the Health Quality and Safety Commission (HQSC) to implement consumer engagement programmes e.g.: patient safety week, patient experience week • Continue involvement in the HQSC sponsored National collective of Consumer Councils	ongoing	

ATTACHMENT Consumer Engagement Strategy.

CONSUMER ENGAGEMENT STRATEGY

EXECUTIVE SUMMARY

Consumer engagement refers to the wide range of approaches in which consumers are involved in the planning, service delivery and evaluation of healthcare. Done well, it contributes to fostering a culture of person and whānau centred care. It supports active, ongoing partnership and communication that benefits consumers, staff and will ultimately transform the system.

We recognise that across the Hawke's Bay health sector there are a number of examples where consumer engagement is already occurring. This is particularly strong at governance level and in some areas of direct care and service development. However, in other cases this is not always structured or consistent. There is confusion as to when, how and at what stage we should be engaging with consumers, which consumers to approach, how to connect with those who aren't engaging with services and how we recognise the contribution of consumers. There is currently a lack of guidance, practical resources and tools to support effective engagement.

Hawke's Bay is a great place to live, but not everyone has the same opportunity to be healthy. Inequities exist within our health system and in our wider society. Māori don't experience the same health status as non-Māori and improving health outcomes for Māori is a key focus. This will only be achieved through targeted efforts to engage and partner with Māori and disadvantaged communities in new and innovative ways. This will help us to understand the opportunities for improvement through the consumers eyes; ensuring that any change we make reflects the needs of the community we serve.

This strategy is not a detailed work plan. It provides direction for the future and a framework for making decisions. It provides guidance around types and levels of engagement and the benefits of engaging. The goal being that consumer engagement at all levels is an embedded way of working and a driver for achievement of the 'Triple Aim'.

This is not a standalone strategy. To be effective, consumer engagement should be seen as a "way of working" and part of our 'culture', rather than additional work on top of an already demanding workload. It should be linked to other organisational plans and build on existing skills and the work we are already doing. Effective consumer engagement supports the Hawke's Bay Health Sector vision of "*Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community".*

PURPOSE

The goal of this strategy is to strengthen and embed consumer participation at all levels in the health sector and at every step along the way, ensuring consumers are active partners in their own care and how we design, deliver and improve services. It is a driver for improving experience of care, quality and safety of care, health outcomes and best value. The strategy

also exists to build knowledge and educate health sector staff about the value of consumer engagement.

Ultimately, our aim is to create a person and whānau centred culture which puts our people at the centre of everything that we do, and one that is respectful of, and responsive to their needs, preference, and values. The health system has developed in a way that has encouraged passivity in consumers, where they present with problems for clinicians to fix. Increasingly there has been a recognition of the need to shift from traditional interactions to collaborative partnerships where consumers play an active role in improving their own health and systems and services by making them more aligned to their needs. Consumer engagement is one enabler of a person and whānau centred culture and this strategy exists alongside others to achieve culture change.

WHAT IS CONSUMER ENGAGEMENT?

Consumer engagement refers to the wide range of strategies in which consumers are involved in the planning, service delivery and evaluation of healthcare. It can be at an individual, service, governance or community level.

Consumer refers to people and their families / whānau / caregivers / personal support persons, who have had personal experiences in the health and disability system. The term also includes those who might use services in the future and members of the public generally, given they are the targeted recipients of health promotion and public health messaging and services.

BACKGROUND

The Hawke's Bay Health Consumer Council was established to provide a strong voice for the community and consumers on health service planning and delivery. In partnership with Hawke's Bay Clinical Council they initiated a quality improvement and safety framework with priorities identified to support consumer engagement. In partnership, the vision and plan for consumer engagement was discussed and developed as one piece of a multi layered approach to shifting our culture. The establishment of the People and Quality Directorate further cements the overarching focus of shifting organisational culture to be person and whānau centred. Further detail on the background can be read in Appendix 1.

Legislative background

The Code of Health and Disability Services Consumers' rights and Te Tiriti o Waitangi underpin consumer engagement in New Zealand. Te Tiriti o Waitangi describes the principles of partnership, participation and protection. The New Zealand Health and Disability Act (2000) upholds these principles and specifically addresses the need to provide mechanisms to enable Māori to contribute to decision making and participate in the delivery of health and disability services, which are at the heart of consumer engagement.

Health Quality and Safety Commission

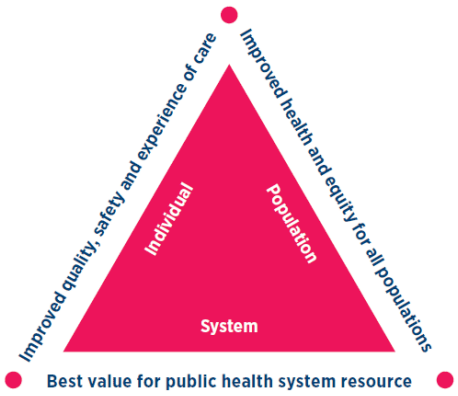
The Health Quality and Safety Commission takes a leadership role in building consumer partnerships in healthcare. They provide examples of best practise and work with health provider organisations and consumers to build recognition of the benefits of consumer engagement. They have developed "Engaging with Consumers: A guide for district health boards" and provide tools and support for effective engagement.

WHY ENGAGE WITH CONSUMERS?

Consumer engagement done well fosters a culture of person and whānau centred care. It supports active, ongoing partnership and communication that will benefit consumers, staff and ultimately transform the system.

There is evidence to support the benefits of engaging with consumers. These include improvements, such as more responsive services, improved clinical quality outcomes, and improved patient experience. In addition, safer care, less waste, reduced length of stay, lower costs, better consumer and health provider satisfaction and staff retention.

Consumer Engagement supports the New Zealand Triple Aim framework (right) for quality improvement at individual, population and system levels. One of its aims is improved health and equity for all populations. Hawke's Bay is a great place to live, but not everyone has the same opportunity to be healthy. Health inequities exist in some parts of our community. Successful consumer engagement will focus on how to be effective within this broader context. Consumers that are disadvantaged or not accessing services are an important group of people to engage with and will require different and innovative approaches.



Without proactive consumer engagement, the drive for change is usually either motivated through system failures (eg adverse events) or from external advocacy to improve the quality and safety of care. Waiting until there is a problem creates avoidable costs for consumers (physical, psychological and economic) and organisations (review processes, staff morale and more expensive treatments).

HOW DO WE ENGAGE?

Engaging with consumers can and should happen at different levels depending on the situation, and as early as possible. How we engage will be determined by the purpose, timeframes and level of impact of different projects, initiatives or programmes of work. Many will require multiple engagement methods at multiple levels.

Principles of engagement

The following five principles have been developed based on the Health Quality and Safety commissions consumer engagement work and Hawke's Bays shared values of He kauanuanu/Respect, Ākina/Improvement, Rāranga te tira/Partnership and Tauwhiro/Care.

1. **Being open and honest -** Consumer engagement is more successful when all parties involved are mutually respectful, listen actively and have the confidence to participate in full and frank conversations.

2. **Providing support -** Support for consumer engagement means being welcoming when meeting consumers, valuing their expertise, and acknowledging and taking consumer viewpoints seriously.

3. **Being real -** Consumers and providers know when we are simply going through the motions of consulting with consumers. Consumer engagement needs to be genuine. All parties should know the purpose of why engagement is taking place and real possibilities for change and improvement.

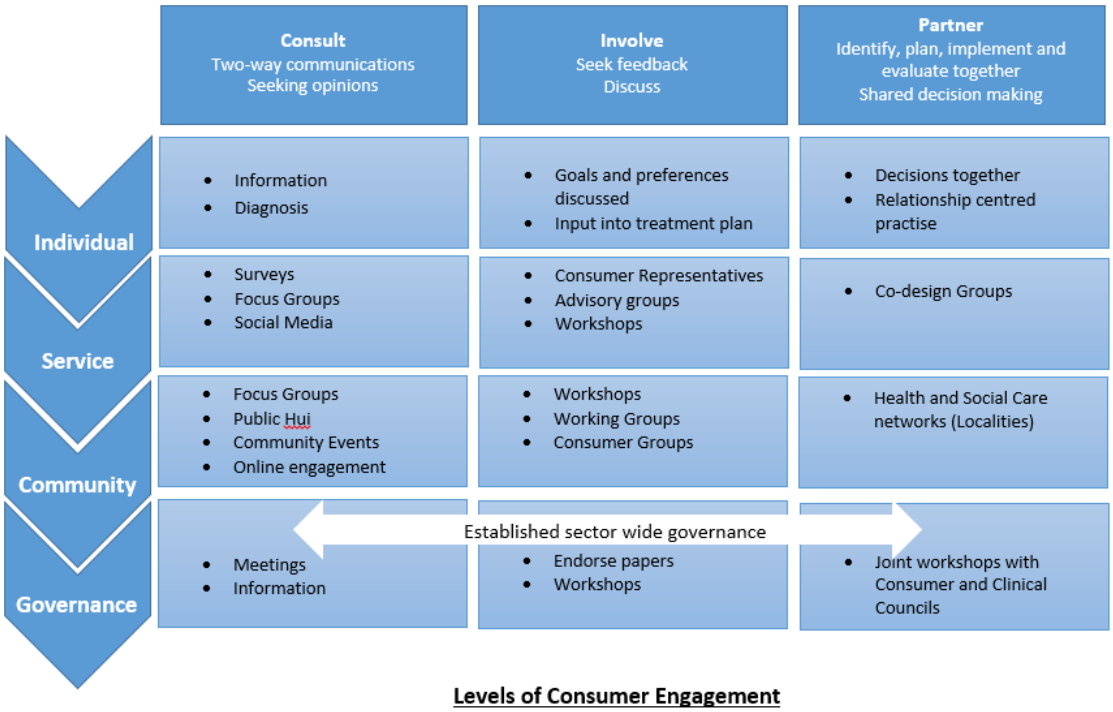
4. **Person and whānau focus -** All consumer engagement needs to keep the focus on person and whānau centred care. It is important that providers and staff are supported to maintain their focus on person/family/whānau as a core aspect of care.

5. **Easy to understand -** Making sure healthcare is easy for people to find, understand and use is a foundation stone of consumer engagement. It is the responsibility of providers to support better understanding for consumers.

Levels of engagement

Individual engagement includes consulting, involving and partnering with individuals in shared decision making about their own health. Put another way – *" 'my say' in decisions about my own care and treatment".* This is covered in more detail within the work being undertaken in the health literacy project, engaging effectively with Māori, and relationship centred practice training.

Collective engagement includes consulting, involving and partnering with individuals or groups of consumers at a service, community or governance level. Put another way – *" 'my' or 'our say' in decisions about planning, design and delivery of services".*



Levels of Consumer Engagement

16.1

It is easy to see and value the role of consumers at an individual level – engaging in and contributing to decisions about their own care, or that of loved ones. However, the case is also strong for involvement of consumers at more collective levels, to ensure that our organisation and health sector is person and whānau centred. Consumer participation extends beyond attending meetings.

As seen in the previous diagram, consumers can be engaged collectively in various ways, at multiple levels including:

- As equal partners when redesigning services through co-design groups
- As members of committees, advisory and governance groups
- Through workshops, working groups, steering groups, focus groups and public hui's
- Through consumer experience surveys and feedback mechanisms (complaints and compliments)
- Involvement in consumer interviews, consumer stories, patient journey mapping

WHAT DOES SUCCESS LOOK LIKE?

For the implementation of the consumer engagement strategy to be effective it requires a health sector that is genuinely committed to putting the consumer at the centre of health care.

Measures of success might include:

- A strong governance structure including sub groups of consumer council, where consumers and clinicians work together in partnership

- Increased consumer representation on clinical committees, transform and sustain projects and quality improvement forums
- Services confident to solve problems, develop new services and improve existing services in partnership with consumers and whānau (co-design)
- Increased engagement with Māori communities and consumers
- Improved quality, safety and experience of care

LINKS TO OTHER STRATEGIES

It is important to acknowledge other strategies and frameworks that link to the implementation of this strategy:

- The Quality Improvement and Safety framework "working in Partnership for Quality Healthcare in Hawke's Bay" (2013) outlines priorities that support consumer engagement in Hawke's Bay.

- People and Whānau at the centre and services developed around their needs is a core principle of Hawke's Bay Health System – Transform and Sustain 2013 – 2018

- Youth involvement is a core principle of The Youth Health Strategy 2016 – 2019 in building health system resiliency through youth participation in governance, leadership, design and delivery of work.

- The Mai Māori health strategy focuses on engaging better with whānau and responding to the needs of Māori in the way they prefer services and care.

- The Pasifika Health Action Plan 2014 – 2018 supports a collaborative approach with pacific communities.

- Significant consumer input will be required to make a 'health literate sector' a reality.

- The People Strategy will address the development of a culture for the health sector that will need to include respecting and communicating effectively with consumers

- The development of Health and Social Care Localities includes significant requirements to consult with and engage local communities in decision making.

SUMMARY

The solutions to challenges in the health care sector won't come from doing business as usual. They will come from fostering a person and whānau centred culture and building equal and sustainable partnerships with consumers who care about improving the health and wellbeing of our people and reducing inequities within our community. Effective consumer engagement that is embedded in our "way of working" and part of our 'culture' will benefit consumers, staff and will ultimately transform the system.

APPENDIX 1

Background to Consumer Engagement in Hawke's Bay

2013 – The Hawke's Bay Health Consumer Council was established to provide a strong voice for the community and consumers on health service planning and delivery.

2013 - Hawke's Bay Clinical Council, in partnership with the Hawke's Bay Health Consumer Council initiated a quality improvement and safety framework: Working in Partnership for Quality Healthcare in Hawke's Bay. The document divided quality improvement and safety into four areas to provide a focus for our work and help us identify opportunities for improvement. These domains and the priorities within them support consumer engagement in Hawke's Bay.

2014 - To realise the objectives and direction outlined in the Quality Improvement and Safety Framework it was identified that change was required in the way services to support this framework were structured. This led to the development of the Quality Improvement and Patient Safety Service and the new role of Consumer Engagement Manager, appointed in July 2015.

2015 - Partners in Care: Consumer Engagement – a case for change was presented to Clinical and Consumer Councils for feedback and consideration. Workshops were held and the vision and plan for consumer engagement discussed. This was further developed where Consumer Engagement was identified as one piece of a multi layered approach to shifting our culture to being people centred - putting consumers and their whānau at the centre of everything we do.

2017 - The establishment of the People & Quality Directorate through the merger of the Human Resource and Quality Improvement and Patient Safety Services in February 2017 further cements the overarching focus of shifting organisational culture to be people centred.

HAWKE'S BAY District Health Board Whakawāteatia	**Position on Reducing Alcohol Related Harm – progress report**
	For the attention of: **Maori Relationship Board (MRB), HB Clinical Council and HB Health Consumer Council**
Document Owner:	Tracee Te Huia, ED Strategy and Health Improvement
Document Author:	Dr Rachel Eyre, Medical Officer of Health
Reviewed by:	Executive Management Team
Month:	September 2017
Consideration:	For Information and Decision

RECOMMENDATION

That MRB, Clinical and Consumer Council:

1. **Accept** this progress report on the Alcohol Harm Reduction Position Statement to go to the Board (at 27 September Board meeting)
2. **Support** and mandate the establishment of a Steering Group with wide DHB representation to provide oversight to the alcohol harm reduction activities across the DHB and report to the Clinical Council (and/or other groups as advised) on a regular basis (as referenced in Appendix 1: Terms of Reference for an Alcohol Harm Reduction Steering Group).
3. **Endorse** the Strategic Framework and Priorities to be considered and accepted by the HBDHB Board at their September meeting (as referenced in Appendix 2: 'Tackling Alcohol Harm in Hawke's Bay' *Draft* Strategy).

Additionally, that Clinical Council :

4. **Agree** to the proposal that Clinical Council adopt the clinical governance role (at its 13 September Clinical Council meeting).

OVERVIEW

In November 2016 the HBDHB Board adopted a Position on Reducing Alcohol Related Harm and requested a progress report after six months. The Position effectively acknowledged that alcohol is a priority health and equity issue for our DHB as evidenced by the earlier Health Equity report (2014). The Position includes a vision, principles for engagement and the outcomes we seek to achieve. In addition there are 'next steps' for action with linkages to key relevant strategies, policies and plans (both from our DHB and nationally as per the National Drug Policy).

In adopting the position statement the Board sought assurance that *all building blocks, operational and governance structures would be in place,* noting that *the work was not being done in isolation but in collaboration with other agencies within Hawke's Bay.*

This document reports on progress with each of the steps endorsed by the Board and in particular reports on progress in establishing building blocks, operational and governance structures.

PROGRESS REPORT ON THE POSITION'S 7 'NEXT STEPS'

1. Identify the appropriate capacity and resource to lead the development of an Alcohol Harm Reduction Strategy and Implementation Plan

Prior to June this year the Population Health Service took responsibility for operationalising the 'next steps' and building blocks agreed to by the Board. Some steps, such as those linked to the delivery of Medical Officer of Health regulatory responsibilities under the Sale and Supply of Alcohol Act 2012, are best operationalised by Population Health. Other steps are linked to the community based work of the SHI Directorate and in particular the Health Promotion team.

The role to establish DHB wide support structures or the provision of services and interventions within clinical settings will be managed by clinical services. These services will lead the work to identify and address any gaps in addiction services and to promulgate screening and brief intervention.

During May and June an external contractor worked with the author and a stakeholder group to undertake some initial scoping work. This involved a stocktake of programmes, services and health sector consultation. A DHB-led health sector workshop was held on 5 July to report back findings, agree priorities and to agree an outline strategic framework. This culminated in the *Draft Strategy* report 'Tackling Alcohol Harm in Hawkes Bay' (see Appendix 2).

At the EMT meeting on 27 June, the CEO formally allocated responsibilities across the two DHB Directorates with the Executive Director SHI to take responsibility for external (or population) focused work involving collaboration with external agencies and to the Executive Director Provider Services to lead internally (personal health) focused work across primary and secondary care. EMT also requested a report on how the work was to be led and managed prior to this paper going to the other committees and then to the Board.

On 2 August a meeting was held to agree a coordinated steering and delivery structure for the DHB's Alcohol Harm Reduction Strategy. The Terms of Reference were agreed subsequent to this meeting (see Appendix 1).

2. Identify a governance and management structure to guide and provide an accountability mechanism for the Coordination and Strategy/Plan delivery

Feedback from the May/June stakeholder consultation recommended that the Clinical Council provide clinical governance for both strategy and plan delivery. In particular it was thought that the Council can provide assurance that quality evidence-based strategies will be advanced to achieve the outcomes consistent with the National Drug Policy and the DHB's position. This will give a stronger sense of ownership by clinical teams to the work that is required of them to address alcohol-related harm, akin to the cultural change efforts required across the sector to address smoking.

Higher level governance for the cross sector efforts and leadership has yet to be fully determined. However this work could be driven by the Board and potentially the Social Inclusion Strategy could provide an overarching framework for this work given alcohol is a priority issue for Hawke's Bay. There are also other possibilities for example, through working with broader cross sector Family Harm governance structures.

At the operational level, the Steering Group will drive this work across the different departments. This group will guide and assist those who are charged to deliver on the Implementation Plan, once developed by the clinical services. The responsibility for delivery will be allocated to those departments in which the activity sits. There will be no new resource allocated so it will require a shift in resources and inclusion in workplans. The challenge will also be to ensure there is good coordination of interventions and connections made to create mutually reinforcing activities and momentum. The programme coordination function, provided by Population Health, will service the Steering Group and take responsibility for planning, monitoring and reporting of the delegated actions.

The Steering Group, via the Programme Coordinator, is anticipated to report to the Clinical Council on a regular basis as a high level accountability mechanism.

3. **Support high-level Champions within our health system and in the community to act as spokespersons and be credible role models to help influence staff, community, whānau, family and individual attitudes to reduce harmful alcohol consumption**

   A number of Champions have already been identified both within the health sector and in the community. An example is the Māori Relationship Board requesting that the DHB cease making alcohol available at the Hawke's Bay Health Awards. However the Implementation Plan would specify the support provided to Champions to help deliver key messages in strategic ways.

   Relevant Champions would assist to deliver key messages to target audiences e.g. Samoan Rugby Club Team members to Pasifika around FASD.

4. **Identify the best way to input into the review and delivery of the Napier City and Hastings District Councils' Joint Alcohol Strategy to limit availability and promote safe, responsible drinking**

   The HBDHB has been a key player in the Joint Alcohol Strategy (JAS) (Napier City Council and Hastings District Council) since 2011. The JAS has recently been reviewed by Councils and has been forwarded to our DHB for feedback. The Council's priority groups are very similar to our own with the exception of including specific target groups of Men and Māori, and obviously excluding a focus on health services. Collaborative regulatory and non-regulatory activities sit under this Strategy and the role of the DHB is acknowledged in both these areas. Leadership is similarly identified as a Council priority. The JAS has included the DHB's position as an appendix to show how the Council and DHB activity will partner one another to achieve their Strategy. Clearly there is an opportunity for both the Council and DHB to work together and support each other's leadership role, whether that be through role modelling healthy events, encouraging community to be 'active citizens' when it comes to having a say around licensing decisions, or protecting the most vulnerable in society, such as children (by reducing exposure to alcohol) and helping those with addictions, by provision of clear pathways for support.

   Whilst the Napier/Hastings and Central Hawke's Bay 'Local Alcohol Policies' are currently subject to appeal, the Wairoa District 'Local Alcohol Policy (LAP)' is currently being drafted for community consultation later this year. There is potential for community to use the Wairoa LAP process to have more voice around licensing and availability of alcohol in their community.

   NB. A specific request from a Board member that greater visibility be given to health and alcohol advocacy to local authorities is an opportunity we must take.

5. **Establish the best method to engage the relevant departments across the DHB and PHO, and to engage with Iwi, Pasifika, young people and community (building on existing groups - Safer Communities, Māori NGOs etc.), to develop appropriate strategies and to provide support**

   There has been some initial consultation in developing the Strategic Framework and priorities, however as an effective way to develop Iwi and community-led initiatives, a more comprehensive communication and engagement plan will be a key approach to be outlined within the Implementation Plan during its development.

6. **Consider the development of a local Alcohol Coalition of NGOs and other agencies, akin to the Hawke's Bay Smokefree Coalition to build support at a community level**

   There is support for this concept but forming such a group will require resources and time not just for the DHB but for other agencies too. Other coalitions could potentially pick up on alcohol too. For example, Safer Communities, fora around Family Harm, locality groups, and the Health and Social Care Localities. Whether the community interest in other drugs is interested in tackling alcohol harm, which is more widely prevalent but more widely tolerated, remains to be tested.

7. Identify service gaps and priority objectives for local DHB action to include:

- Improved systems for health data collection/screening and brief intervention (e.g. in the Emergency Department, Maternity and Primary Care)
- Appropriate clinical referral pathways and treatment services
- Support for strong, effective and consistent health messaging (such as no drinking during pregnancy)

The Emergency Department (ED) has begun last month to screen all presentations to the ED to ascertain whether alcohol is involved or not, directly or indirectly. This data is now mandatory required by the Ministry of Health. This provides a unique opportunity to monitor the extent to which alcohol is a contributor to the burden on our ED, and to monitor the harm in our communities and the cost to our health system. This data collection also allows for the development of further brief intervention and treatment pathways and targeted initiatives e.g. to under 18s, frequent attenders, etc. This data collection could also be useful for advocacy to influence alcohol licencing decisions.

The support for strong consistent health messaging is a key action that has come out of the initial consultation. Within the FASD Discussion Document (2016) there is a commitment by our DHB to increase community knowledge and awareness about FASD with resulting behaviour change and to reduce the number of pregnant women who drink whilst pregnant. Limited progress has been made in the FASD prevention area to date however the Population Health team has now made this a priority within their annual plan.

Consultation to date

The 5 July workshop was open to all stakeholders involved in an initial consultation and stocktake exercise, led by Jessica O'Sullivan (DHB-contractor)[1]. The purpose of the workshop, which was opened by Dr Kevin Snee, was to gain agreement across our health sector around a strategic framework and priorities, and how we can initiate some traction in these areas within existing resource. There was widespread agreement around the priorities and an outcome of this meeting was the Draft Strategy document (see Appendix 2).

Consultation with other groups such as Police, Councils and community groups is essential but is anticipated will occur at a later stage. The main purpose of the work to date has been to secure the commitment and agreement from within our health services first, before moving wider into the community. The stakeholders who could potentially have a voice around alcohol harm are very broad as the problems and solutions extend well beyond those people who have an alcohol problem. It is important that as a Health sector we recognise alcohol as a significant health issue first and that we understand the culture change required and to counter any resistance from within before expecting wider societal change.

Final Comments

There is much to do, the position statement has clearly established priorities that have been supported by stakeholder consultation and formalised into the current draft strategy which is for five years (2017-2022).

There is good evidence for what works for reducing alcohol related harm, which shows that there is a place for both population health and targeted approaches. While current national policy settings are relatively weak, changing cultural norms through leadership and role modelling, and providing brief intervention in a range of settings with improved treatment services, are the areas where we can make a difference to improve the health and equity of our Hawke's Bay population. The new Steering Group will be able to draw on an extensive literature in this area and join the dots with other addictions and related areas so that the work is not siloed.

[1] (See attached)

APPENDIX 1

Terms of Reference
HBDHB Alcohol Harm Reduction Strategy Steering Group

AIM

Overall: To enable the Strategy vision, *"Healthy communities, family, and whānau living free from alcohol-related harm and inequity"* to be achieved.

The Alcohol Harm Reduction Strategy Steering Group (referred to the 'AHR Steering group') reports to the Clinical Council (who has overall governance responsibility) and delegates to the Health-sector Programme Working Groups, namely the Clinical Service Programme Working Groups and Population Health Programme Working Groups (these are referred to as 'PWGs'). The AHR Steering group will be expected to take a leadership role in relation to alcohol related harm issues.

The Steering Group is predominantly responsible for initiating and monitoring progress of the Health-sector PWGs and for resolving issues that may compromise the successful delivery of the Strategy overall. The PWGs will address the priority action areas outlined in the Strategy i.e. 'health services', 'youth' and 'unborn babies'.

The external facing work on 'youth' and 'unborn' babies that needs to engage with community, Iwi and other agencies such as Councils and Police may in time develop a separate 'governance' mechanism outside of the DHB. In the meantime the ED SHI Directorate, will be the conduit for the communication around the broader population health and community development approaches adopted in partnership with non-DHB entities (these wide-ranging activities already report in the main to Population Health). However the initial role of the AHR Steering group will be to *mobilise the health workforce to address alcohol harm as a health issue* within and across clinical services. The Steering Group may wish to identify Health-sector Champions to help gain profile for this work.

PRINCIPLES AND VALUES

The Steering Group will be most successful in achieving the aims by:

- Demonstrating leadership
- Fostering a culture of collaboration and mutual respect for each other's contributions
- Being responsive to Māori and applying an equity lens on all projects
- Ensuring culturally and age appropriate strategies
- Being evidence-informed
- Considering a consumer perspective for all projects
- Regular information sharing and establishing an outcome measurement framework to report on to the Clinical Council
- Keeping the workforce and community informed regularly around alcohol-related harm in Hawke's Bay and the health system response
- Using other relevant fora to highlight and respond to the issues – e.g. NCC and HDC Joint Alcohol Strategy group, 'DHB-Police Partnership', Intersectoral forum, Safer Community groups, Wairoa and CHB Health and Social Care Localities groups
- Being systematic and coordinated in our approach and making change sustainable

RESPONSIBILITIES

The Steering Group will:

- Ensure that projects are 'set up to succeed' (realistic timeframes and appropriate resources)
- Identify and support lead staff of PWGs and provide overall guidance and direction to the projects as required, ensuring they remain viable and within agreed constraints
- Approve changes to the PWGs (within delegations/tolerances)
- Ensure that risks, issues and dependencies to the projects are being managed effectively and make decisions & clear roadblocks as required
- Manage communications to internal and external stakeholders regarding the Strategy and projects via a Communications Plan
- Provide assurance that the Strategy and projects are being delivered satisfactorily
- Escalate issues to the appropriate GM or ED, that cannot be adequately resolved by the AHR Steering Group

- Undertake periodic reviews of the overall Strategy achievement and the effectiveness of the project/s and take appropriate action where required

ACCOUNTABILITY
The HBDHB Clinical Council will receive a six-monthly report on progress on the Steering Group's workplan and Strategy progress.

MEMBERSHIP
Membership will be based on a formal membership process including representation from:
- Clinical Council representation
- ED SHI Directorate (Tracee Te Huia)
- EDPS (Sharon Mason)
- ED Primary Care (Chris Ash)
- Service Director for Community, Women and Children (Claire Caddie)
- Emergency Department Clinical representative
- Primary Care Clinical Representative (Primary Care) lead
- Mental Health and Addiction Services Clinician (Mental Health) lead
- Public Health Advisor / Strategy (Public Health) lead
- Consumer representation
- Communications expertise
- (IS support* - for data collection, screening and brief intervention tools and referral processes)

*On an as required basis

CHAIRPERSON
The Chair will, in the first instance, be the ED SHI Directorate whilst the structures, processes and initial workplan are developed. The Chair will be reviewed after six months to reflect the workplan (anticipating that a priority will be the establishment of a Health Services Screening and Brief Intervention project).

QUORUM
Six members (half of total) must be present for confirmation of decisions.

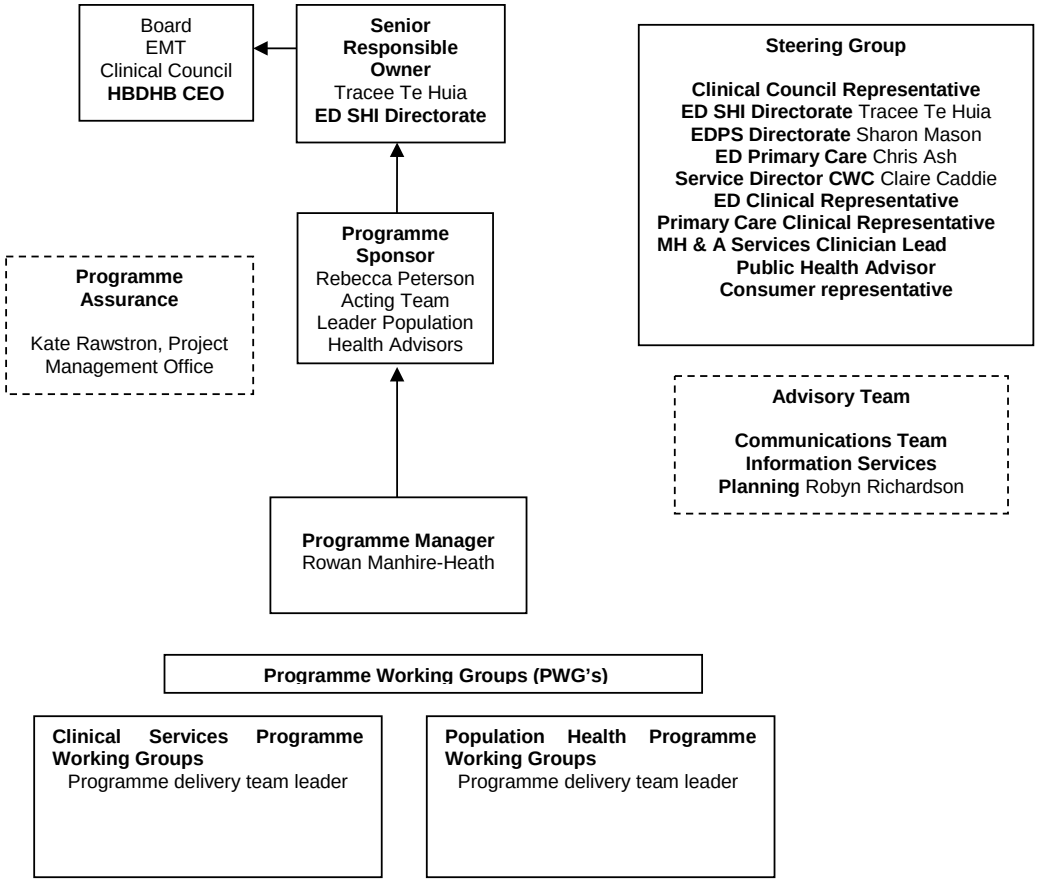
MEETINGS
A minimum of 6 meetings a year (approximately every 2 months)
Meetings will be time-tabled for the entire year by administration support

AGENDA
A written agenda will be developed and approved by the Chair and circulated 5 days prior to the meeting by admin support. Members will send any agenda items to the Chair prior to the meeting.

MINUTES
Minutes will be recorded by administration support and be approved in the first instance by the Chair. These draft minutes will be circulated to all members for final approval at the next meeting. Administration services will be provided by the SHI Directorate for the first six months.

REVIEW
These Terms of Reference and project structure will be reviewed after 6-12 months, as required.

PROGRAMME MANAGEMENT TEAM STRUCTURE



ROLE DESCRIPTIONS

Senior Responsible Owner

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

Programme Sponsor

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

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 Programme Sponsor to resolve strategic and directional issues within the programme which need the input and agreement of senior stakeholders to ensure the progress of the programme.

Advisory Team

- Provide expertise at specific points of programme development and implementation

Consumer Rep

- TBC based on specific programme consumer engagement

Programme Manager

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

Programme Delivery Team Leader

- Coordinates Completion of tasks and effective management of resources
- Works to agreed timeframes
- Report progress and elevates issues to the Programme Manager in a timely way

Programme Working Groups

- 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 programme to use best practice processes to create the deliverables and appropriately follow the programme management processes

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Healthy Weight (national indicator)**
	For the attention of: **Māori Relationship Board (MRB), HB Clinical Council and HB Health Consumer Council**
Document Owner:	Tracee Te Huia, ED – Strategy & Health Improvement
Document Author:	Shari Tidswell, Intersector Development Manager
Reviewed by:	Patrick Le Geyt and Executive Management Team
Month:	September 2017
Consideration:	Monitoring

RECOMMENDATION

That MRB, Clinical and Consumer Council

Note the contents of this report

OVERVIEW

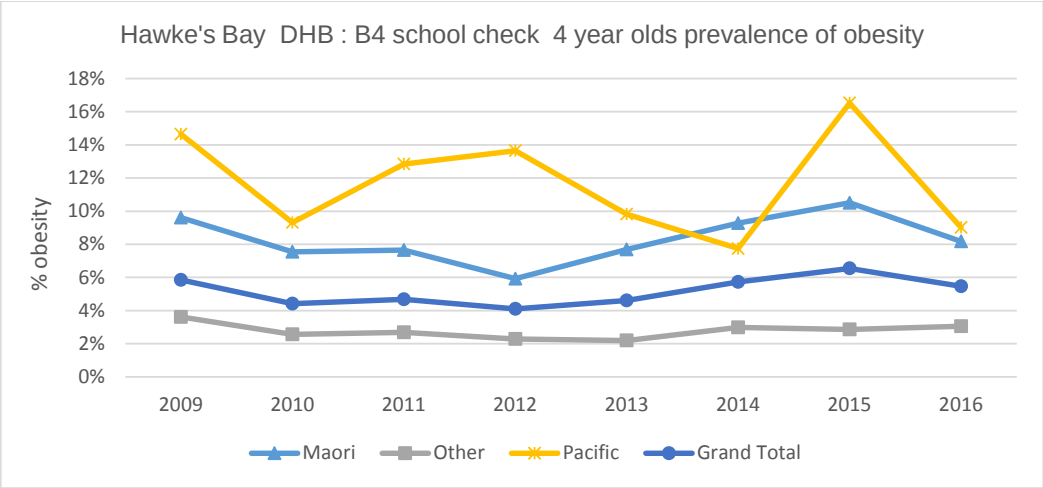
Te Ara Whakawaiora (TAW) is an exception based report, drawn from Annual Maori Health Plan (AMHP) quarterly reporting, and led by TAW Champions. Specific non-performing indicators are identified by the Māori Health Service which are then scheduled for reporting on progress from committees through to Board. The intention of the programme is to gain traction on performance and for the Board to get visibility on what is being done to accelerate the performance against Māori health targets. Part of that TAW programme is to provide the Board with a report each month from one of the champions. This report is from July 2016 to July 2017, Champion for the Indicators is Tracee Te Huia.

UPCOMING REPORTS

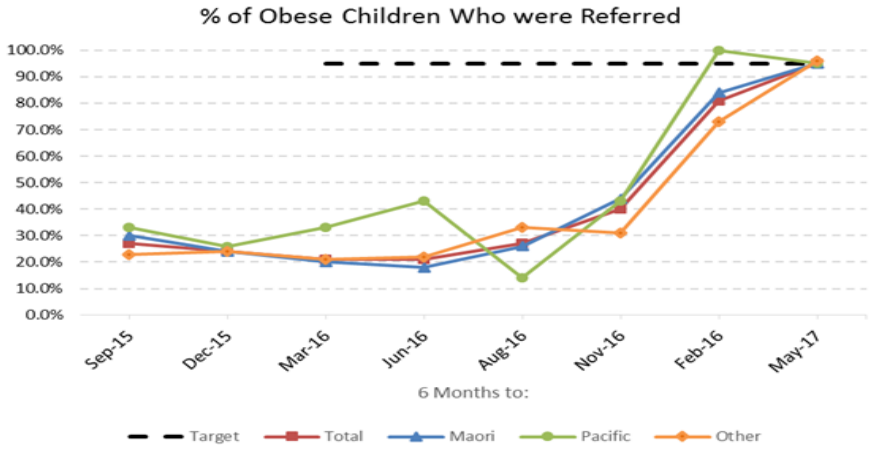
Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
Obesity *National Target*	B4SC 4 year olds identified as obese are referred for clinical support and provided with whānau lifestyle change support	95 %	Tracee Te Huia	Shari Tidswell	October 2017

MĀORI HEALTH PLAN INDICATOR:

Below are tables tracking obesity rates and the national target data. From 2014 to 2016 rate for Māori dropped from 9.3% to 8.2% in 2017 and Other have stayed static around 3%. The gap is reducing slowly.



The national target "Raising Healthy Kids" -95% of children attending a B4 School Check and identified as obese (BMI 98th percentile) are referred to a health professional and given whānau based lifestyle support. Table below show the tracking for the target, note the new Target did not start until July 2016.



Key Performance Measures	Baseline [1]	Previous result [2]	Actual to Date [3]	Target 15-16	Trend direction
Māori	30.0%	84% (U)	95% (F)	≥95%	▲
Other	23.0%	73% (U)	96% (F)	≥95%	▲
Total	27.0%	81% (U)	95% (F)	≥95%	▲

The Raising Healthy Kids target has been achieved for Hawke's Bay quarter four- 95 %4. This is ahead of the Ministry's timeline by 6 months. This includes equitable referral rates across ethnicities and 100% referral acknowledgement rate. Also all whānau were provided with a healthy weight plan.

1 6 months to September 2015

2 6 months to February 2017

3 6 months to May 2017

4 The table above are the reported data to the Ministry of Health for quarter 4

WHY IS THIS INDICATOR IMPORTANT?

Obesity is the second leading risk to health in Hawke's Bay. Medium and long-term costs of not addressing obesity are very high, as obesity leads to a range of diseases with high health sector costs. A third of our population are obese; 48% and 68% for Māori and Pacific populations respectively. Childhood weight is a significant influence on adult weight and changing behaviors to increase healthy weight are more effective during childhood years. Measuring BMI at four years should provide an indicator for future obesity and health outcomes.

We are seeing the start of a slow decrease in 4 year old obesity rates and the response for whānau of obese children is equitable with 95% of Māori whānau being referred to a general practitioner for clinical assessment and 100% developing a whānau healthy eating plan with their B4 School Check nurse.

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

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

Delivered activity to support healthy weight under-fives:

Activity	Outcomes
Mama Aroha training and resource provided to key community workers to support and all wāhine delivering pepe.	Mama Aroha programme delivered and resources distributed to providers and wāhine.
Maternal Green Prescription (GRx) delivered-target of 160 referrals with 50% of these being Māori or Pasifika.	Referrals met targets.
Gestation Diabetes management- 100% of pregnant women with gestational diabetes are screened and 75% engaged with support.	Screening targets have been met and the support exceeded 94%.
"Health First Foods" programme delivered via Well child and Tamariki Ora providers.	120 whānau engaged in the sessions (66% Māori). Recipes cards have been developed and are being distributed
Active Families Programme, target of 40 referrals and 50% of these being Māori or Pasifika.	Targets exceeded.
Healthy Conversation Tool developed and trialled in B4 School Checks	Implemented, including whānau input into design and training for nurses to implement. Initial feedback is very positive.
Insector forum establish to support healthy weight leadership and activity across sectors	Forum is established, member are implementing activities to be role models as employers. Map developed to provide oversight of current impact and delivery. Also an advisory group has been establish to support the healthy sector implementation of the Best Start Plan.

Next steps:

- Increase the volumes for Active Families under 5 to meet demand created via the national Target and support earlier engagement (2 and 3 year olds) in Active Families.
- Complete evaluations and work with Advisory Group to action recommendations
- Engage with early childhood education (ECE) sector to design resources to support healthy weight environment and learning for whānau engaged in ECE.
- Find further opportunities to support healthy weight messages via services with existing relationships with whānau
- Continue to monitor contract targets and national Target
- Continue to develop the intersector relationships

RECOMMENDATIONS FROM TARGET CHAMPION

Key Recommendation	Description	Responsible	Timeframe
Complete the evaluations and action based on recommendations	Take the recommendations to the Best Start Advisory Group to develop actions for improvement	Shari Tidswell	Dec 2017
Complete variations to contract to increase the volumes for Active Families Under 5	Secure additional funding from MoH Complete a contract variation	Shari Tidswell	Sept 2017

CONCLUSION

We will continue to work and ensure the Target is met. This will be supported by the work delivered under the Best Start Plan, particularly implementing recommendations for the evaluations currently underway - which will provide guidance for improvements and development.

HEALTH HAWKE'S BAY
Te Oranga Hawke's Bay

Agenda

Health Hawke's Bay Clinical Advisory and Governance Committee

Date:	12 September 2017	**Time:**	5.30 – 7.30pm
Venue:	Tukituki Meeting Room, Second Floor, GJ Gardner Building		
Present:	Chris McKenna (Chair), Bayden Barber, Julia Ebbett, Maurice King, Mark Peterson, Andrew Phillips, Tae Richardson, Catrina Riley		
In Attendance:	HHB: Wayne Woolrich, General Manager; Linda Dubbeldam, Manager Innovation & Development; Sara Salman, Clinical Advisory Pharmacist; Stephanie Maggin (minutes)		
Guests:	Lillian Ward, Senior Maori Advisor/Equity Project Manager, HHB; Val Guay, Improvement Advisory | People & Quality, HBDHB		

	Paper	Action	Lead
1. Administration			
1.1 Apologies	Verbal	Acknowledge	Chair
1.2 Interest Register	Paper	Noting	Chair
1.3 Conflicts with today's Agenda	Verbal	Noting	Chair
1.4 Draft Minutes from 25 July 2017	Paper	Confirm	Chair
1.5 Action Items	Paper	Noting	Chair
1.6 Committee Work Plan	Paper	Acknowledge	Linda Dubbeldam
1.7 Items approved since last meeting	Verbal	Verbal	Chair
2. Strategic Discussion (one hour) Clinical Governance			All
3. Items for Discussion			
3.1 Whānau Wellness Resource Programme Evaluation	Paper	Acknowledge	Lillian Ward
3.2 Clinical Risk Report (including incidents and complaints)	Paper	Acknowledge	Linda Dubbeldam
4. Other Items for Information			
4.1 HHB Annual Plan, quarterly report	Paper	Acknowledge	Linda Dubbeldam
4.2 System Level Measures, quarterly report	Paper	Acknowledge	Linda Dubbeldam
4.3 PHO Enrolment, quarterly analysis	Paper	Acknowledge	Adrian Rasmussen
4.4 Clinical Services Plan Update	Verbal	Noting	Wayne Woolrich
Any other business			
Next Meeting	7 Nov. 2017	5.30pm	

OURHEALTH HAWKE'S BAY Whakawateatia	**Falls Minimisation Committee Update**
	For the attention of: **HB Clinical Council**
Document Owner:	Chris McKenna, Chief Nursing Officer
Reviewed by:	
Month:	September 2017
Consideration:	For Information

RECOMMENDATION

That Clinical Council:

- Note the contents of this report.
- Support the appointment of Kerri Cooley as chair of this Committee

Overview

In line with the proposed Clinical Committee Stucture change this committte will report thorugh to the Patient Safety and Risk Committee. With this change comes the appointment Kerri Cooley, Nurse Director – Surgical Directorate as the new Chair of the Falls Minimisation Commitee.

Membership

The membership of the Committee has extended over time and now includes a range of partners including ACC, SportHB, St John and Enliven along with additional HBDHB staff. The Commitee is currently reviewing the ToR including the membership to ensure there is appropriate representation from all relevant parties. The Committee will develop a draft workplan for 2017 – 2918 in September.

ACC Business Case

ACC and the DHB Business Case is now 7 months into implementation and both the Falls Coordinator and Fracture Liaison Coordinator have been appointed to. Resources are also available through ACC and are being well received. Pathways have been developed and the focus is now on building the communities strength and balance programme. Targets will be challenging and development of a process and reporting tool to enable tracking and visability of key targets back to ACC is is being discussed.

OURHEALTH HAWKE'S BAY Whakawateatia	**Maternity Clinical Governance Group January to June 2017**
	For the attention of: **HB Clinical Council**
Document Owner: Document Author	Chris McKenna, Chief Nursing Officer Jules Arthur, Midwifery Director
Reviewed by:	Chris McKenna
Month:	February 2017
Consideration:	For Information

RECOMMENDATION

That HB Clinical Council

Note the contents of this report.

OVERVIEW

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

The initial objectives of the Maternity Quality and Safety Programme of appointing a programme co-ordinator, establishing consumer representation and to implementing a multidisciplinary governance group to have the overview of the quality of the Maternity Services and identify areas for improvement were all achieved up to this point. From January 2017 onwards the Maternity Quality and Safety Programme will no longer have a specifically appointed programme coordinator and the responsibility of the programme will move solely to the Midwifery Director

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

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

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

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

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

The Maternity Quality Safety Programme is three-quarters of the way through executing the three year plan of the current "Establishing Contract" and has provided the Ministry with a further updated 1 year plan (see Appendix 1)

The plan presents an update on the three 'Key Actions Projects' and identifies further current quality initiatives for the 17/18 financial year.

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

Additionally, the Maternity Quality and Safety Programme monitor and respond to the National Maternity Clinical Indicators internal and external reporting. The New Zealand Maternity Clinical Indicators were established from a collaboration between the Ministry of Health and maternity stakeholders representing consumer, midwifery, obstetric, general practice, paediatric and anaesthetic perspectives. There are currently 21 maternity clinical indicators and our 2016 data reflects significant improvement in a number of these. Evaluators of our indicators need to remain mindful of the population we serve being one with significantly high health inequalities. Compared to other areas of New Zealand, Hawke's Bay is a region with significant health inequalities. This is contributed to by our 25% Māori population (10% higher than average), 35% of our population residing in the most deprived areas of the region, 30% of our young Māori not in education, training or employment, one in three of our adult population determined as obese, one in five are not smoke free, and one in every four Hawke's Bay adults are classed as a hazardous drinker. These, along with numerous other factors, present significant health inequalities that lead to poor access of primary care and high rates of complex pregnancies for Hawke's Bay.

The reported 2015 MOH clinical indicator trends benchmarked against the national average, enable us to adjust current clinical management and address areas where quality and patient care can be improved. The table demonstrating how Hawke's Bay benchmarks against the 2015 national average with our 2016 data which is being published in our annual clinical report.

2016 Clinical Indicator Overview Table: based on 2015 MOH data	National	Hawke's Bay	Desired Position
6. Intact lower genital tract among standard primiparae giving birth vaginally	28.3%	40.2%	Above National
7. Episiotomy and no third- or fourth-degree tear among standard primiparae giving birth vaginally	22.2%	12.4%	Below National
17. Women giving birth with a BMI over 35 at registration	9.3%	2.8%	Below National
12. Blood transfusion during birth admission for vaginal birth for all women	2.0%	1.4%	Below National
3. Instrumental vaginal birth among standard primiparae	16.3%	16.0%	Below National
9. Episiotomy and third- or fourth-degree tear among standard primiparae giving birth vaginally	1.5%	1.6%	Below National

19. Small babies at term (37-42 weeks gestation)	3.1%	3.3%	Below National
21. Babies born at 37+ week's gestation requiring respiratory support	1.9%	2.4%	Below National
10. General anaesthetic for all women giving birth by Caesarean Section	8.8%	8.5%	Below National
11. Blood transfusion for all women giving birth by Caesarean Section	2.9%	2.5%	Below National
2. Spontaneous vaginal birth among standard primiparae	68.70%	67.30%	Above National
8. Third - or fourth - degree tear and no episiotomy among standard primiparae giving birth vaginally	4.40%	4.60%	Below National
18. Preterm births, 32 to 36weeks gestation, for all women	7.30%	8.60%	Below National
4. Caesarean section among standard primiparae	14.9%	16.7%	Below National
5. Induction of labour among standard primiparae	5.7%	9.2%	Below National
16. Maternal tobacco use during postnatal period for all women: status at discharge	12.0%	22.9%	Below National
20. Small babies at term born at 40-42 weeks gestation	38.4%	40.0%	Below National
1. Registration with an LMC in the first trimester of pregnancy, all women	70%	57.44%	Above National
13. Diagnosis of eclampsia during birth admission for all women	26	0	N/A
14. Peripartum hysterectomy	30	0	N/A
15. Mechanical ventilation during pregnancy or postnatal period	16	0	N/A

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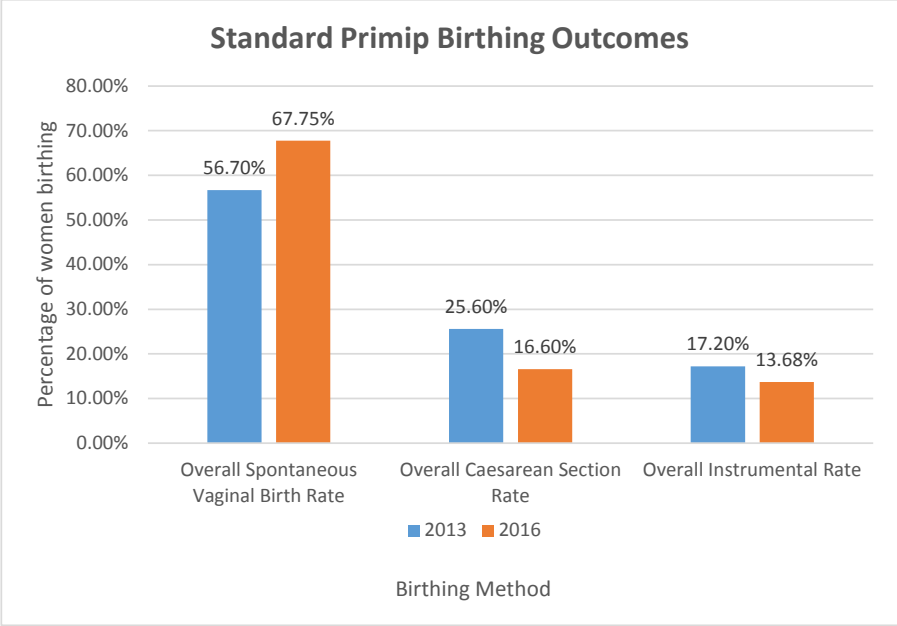
The 2016 maternity annual clinical report is nearing completion and will be sent to the Ministry of Health by the end of September. This report will be available on line for everyone. The findings are very encouraging with some significant positive movement in a number of key clinical indicators. The ability to pull data for all the clinical indicators is still a challenge and is currently being worked on.

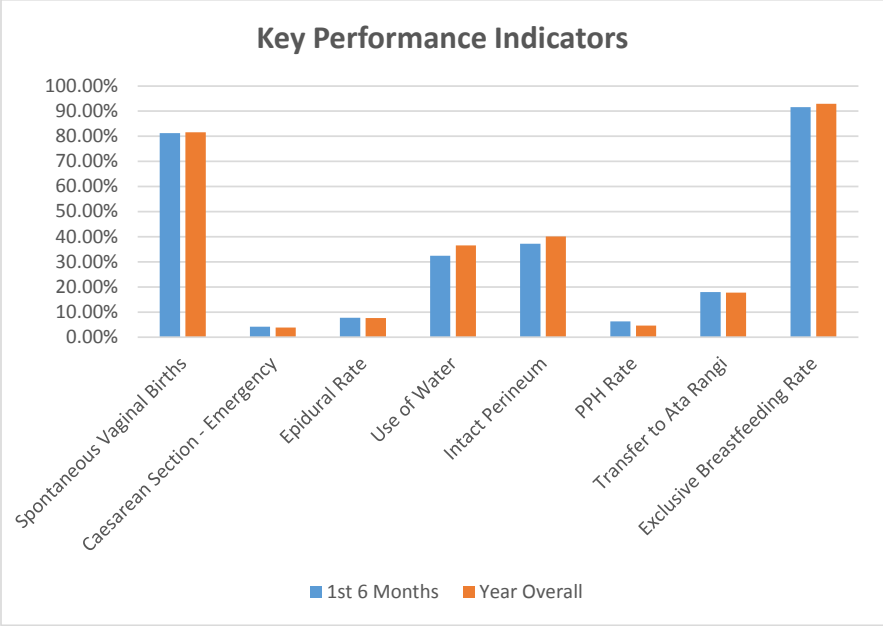
Please also note the Jan-Jun 17 internal clinical indicator data. A simplified traffic light system has been used to highlight strengths, opportunities and challenges

January to June 2017 Internal Data Clinical Indicator Overview based on 2016 Internal Reporting	2016	2017	Desired Position
1. Registration with an LMC in the first trimester of pregnancy - All Women	57.44%	64.60%	↑
2. Spontaneous vaginal birth among standard primiparae	67.30%	67.70%	↑
5. Induction of labour among standard primiparae	9.20%	5.50%	↓
6. Intact lower genital tract among standard primiparae giving birth vaginally	40.20%	43.30%	↑
7. Episiotomy and no third or fourth degree tear among standard primiparae giving birth vaginally	12.40%	10.40%	↓
8. Third - or fourth -degree tear and no episiotomy among standard primiparae giving birth vaginally	4.60%	3.70%	↓
11. Blood transfusion during birth admission for Caesarean Section delivery	2.50%	1.40%	↓
16. Number of women not smokefree at postnatal discharge	22.91%	19.89%	↓
18. Preterm births, total number of babies born under 37 weeks gestation, for all women	8.58%	6.11%	↓
3. Instrumental vaginal birth among standard primiparae	16.00%	15.90%	↓
4. Caesarean Section among standard primiparae	16.70%	16.50%	↓
9. Episiotomy and third or fourth degree tear among standard primiparae giving birth vaginally	1.60%	1.20%	↓
10. General anaesthetic for women giving birth by Caesarean Section	8.50%	8.00%	↓
12. Blood transfusion during birth admission for vaginal birth	1.40%	1.50%	↓
17. Women giving birth with a BMI over 35 at registration	2.84%	2.09%	↓
21. Babies born at 37+ week's gestation requiring respiratory support	2.95%	3.04%	↓
13. Diagnoses of eclampsia during birth admission for all women	0.00%	0.00%	↓
14. Women having a peripartum hysterectomy	0.00%	0.00%	↓
15. Women admitted to ICU and requiring ventilation during the pregnancy or postnatal period	0.00%	0.00%	↓
19. Small babies at term (37-42 weeks gestation)	N/A	N/A	↓
20. Small babies at term born at 40-42 weeks gestation	N/A	N/A	↓

Key Actions Projects
Increasing normal birth and decreasing intervention – **Waioha 1 year on**

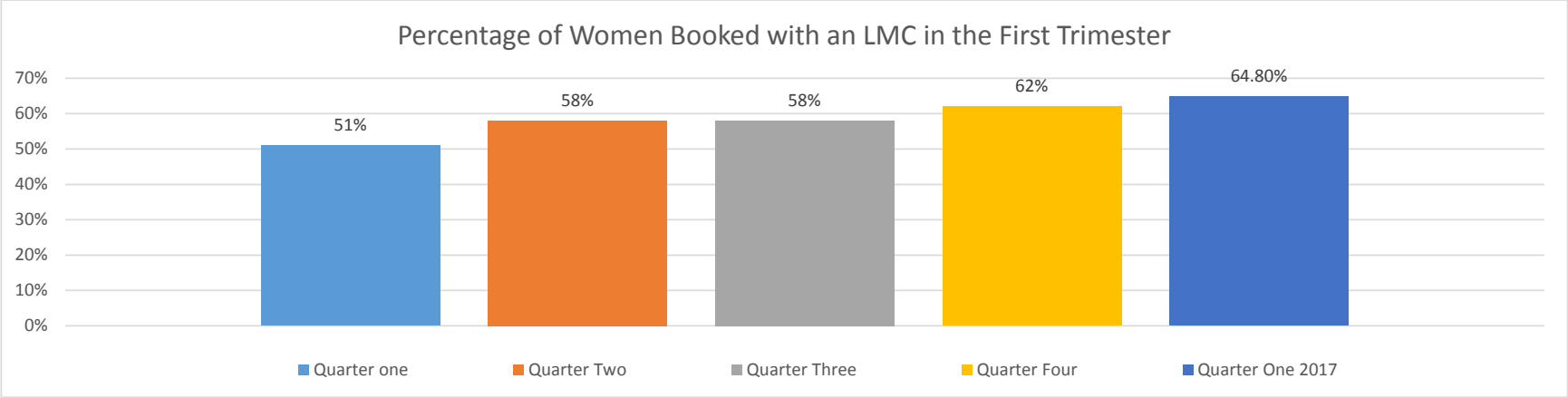
- Waioha presentation clearly identifies significant improvement in outcomes for our standard primip population (this is our low risk group of women having their first baby with no medical complications) Please see graphs below
- Consumers engagement through the survey monkey on discharge continues to be highly successful in capturing feedback from all users. Feedback is overwhelmingly positive from consumers; particularly in relation to the calm and relaxed atmosphere, the provisions made for support persons and whanau and being able to stay in one room throughout the whole episode of care
- An Official opening ceremony was held on the 1st March with Bronwen Pelvin, Principal Maternity Advisor MOH opening Waioha and unveiling a plaque
- Final project report is completed with key benefits and lessons learnt outlined
- Your Birth, Your Power project is underway with a project midwife appointed to specifically focus on changing our birth culture with our community and our clinicians.
- First year outcomes are demonstrating a change in birth outcomes for our standard primips and decreasing intervention for those women using Waioha. 578 babies have been born in Waioha in the first year and Waioha has achieved BFHI accreditation with an average 93% exclusive breastfeeding rate.





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

- Further public campaign has been launched in July/August with the promotional material of Top5 for my baby to thrive being rolled out across the community.
- Reengagement with GP practices in partnership with the smokefree liaison midwife is being received positively. The first quarter of this year revealed a significant increase in the number of women registering within 12 weeks – total 64.8% with a 10% increase in Maori women to 55%. Utilisation of Napier maternity resource centre is highly successful with 2200 attending midwifery clinics, 21% of women with confirmed pregnancy tests and 81.6% engaged within 12 weeks of pregnancy



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

Our two consumer members continue to be active engaging across our community and representing consumer views on our quality initiatives.

Current activities include

- CHB consumer forum – have a cuppa date booked for September
- Participation in the Maternal Mental Health pathway initiative
- Actively promoting survey monkeys for Ata Rangi, Waioha and a new breastfeeding survey
- Strengthening relationships with Maori Providers such as TTOH
- Continued engagement with Teen Parent units
- Working in partnership with Consumer Council member Sami McIntosh
- Connecting with a new Dadz First support group
- Participation in the Early Engagement Campaign
- Involvement in the Your Birth, Your Power project
- Worked in partnership with the Jammies 4 June initiative with Kids Out and About in HB
- A new Our Babies initiative which will see our most needy babies leave maternity services with a keeping your baby warm pack.
- Continued attendance and participation on MCGG

Appendix 1

Hawkes Bay DHB One Year Maternity Quality and Safety Plan 2017-2018

From the Maternity Quality and Safety Programme contract

1.1. By 31 August 2017, the DHB will submit a one year programme plan which outlines:
(a) any remedial programme establishment actions and delivery dates; and
3-5 Maternity Quality and Safety Improvement Projects that will be delivered over the term of the Agreement. For each project the DHB must identify the rationale, main phases of work and deliverables, with indicative dates.

Programme Operations – this is an update from our original strategic MQS plan submitted 3 years ago.

Give logistical details how the programme will be implemented, supported by the funding allocated through the CFA Variation:

- Health services reconfiguration has impacted on the original make up of the maternity quality and safety team. Current specific positions include:
    - MQSP Administrator – 0.9FTE – fixed term for 3 years currently
    - Two consumer members
    - The Maternity Governance coordinator was disestablished in 2016 and the entirety of the programme now sits with the Midwifery Director role

- Development of the IT maternity universe continues to be ongoing due to significant changes to Healthware when our Waioha alongside primary maternity centre opened – this has created challenges in rewriting reporting programmes. For the past year the ability to pull information from Healthware has been manual and challenging. Progression of this work is now underway to support automated reporting of required clinical indicators
- HBDHB will follow existing policy regarding reimbursement and support for consumer/community representation
- This programme is part of the maternity services with strong links across sector with all key stakeholders. Recent review of governance committees now means that our Maternity clinical governance group reports through to the Patient Safety and Risk committee which then reports to Clinical council. MCGG reports bi-annually
- An annual report is developed and published as per MOH requirements

Networking and Communications
Sector engagement

- Strengthening relationships between maternity stakeholders across hospital and community settings

    - All LMCs hold a DHB email address to facility remote and secure access to communications, sharing of confidential information and access to reports and investigation results
    - In progress is a Primary/Secondary roles and responsibilities interface document developed in partnership between DHB and NZCOM to support improved communications, clarity of roles and handover of care across medical and midwifery professions – ensuring at all times patient and clinical safety – this is expected to be finalised and socialised by the end of October this year
    - The newly amalgamated Communities, Women and Children Directorate is community facing and committed to strengthening partnerships with all key stakeholders; particularly working with our PHO colleagues who are partners around our strategic table
- Developing a supportive environment to ensure open disclosure when discussing professional practice issues
    - Socialisation of national open disclosure policy to all maternity stakeholders has occurred
    - PMMRC meetings continue to be part of our calendared meetings for all maternity stakeholders including: sonographers, paediatricians, anaesthetists, LMCs, DHB midwives, O&G Drs, SCBU RNs – these are PQAA protected and provide a safe environment to share, listen and learn
- Strategies to ensuring that community-based practitioners are represented at the governance level and have ongoing participation in quality improvement
    - All quality improvement activities e.g. Early engagement campaign involve our primary care partners, well child providers, LMCs, consumers, smokefree teams
    - MCGG membership is inclusive of GP, LMC, NZCOM representation alongside DHB health professional colleagues and consumers
- Identify tools to be used to meet the challenges of linking different stakeholders
    - Fortnightly maternity bulletin published across maternity stakeholders to ensure up to date information regarding both clinical and non-clinical activities. This has received overwhelming positive feedback and is highly valued as informative
    - Development of a maternity Facebook page to post consumer relevant information, invitation to participate in activities and feedback on consumer survey what matters to them is a useful forum for engaging with our community and provides another method of feedback using the PM option
    - Utilisation of PHO website and GP portal to share relevant key information and updates e.g. early engagement with a midwife campaign, being smokefree, healthy eating and action
    - Updated DHB website supporting a more interactive and up to date information sharing platform
- Strategies for sharing of data and information sharing between DHB and community groups
    - This continues to be one of our most challenging areas with limited electronic interface particularly between DHB and LMC as well as with our GP colleagues
    - Currently there is no provision to electronically share discharge information with our Well child providers, GPs and LMC colleagues due to the lack of interface between Healthware, ECA and Healthpoint – this continues to be a work in progress with work arounds to maximise communications in a timely manner

    - Good working relationships with our LMC colleagues support provision of data, as seen in our annual clinical report related to their practice stories and homebirth data
- Strategies to link clinicians, consumers and community groups for involvement and feedback about the programme
    - Currently have two specific survey monkeys (Waioha and Ata Rangi) accessible on laptops to capture consumer experience of maternity services prior to discharge. This has significantly increased our consumer feedback across the last year and supported the DHB ability to be responsive to what matters to our women and whanau
    - One of our consumer members runs a high profile Facebook page which accesses a large percentage of the Hawke's Bay parent age group – this page is often used to capture views, opinions and feedback on any issues concerning maternity e.g. breastfeeding services
    - Consumer forums are held across the HB district – 2 very successful forums have been held so far with a third and fourth planned for Central Hawke's Bay and Wairoa communities

Consumer Engagement

Strategies to strengthen consumer engagement in the design and delivery of maternity services in Hawke's Bay include:

- Development of two maternity consumer members affiliated with the programme – key work is involvement in quality initiatives, MCGG core members, facilitating consumer forums, actively seeking consumer feedback in relation to specific topics or issues, correlating consumer survey feedback, participating and commenting on policies and guidelines and commenting and providing material for the ACR
- Key Consumer council member link that holds the Communities, Women and children portfolio
- The Midwifery Director works collaboratively across the DHB organisation with the consumer engagement manager, consumer council members, maternity consumer members providing strategic leadership and support to ensure consumer engagement strategies are well supported across services
- Consumer survey feedback is summarised quarterly and provided to the quality team as part of the DHB consumer feedback which is then reported to Clinical Council. The quality and quantity of maternity consumer feedback is considered highly successful with the ability to demonstrate response to feedback received and improvements made to services
- Consumer forums have been highly successful held in the community to provide an opportunity for mums and whanau to informally engage with maternity services team over a cuppa. These forums have identified specific issues that concern our community and provided us with an opportunity to address and improve these. Consumer forums continue to be part of the calendared activities for 2017/18
- Consideration is being given to developing a birthplace app to support and empower women to make informed decisions regarding their place of birth, strengthen their conversations with their midwife and feel confident and in control of where they choose

to birth their baby. This requires significant financial support and input and potential funders/scholarships are being sought

- Current redesign activities include pregnancy and parenting education and breastfeeding support and services in the first 6 weeks – both of these initiatives involve members of our community to ensure the redesign is woman/whanau centric

Project	Rationale	Actions	Outcomes	Timeline
Early Engagement with a midwife Campaign	MOH and BPS Target of 90% of women registered with a midwife by 12 weeks – current HBDHB status as at March 2017 64.8% women booked by 12 weeks with Maori 55%.	• Roll out public campaign of "top 5 for my baby to thrive"  The top 5 for my baby to thrive with i  Maternity fold out.pdf These were as a result of considerable community, consumer, maori health and maternity stakeholder engagement and involvement to design and complete messaging – supported by our communications team • Working in partnership with General Practice, LMCs and Smokefree team to ensure message received and responded to by key primary practitioners involved in confirming pregnancy – revisiting GPs to provide resources, affirm messaging and offer ongoing support • Provision of pull up banners at CHB, Napier and Wairoa Health Centres with  Adapted Top 5 pull up banner.pdf resources • Visibility and support of Napier maternity resource centre (NMRC) as drop in for pregnancy testing and finding a midwife – significant increase in walk through traffic and midwifery led support to register early in pregnancy • Plan to establish a maternity resource centre in Central Hawke's Bay	Expected outcomes – to reach BPS target over the next year Engage with 50 GP practices Improved awareness and early engagement by pregnant women Increasing numbers visiting NMRC Finalise CHBMRC development	Commenced Aug 17 Ongoing over next two months Completed – next quarter data to increase Ongoing Dec 17

		- Presentation to Health & Social Care Localities group 5/9/17		
Project	**Rationale**	**Actions**	**Outcomes**	**Timeline**
Redevelopment of a woman centric maternal mental health pathway across primary/secondary landscape	Latest PMMRC report provides clear recommendations to focus on reducing maternal suicide rate – currently leading cause of maternal death in NZ Challenges with access to mental health services	• Establish a key stakeholder group inclusive of community based agencies, primary & secondary MH services, WCPs, LMC, NZCOM, Consumers, Quality improvement advisor, GPs, O&G • Use Taranaki diagnostic referral pathway as a tool to support and initiate discussion • Identify workstreams, workplan and timeline	Woman centric pathway for mental health services identified, engaging, accessible and visible 1 year evaluation of pathway from consumer and clinician and community based agencies	Stakeholder group established in July 17 Utilisation of Taranaki pathway underway Jul-Dec17 timeline established
Your Birth, Your Power changing birth culture initiative	Lead on from the opening of Waioha – to empower, strengthen and support women to choose place of birth, prepare and birth well	• Establish project midwife and project team • Identification of work plan and timeline • Develop consumer and clinician healthy birth pathway resources	- Increasing SVBs - 1/3 women birth in Waioha - Women's feedback identifies empowerment, involvement in birth planning and increased satisfaction.	Project MW commenced Aug 17 Workplan & Timeline identified In progress
Introduction of Obstetric Anal Sphincter Injury care bundle	Prevalence of 3/4DT sustained by women has been increasing with evidence that 50:50 SVBs/Assisted Preventative strategies have previously been limited and not well researched HBDHB clinical indicator for standard primips (2016) whilst showing evidence of improving requires further focus and change	• Midwifery Educator to establish education plan to include 4 steps of OASI bundle • Engagement and socialisation of OASI bundle to all maternity care professionals • Partnership with O&G, LMCs & DHB midwives as multi-disciplinary engagement required to support implementation	- Continued reduction in perineal trauma; particularly 3/4DTs - 1 year post implementation audit findings demonstrate compliance with 4 standards of care and reduced perineal trauma	November 2017 Jan/Feb 18 LMC/DHB and O&G meetings in Nov17

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, 9 AUGUST 2017 AT 1.00 PM

PUBLIC

Present:
Dr Mark Peterson (Co-Chair)
Chris McKenna (Co-Chair)
Dr Russell Wills
Dr Robin Whyman
Dr David Rodgers
Dr Kiri Bird
Dr Tae Richardson
Debs Higgins
David Warrington
Maurice King
Jules Arthur *(until 3.30 pm)*
Anne McLeod
Lee-Ora Lusis
Andy Phillips

In Attendance:
Kate Coley, Executive Director – People & Quality (EDP&Q)
Tracy Fricker, Council Administrator and EA to EDP&Q
Graeme Norton, Chair - HB Health Consumer Council
Sharon Mason, Acting Chief Executive Officer

Apologies:
Dr John Gommans and Dr Nicholas Jones

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Chris McKenna (Chair) welcomed everyone to the meeting.

The Chair advised that under item #28 of the Annual Meeting is the election of Chair/Co-Chairs which is a democratic process. The Chair advised that she and Mark Peterson would be standing down from their Co-Chair roles but would remain on the Clinical Council due to their positions of Chief Nursing Officer and Chief Medical Officer – Primary.

Dr Kiri Bird has been on the Clinical Council for four years and her tenure is coming to a close, her last meeting will be in September.

Apologies were noted as above.

2. INTERESTS REGISTER

No conflicts were noted for items on today's agenda.

Dr Tae Richardson advised that she had some changes to make to her interests in the register, and that they had been emailed to the Council Administrator.

Lee-Ora Lusis advised a new interest for Directions.

Action: Changes to interests register to be actioned.

3. CONFIRMATION OF PREVIOUS MINUTES

Graeme Norton (Chair, Consumer Council) advised that he would like additions made to the minutes of the combined meeting of the Clinical and Consumer Council held on 12 July. Under item #2 Clinical Services Plan, it needs to reflect the discussion that the group endorsed the principles laid out in the briefing document and that the consensus of the group was that the Clinical Services Plan needed to be bold and that resources needed to be applied to it.

The Clinical Council members agreed to the additions being made under the Clinical Services Plan item.

Action: ***Additional information to be added to the combined meeting minutes which will then be tabled at the September meeting for sign-off.***

The minutes of the general Clinical Council meeting held on 12 July 2017 where confirmed as a correct record.

Moved and carried.

4. MATTERS ARISING, ACTIONS AND PROGRESS

Item 1: ***Clinical Council Annual Plan 2016/17 Objectives***
On agenda today under item #26. *Item can be closed.*

Item 2: ***Health Awards***
On agenda today under item #15. *Item can be closed.*

The Chair commented that there is a reasonably fair distribution of entries for all categories this year. Emails have been sent out today for the shortlisting process. Council's mandate is to ensure a valid, robust and clinically sound process which will then go through to the external judges.

Sharon Mason, Acting CEO advised that at the Maori Relationship Board (MRB) meeting this morning there was a paper from Heather Skipworth, Deputy Chair of MRB proposing that the Health Awards be an alcohol free event. The MRB endorsed this proposal and will make this recommendation to the Board. Following a brief discussion, the Clinical Council members endorsed this proposal, but were concerned to ensure that this proposal didn't compromise actions by the DHB to also reduce consumption of sugar-sweetened beverages. The Acting CEO advised that a further conversation with EMT would need to be undertaken, as would a discussion with the Communications team who were responsible for organising this event.

Action: ***Heather Skipworth's paper to be circulated to Clinical Council members.***
Proposal to be discussed at EMT Meeting.

Item 3: **Laboratory Guidelines**
Andy Phillips advised that the guidelines, which were approved in principle at the July meeting are now being applied. The finalised version of the document will be provided for the Clinical Council's information with next month's meeting papers.

5. CLINICAL COUNCIL WORK PLAN

The work plan was included in the meeting papers.

On 6 September there is the Hawke's Bay Health Sector Leadership Forum, the agenda for which has been sent out.

The next Clinical Council meeting is on 13 September. A presentation is to be added for "Waioha – the first year".

Action: ***Waioha presentation to be included on work plan for September.***

SECTION 2: DISCUSSION / UPDATES / DECISION

6. KA ARONUI KI TE KOUNGA / FOCUSSED ON QUALITY

Kate Coley, Executive Director, People & Quality welcomed Jeanette Rendle, Consumer Engagement Manager to the meeting to discuss the Quality Accounts.

Quality Accounts are a requirement from the Ministry of Health, they are about engaging effectively with our community on the quality and patient safety initiatives that are happening in the sector. This is the fifth year we have done the Quality Accounts. This year the document is a more condensed version of what we have done in the past. The version in the papers is the draft document and will come back to the Clinical Council in September. The Quality Accounts will be available to the public in November following the release of the serious and adverse event report.

Jeanette Rendle advised that feedback from consumers is that they would like a "day in the life" of a health professional included. Included this year is information from Totara Health on the patient and whanau work ("#Whanau") and also a day in the life of a GP practice in Havelock North during the gastro outbreak.

Any feedback on format or contents is welcomed.

Feedback:

- Format is great, done well to get information together
- The national health targets are all in one colour, can this be changed so that the ones we exceeded are in green or blue to make more visual
- Reflect on the balance, celebrate the good and acknowledge where there are issues/challenges and what we are doing to change
- Looking at the health targets that we are not achieving, add information/narrative what we are doing to achieve
- Choose one theme to focus on e.g. equity and improved outcomes for Maori – there is data to show that things are improving re: proportion of staff who are Maori, immunisations, screening rates etc. This would also create visibility for the work of the Maori Health Service who do a lot of good work
- Add other patient safety challenges / initiatives
- You said / we did – our challenges and opportunities for improvement
- Include a calendar of local and national events for the upcoming year and what consumers can get involved with. This calendar could also be added to the website
- Suggestion that the quality accounts should be on the work plan for the May Clinical Council meeting to do a brainstorm on what could be included for next year.

The Chair thanked Jeanette Rendle for coming to the meeting and the work done on the document so far.

The Clinical Council **endorsed** the new format for the Quality Accounts.

7. TE ARA WHAKAPIRI HAWKE'S BAY – PALLIATIVE CARE OUTCOMES

Dr Mark Peterson advised that this work arose out of the closure of the Liverpool Care Pathway. There is a national programme for Last Days of Life, which we have localised for Hawke's Bay.

The programme has been piloted in a number of residential care facilities and Ward A1 in the hospital. Feedback we have received is that it has been very useful.

Graeme Norton commented at the MRB meeting this morning they felt that no Maori consumers were part of the validation process and they requested that this work be done before they would endorse.

The Chair commented that the document is a proforma for managing the last days of life and ensures that consumers are having their symptoms managed, that family/whanau are included and that there is a clear course of action with some presumptive prescribing. It is appropriate to be rolled out in aged residential care and the adult medical/surgical wards.

The Chair welcomed Leigh White, Long Term Conditions Portfolio Manager, Strategic Services to the meeting. Leigh advised that there was good discussion at MRB this morning where they asked how the document aligns to Advance Care Planning (ACP). Last Days of Life is for consumers who have been diagnosed as dying and ACP is a preparation document that all people should be discussing prior to being in the situation. The other concern was the evaluation not having a cultural competency lens on it. At the time of the evaluation it was on the tool itself and not on feedback of how well the tool was used. Also in the evaluation there was no Maori input of the tool because Maori don't usually die in aged residential care. An MRB member also asked if the tool could be implemented in the renal unit, Ballantyne House, which would come under the hospital services when rolled out. The question was also asked about roll out to primary. It is important to have the tool working well in aged residential care and the hospital before it is rolled out further in the community. Leigh asked if the members had any questions or feedback on the plan and toolkit.

Feedback / Questions:

- No mention of pharmacies as a community provider, can this be added as well as being notified when a consumer dies
- This document is a good starting point
- Concern expressed that we continue to create in the health service without consulting our most underserved populations, Maori are our treaty partners. We need to give clear clinical governance that this is unacceptable from a clinical quality perspective. The fault is institutional racism
- Under the palliative care strategy outcome measures were looked at for the delivery of the pathway, which would be a measure in the extent to which the strategy was used and achieved. Another was around ACP and the outcome measure proposed was the proportion of people who had an ACP in place. In primary care having an ACP as part of the initial palliative care engagement. The next stage for this will be an investment bid through the Clinical Council prioritisation process
- Need to be careful not to confuse palliative care with advance care planning. ACP should happen earlier as part of "care plus". Strong objection to fixing palliative care funding with advance care planning as this perpetuates that you only need an advance care plan when you are dying, which is not the case
- Transference of information is an issue. If a patient has an ACP, we need to know it exists and what it says. There is no current mechanism for that
- All clinicians need to start taking about advance care planning to talk openly to change the culture
- ACP needs to be owned by the community and not by health.

The Clinical Council supports the ongoing work undertaken and **endorsed** the roll out of the Last Days of Life Care Plan and toolkit, with the adjustments around pharmacy and the changes requested by the Maori Relationship Board.

8. LEARNINGS FROM ICU REVIEW 2013 – PROGRESS UPDATE

Kate Coley, Executive Director, People & Quality advised that this is the latest quarterly report. The only outstanding item is finalising the job sizing with ICU Consultants, they are currently working on the modelling and there is a meeting with the union at the end of the month. All the other recommendations from the 2013 review have been completed and the other recommendations that were identified when the last review was done have also been implemented. The next update report is due in 3 months, which should be the final report.

Andy Phillips commented that one of the challenges we have is the nurse staffing in ICU as the care capacity demand management (CCDM) process does not apply to ICU. Chris McKenna advised that it does apply, and it shows what we already know that there is a deficit in base staff in ICU. David Warrington advised that a paper was taken to the Health Services Leadership Team around the senior nurse presence in ICU in terms of it being 24/7 and that paper has been given the go ahead. They are currently working on a change paper for ACNM working rostered rotating duties which will also give an additional 0.7 staffing fte to the floor. Andy Phillips also commented that in the future we will also need to look at the size of the ICU, which will come through the Clinical Services Plan work and Surgical Expansion project. The CCDM piece is outside of the scope of this report.

Andy Phillips advised that Executive Management Team have supported the Speech Language Therapist who is now working in ICU for a Health Quality Safety Commission leadership award for the work undertaken in the department. There is some good work occurring in ICU.

Sharon Mason, Acting CEO advised that the CCDM from a nursing point of view will be picked up as part of the overall CCDM picture which is a different workstream and the job sizing will be managed through normal business as usual processes.

Clinical Council raised concern that they did not want what happened with ICU to occur again in the future with other services. Kate Coley advised that a monthly Health Services Risk Management meeting now occurs to discuss clinical risk and that risk registers are in place which identify things which might be an issue. We should not get into a similar situation in the future.

The Clinical Council **noted** the contents of the report.

SECTION 3: MONITORING FOR INFORMATION

9. TE ARA WHAKAWAIORA / MENTAL HEALTH

The Chair welcomed Alison Stevenson, Acting Executive Director, Provider Services, Justin Lee, Acting Service Director, Older Persons, Mental Health, NASC HB and Allied Health Services and Peta Rowden, Acting Nurse Director to the meeting. The report was taken as read.

Alison Stevenson advised that some improvement has occurred but there are still continuing issues with:

- Rate of Compulsory Treatment Orders (CTO) for Maori
- Number of children and youth without a discharge plan
- Wait times for non-urgent mental health or addiction service

Discussion took place regarding the current situation in mental health services and that it is a whole of sector issue not just health and that we need to work in collaboration with other agencies e.g. CYFS, MSD, justice, education etc.

Comments/feedback:

- Need early intervention, assessment, engagement with the family and the patient. Often people who end up on CTO their problems begin in childhood they have a history of abuse, neglect and family violence
- Strategically we need to look at the division of resources within the Mental Health and Addiction Service if we want to see an improvement in population level measures in adult mental health
- There is good collaboration between CAFS and the adult mental health service with opportunities to have wraparound services for families
- Time needs to be invested on how we work with other agencies across the sector to impact on the number of people with serious and enduring mental health problems
- Primary and secondary are working together on the model of care, looking at ways primary and secondary can support each other
- The mental health credentialling process for primary care nurses is going well. There are a lot of referrals that could be managed in primary health and providing the tools to primary would assist the hospital to look after the most severe cases
- Concern raised in primary re: access to psychiatrists for advice. We need to build the confidence in primary care that other health professionals who are not doctors can provide a good liaison service to GPs
- Relationship and collaboration with primary health is important.
- At a governance level we need to look at a whole of system change. Every step of the journey there are barriers to access if you are Maori
- Mental health work under specific legislation and there are a lot of legal requirements we need to challenge at that level

Graeme Norton commented that during discussions on the clinical services plan it was agreed that a lot of the drivers for ill health were not the clinical models of care, we need to be bold about doing things in different ways collectively to change these stats. There are fundamental things we need to change to get different answers and that at a governance level we can make a significant contribution to ensure that whatever the plan is to guide us is bold and different to get us to a better place for our population.

The Chair closed the discussion and summarised that we need to look at governance leadership and set a date for a future workshop to support what mental health are doing.

The Clinical Council **noted** the contents of the report.

10. ANNUAL MAORI PLAN Q4 APR-JUNE 17 / DASHBOARD

The Chair welcomed Patrick LeGeyt, Acting General Manager Maori Health to the meeting. Patrick commented that this is the last quarter report for this report as it is. In future the annual plan and will include 74 indicators for Maori, Pacific and other ethnicities.

Patrick advised he liked the statement by Dr Katherine Gottlieb from the Nuka Health System - “the challenge is not about taking culture to services, it’s about taking services to culture the more we understand about the culture, values and behaviours of the consumers the greater impact we could have”. Progress is being made against some of the health indicators. A lot of good work has been done with the ASH rates. Our role is to say where are the issues and partnering with our clinical leaders, services and communities to see what we can do. This is working well with maternity and respiratory services. The trends show fragmented, un-co-ordinated services and poor communication when investigations are done. Improving communication, co-ordination and joined up planning, thinking and action is the way to make a difference.

We need to prioritise what is important and where we can make the most impact and use our resources wisely, especially going to 74 indicators.

Comments/Feedback:

- It is great that we exceeded our cervical screening coverage for Maori but would like to see information on family violence prevention screening as it has a real impact on women going in, particularly around historic sexual assaults it is a hard sell sometimes in primary care to get people to do screening, if they see it is impacting on a target like this, that is good
- Good to see that every profession in the organisation trending up in percentage of Maori in the workforce.
- Would like to see a clinical services plan where we make a difference to the third world diseases in our community. We need to maintain our sense of horror and urgency about these statistics, they are not just colours on a page
- For the next iteration of the annual plan, is there a place where we can integrate data from social services, education and justice into a wider picture of Maori wellbeing and try and bring those threads together.

Patrick commented in future they want to put into service plans three foundation measures: workforce, cultural competency activities and health indicators. Those things mean something, are tangible are within a planning cycle and are accountable and measurable.

The Chair complimented Patrick and the team on their work there are some real highlights in the report as we move to the next stage.

The Clinical Council **noted** the report.

SECTION 4: COMMITTEE REPORTS

11. CLINICAL ADVISORY & GOVERNANCE GROUP (CAG) REPORT

Dr Tae Richardson advised that CAG met on 25 July and provided a brief verbal update:

Key points:

- The committee had the opportunity to meet new members of PHO staff and had a robust conversation around the committee work plan. The PHO quality team is hoping to move towards a proactive rather than reactive mode of governance
- Pharmacy Services in the Community *(this topic was discussed at the Clinical Council meeting in July)*
- Clozapine Contract Renewal – pilot since 2012 to move stable patients receiving clozapine as a treatment to management by their GPs, there is a credentialling process which has been audited, feedback on that audit is that everything is in hand moving forward
- BMI Assessment Tool – information paper on how to embed this into the before school check
- Update on system level measures for Hawke's Bay - draft plan has gone to MoH and the PHO is currently in discussions with stakeholders looking at financial incentives.

The Chair acknowledged that it had been sometime since CAG had met and that having a proactive work plan is the way to go.

12. RECOMMENATION TO EXCLUDE THE PUBLIC

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

13. Minutes of Previous Meeting (Public Excluded)
14. Matters Arising – Review of Actions (Public Excluded)
15. Health Awards
16. Investment Prioritisation
17. Member Issues / Topics of Interest

The meeting closed at 2.40 pm.

Confirmed: _____
Chair

Date: _____

MINUTES OF THE HAWKE'S BAY CLINICAL COUNCIL ANNUAL GENERAL MEETING HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE ON WEDNESDAY, 9 AUGUST 2017 AT 3.40 PM

PUBLIC

Present:	Dr Mark Peterson (Co-Chair) Chris McKenna (Co-Chair) Dr Russell Wills Dr Robin Whyman Dr David Rodgers Dr Kiri Bird Dr Tae Richardson Debs Higgins David Warrington Maurice King Anne McLeod Lee-Ora Lusis Andy Phillips
In Attendance:	Kate Coley, Executive Director – People & Quality (EDP&Q) Tracy Fricker, Council Administrator and EA to EDP&Q Graeme Norton, Chair - HB Health Consumer Council Sharon Mason, Acting Chief Executive Officer
Apologies:	Dr Nicholas Jones, Dr John Gommans and Jules Arthur

SECTION 6: ANNUAL MEETING

18. WELCOME AND OPENING

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

22.1

Graeme Norton, Chair of the Consumer Council took the opportunity to advise the Clinical Council that as of 1 September there will be a new chair of the Consumer Council. Graeme will still be a member of the Consumer Council for six months to ease in the transition. This will be announced at the Consumer Council meeting tomorrow and will be confirmed by the Board at the end of the month. The new chair will only be chairing the Consumer Council meetings and going to the Board meetings. Graeme will still attend the Clinical Council meetings as the Consumer Council representative.

Kate Coley acknowledged Graeme Norton's role as Consumer Council Chair and all the work he has done and will continue to do at a local and national level and is supportive of Graeme remaining on the Clinical Council. Debs Higgins also acknowledged the work she has witnessed in her role as the Clinical Council representative on the Consumer Council and the progressive nature of the work that Graeme has done for the Clinical and Consumer Councils.

19. APOLOGIES

Apologies were noted as above.

20. MINUTES OF PREVIOUS ANNUAL MEETING

The minutes from the previous Annual General Meeting held on 10 August 2016 were confirmed as a correct record of the meeting.

Move and carried.

21. MATTERS ARISING FROM PREVIOUS ANNUAL MEETING

There were no matters arising from the Annual General Meeting in 2016.

22. ANNUAL INFORMATION

Review of the Last 12 Months (2016/17) Year in Summary

The Chair commented that a summary of work that the Clinical Council has looked at over the past 12 months was provided in the meeting papers. It is an extensive list. One of the challenges we may want to talk about in regard to the work plan is that too much and are we doing justice to what we do? This needs to be taken into consideration when the work plan for next year is discussed.

Attendance over the prior 12 months

The attendance rate for Clinical Council meetings are very good which reflects that it has value for the people coming.

Changes from attendance list provided in the meeting papers:

- Tae Richardson attended the December, February and April meetings
- Anne McLeod attended the February meeting

Tenure

Dr Kiri Bird is reaching the end of her term. Kiri advised that she will be stepping down to allow some refresh of the Clinical Council. The Chair thanked Kiri for her time on Clinical Council her input and work has been valued. The Chair advised that Kiri's last meeting will be September.

23. REVIEW OF HB CLINICAL COUNCIL TERMS OF REFERENCE

The Chair asked if there was any feedback on the Terms of Reference (TOR).

Feedback:

- The TOR may look different once the clinical council committees' structure is up and running, should the review of the TOR be parked for 2-3 months. Rather than the Clinical Council becoming the clinical "tick box" for some of the papers that go through to the Board, there is an opportunity for this Council to focus on some key challenges in terms of patient safety and clinical quality and other matters.
- Look at the longstanding issues we have from a clinical quality and safety perspective and doing work on those instead of business as usual.
- Are we spending our time proportionate to the big issues e.g. the mortality rate and looking at the drivers for that. Where we direct our influence needs to be related to the big issues.
- Need to be more proactive on having workshops on the topics.
- Clinical Council needs to have a dashboard which can be monitored and can take action when there is some variance and be front footing as clinical leaders. Kate Coley advised that next month we are due to bring a draft concept dashboard to Clinical Council from a

patient safety perspective which will be a good starter for ten in terms of a robust discussion is the hospital and primary care safe.
- We need to be circumspect on what comes to Clinical Council, our time is valuable and are we focusing on the right things.
- The agendas are overwhelming when they arrive, trying to read the information in a few days can be difficult. What we should focus on are things that have the greatest clinical importance
- It is also about making sure that we have the right subject expertise around the table and if there are knowledge gaps that we have the right people here.
- The Hawke's Bay Health Alliance will also be around to help the committees address some of the health inequity issues and social deficits if we do it right
- Identify the gnarly issues and put them on the work plan for the next 12 months.
- Would like to look at safety, there are real concerns about patient safety. A conversation on our priorities are would be valuable

Graeme Norton commented that the Consumer Council have a sub-group which meets before the meeting and looks at what needs to go to the Board and requires endorsement and then they look at what is important and what they can make a difference with and the rest is included for information. If people want to initiate something there is a process. They focus on 3-4 key things and that works well. An example is that at tomorrow's meeting there is a session on whether or not the Consumer Council should initiate work on a disability strategy for HBDHB. Information has been gathered and will be talked about and it will assist to shape a paper which will be shared with the Clinical Council. This is working proactively on something the Consumer Council thinks is important.

Chris McKenna commented that one of the challenges as chair is getting people to speak out and contribute, it can be a challenge to set that scene. We all have a responsibility to bring these issues to the table and start the discussion especially when we have papers that clinical leaders and wise heads around the Clinical Council don't agree with. We need be more articulate and deal with that at these meetings. That has been a difficulty sometimes.

Mark Peterson reflected on his time on the Clinical Council and felt that we have regressed somewhat and that these meetings started off much better than now looking at clinical safety issues. We have become monitors with all of these monitoring papers and are doing too much. Reporting papers do not need to come to Clinical Council. Hopefully this discussion will help to reduce the size of the agendas and make them more relevant. There is an element of monitoring that a Clinical Council needs to do and the dashboard will assist with that.

Chris McKenna commented that hopefully the committees will do the monitoring and that the Clinical Council can act as true governors and lead to solutions.

The TOR do not need changing it is all in the document, the Clinical Council just need to work to the TOR.

The Chair thanked everyone for their feedback which will hopefully implement change for future agendas.

24. QUALITY ANNUAL PLAN REVIEW 2016-17

Kate Coley advised that Quality Plan last year was endorsed by Clinical Council and FRAC. There has been a significant amount of work achieved over the last 12 months:

Key points:

- We have moved on with consumer engagement in the services and making improvements there, where services are coming to us at the start and not at the end
- The Improvement Advisors are working well with the teams across the sector

- We have attained all the health quality safety markers and have retained our number one position with hand hygiene
- The Clinical Committees governance structure is now in place
- There has been a significant amount of work around relationship centred practice
- An integrated risk management system will be implemented by the end of this year and this will be will shared this with primary care and community providers in the future.
- Next year the Quality Plan will not include the day to day business as usual information, it will be the big pieces of work and projects like health literacy, clinical governance structure, consumer engagement including the local patient experience survey, which are key priorities for 2017/18
- The dashboard will be come to clinical council in September as a draft concept. It will evolve overtime and will bring a greater visibility from a quality and safety perspective for Clinical Council. There is a lot of work locally and nationally looking at data quality which will help with our dashboard to give us a clear picture of safety.

Discussion held regarding the difficulty of accessing data and it being integrated. Graeme Norton used the example of the system used in Canterbury that works well in the South Island.

The Clinical Council **noted** the contents of the report.

25. CLINICAL GOVERNANCE STRUCTURE

David Warrington advised that the structure has been completed and the TOR for each committee has been drafted by Ken Foote, Company Secretary. The Chairs of each of the committees were to feedback. The next step is to ensure that the TOR for all the advisory groups were reviewed, including structure and membership.

Graeme Norton advised that a group came together around the Patient Experience Committee and they have drafted up a plan for it.

David Warrington advised that with the Nursing and Midwifery Council TOR, they have looked at the percentage of Maori within the committee. If we are working in true partnership 25% of the positions on the committee should be dedicated to Maori, not just having representation of Maori, but also focusing on Maori in terms of having a Karakia and introducing new members. A challenge needs to be sent to other committees like the capital committee who are not part of this process.

Andy Phillips proposed that that the Clinical Council ratify the structure included in the meeting papers as the approved version of the clinical committees' structure. This was **approved** by Clinical Council members.

General updates provided below:

Clinical Effectiveness & Audit Committee

- Clinical Audit – there hasn't been a clinical Audit group that has met regularly. There is clinical audit done in the organisation but it is ad-hoc, sporadic and the results don't come back anywhere to close the audit cycle so there is significant work to do
- Clinical pathways – this work is going well
- Equity & Health System Integration – both are new groups and it has been a challenge as to whether we have these advisory groups. Reflection on discussion today is that we clearly do need some focused attention on both these. Work is to be completed on the TOR for these groups and any issues of health system integration and equity will be reported to clinical council on a regular basis
- Laboratory Committee – has been ably chaired by Dr Kiri Bird, but will need to find a new chair
- Pharmacy & Therapeutics – have been doing reasonably well

- Radiology Services – was blind to a number of the issues in the radiology department which was an issue.

Patient Safety & Risk Management Committee

- This is the largest committee with 10 advisory groups, most of which are working well and get exceptional results. We are looking to refresh membership and looking at where we can recruit more talent because these are all groups where there is an opportunity to recruit talented young clinical leaders and support their development
- Patient at Risk Advisory Group - will be re-purposed to meet the HQSC guidelines and chaired by Dr James Curtis, the Head of Department - Medicine
- Morbidity &Mortality Review Advisory Group – this is a new group. There are mandated groups which report nationally and then there are other ad-hoc groups that have no guidelines or standardisation. M&M reviews are not MDT and are not shared. This will be a big piece of work

Professional Standards & Performance Committee

- Allied Health Professions Forum – continues to meet monthly. Most recently has been occupied with designing the Allied Health Strategy
- Nursing & Allied Health Credentialling Committee – met in April to progress credentialling in various areas. The committee has concerns about Maori representation within credentialed activities and will address this at future meetings
- SMO Credentialling – has received/endorsed two biennial credentialling reports (Anaesthesia and Orthopaedics), has approved five new long term SMO appointments and is reviewing another four new SMO appointments
- Research – TOR and membership to be updated and presented to Clinical Council in October; a new consumer representative is to be sourced; next research forum is scheduled for 9 October, the theme s PHD with three key speakers, August meeting will include a workshop around research opportunities and how to tie in to existing strategies and initiatives in the DHB
- Pre-vocational Training / RMO Training – Community based attachments are progressing; PES are continuing to encourage clinical supervisors to participate in timely and engaged feedback with the PG1/2; documentation relating to training issues including medical education leave for RMOs and guidance for supporting struggling interns is almost complete; with increasing numbers of PG1/2 from November, a fifth PES is needed, once funding is assured an expression of interest will be circulated.

26. REVIEW OF CLINICAL COUNCIL'S ANNUAL WORKPLAN 2016/17

Information included in the meeting papers.

27. DEVELOPMENT OF COUNCIL'S ANNUAL WORKPLAN FOR 2017/18

Discussion took place under item #23.

28. ELECTION OF CHAIR / CO-CHAIRS 2017/18

Dr Mark Peterson advised that both he and Chris McKenna were stepping down as Co-Chairs.

Dr Mark Peterson nominated Dr John Gommans as Chair. This was seconded by Chris McKenna.

Dr Robin Whyman nominated Andy Phillips for Co-Chair/Deputy Chair and this was seconded by Dr Russell Wills.

Dr David Rodgers commented that should the role of Co-Chair be someone who sits outside of the Executive Membership Team.

As no other nominations were forthcoming, the Clinical Council endorsed the nominations.

Sharon Mason, Acting CEO advised that these nominations needed to be approved by Dr Kevin Snee as the Clinical Council reports to the Chief Executive Officer.

Action: ***Nominations to be presented to the CEO for approval.***

The meeting closed at 4.40 pm.

Confirmed: _____
Chair

Date: _____

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

Action No	Date issue raised	Action to be Taken	By Whom	By When	Status
1	12/07/17	***Laboratory Guidelines*** Approved in principle at July meeting. Guidelines document to be tabled for information at Clinical Council when finalised.	A Phillips	Aug/Sep	Pending
2	09/08/17	***Interests Register*** Changes to be made to register as advised for Dr Tae Richardson and Lee-Ora Lusis.	Admin	Sep	Actioned
3	09/08/17	***Combined Clinical and Consumer Council Minutes – July*** Clinical Services Plan item to be amended to reflect discussion.	G Norton	Sep	Pending
4	09/08/17	***Health Awards*** Proposal Paper re: alcohol free event tabled at MRB Meeting to be sent to Clinical Council members. Proposal to be discussed at EMT Meeting	Admin S Mason	Aug Aug	Actioned Actioned
5.	09/08/17	***Work Plan*** Include presentation on Waioha – 1st Year Findings on agenda	Admin	~~Sep~~	Deferred to October Mtg

OURHEALTH HAWKE'S BAY Whakawateatia

HB CLINICAL COUNCIL WORKPLAN 2017-2018

Meeting Dates	Papers and Topics	Lead(s)
11 Oct 17	Establishing Health and Social Care Localities	Tracee TeHuia
	Bowel Screening – NEW	Tracee TeHuia, Alan, Malcom
	Social Inclusion	Tracee TeHuia
	Waioha Primary Birthing Unit - Benefits Realisation (moved from Sep)	Chris McKenna/J Arthur
	Collaborative Pathways Update (4 monthly)	Mark / Leigh White
	Gastro Review – Progress Update (6 monthly)	Kate Coley
	Oncology Model of Care	S Mason/A Stevenson
	Ka Aronui Ki Te Kounga / Focussed on Quality (Final)	Kate Coley
	Serious Events (sign-off final) *public excl.*	Kate Coley
	Building a Diverse Workforce and Engaging Effectively with Maori	Kate Coley
	Monitoring	
	Te Ara Whakawaiora - Culturally Competent Workforce	Kate Coley
	Committee Reports	
	Laboratory Service Committee (4 monthly)	Andy Phillips
	Radiology Services Committee (4 monthly)	Mark Peterson
	Infection Prevention Control Committee update (6 monthly)	Chris McKenna
	HB Nursing Midwifery Leadership Council Update & D/board (6 mnthly)	Chris McKenna
	PHO Clinical Advisory & Governance Committee (monthly)	Tae Richardson
8 Nov 17	Best Start Health Eating & Activity (6 monthly update)	Tracee TeHuia / Shari
	ICU Learnings Report – Action Plan update complete now TBC	Kate Coley
	Legislative Compliance 6 monthly update (FRAC action)	Kate Coley
	Recognising Consumer Participation – Review Policy FROM AUGUST	Kate Coley / Jeanette
	People Strategy update – next viewing wil be February 2018)	Kate Coley
	Surgical Expansion Project	Sharon Mason / J Heinz
	Monitoring	
	Quality Dashboard Quarterly *reporting commences*	Kate Coley
	Annual Maori Plan Q1 July-Sept Dashboard	Tracee TeHuia
	Pasifika Health Plan Q1 July-Sept 17 - Dashboard	Tracee TeHuia
	Tobacco Annual Update against plan (annual)	Tracee TeHuia
	Te Ara Whakawaiora / Smoking (national indicator)	Patrick LeGeyt / Penny
	Committee Reports	
	PHO Clinical Advisory & Governance Committee (monthly)	Tae Richardson
	HB Clinical Research Committee Update (6 monthly)	John Gommans
6 Dec 17	~~Consumer Experience Results Qtly~~ (pulled pending Business Case)	Kate Coley
	The Big Listen to date (Presentation)	Kate Coley
	Clinical Services Plan – First Draft (Presentation)	Tracee TeHuia/C Burgess
	Committee Report	
	PHO Clinical Advisory & Governance Committee (Verbal)	Tae Richardson

Meeting Dates	Papers and Topics	Lead(s)
2018 **14 Feb 18**	Quality Annual Plan 2017/18 – 6 month review People Strategy (final draft) Clinical Services Plan (final draft) Collaborative Pathways Update (4 monthly) Annual Maori Plan Q2 Dashboard ***Monitoring*** Te Ara Whakawaiora / Access 0-4 / 45-65 year (local indicator) ***Committee Reports*** HB Laboratory Services Committee (4 monthly) HB Radiology Services Committee (4 monthly)	Kate Coley Kate Coley Tracee TeHuia / Carina Mark Peterson/ L White Tracee TeHuia / Patrick Mark Peterson Andy Phillips / Lab Chair Mark Peterson
14 Mar 17	Establishing Health and Social Care Localities in HB (6 monthly) ~~Consumer Experience Feedback Q2~~ ***Monitoring*** Te Ara Whakawaiora / Breastfeeding (national indicator) ***Committee Report*** Falls Minimisation Committee Update (6 monthly)	Tracee TeHuia Kate Coley Chris McKenna Chirs McKenna