Hawke's Bay Clinical Council Meeting

Date: **Wednesday, 9 February 2017**

Meeting: **3.00 pm to 5.30 pm**

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

Council Members:

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

Apologies:

In Attendance:

Kate Coley, Director Quality Improvement and Patient Safety (QIPS)
Ken Foote, Company Secretary
Tracy Fricker, Council Administrator and EA to Director QIPS
Graeme Norton, Chair HB Health Consumer Council
Kerri Nuku, Māori Relationship Board Representative
Lee-Ora Lusis, Clinical Council member from March 2017

PUBLIC MEETING

Item	Section 1 – Routine	Time (pm)
1.	Apologies / Welcome	3.00
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	
5.	Clinical Council Workplan	
6.	Review Progress on Annual Plan 2016/17 Objectives	3.10
	Section 2 – For Discussion and Information	
7.	ICU Learnings - Progress Report – Kaye Coley - Action Plan	3.25
8.	Collaborative Pathways Proof of Concept Proposal – Dr Mark Peterson	3.35
9.	13-17 Year Old Primary Care Zero Rated Subsidy Framework – Patrick LeGeyte	3.50
10.	Orthopaedic Review phase 2 (draft) – Andy Phillips	4.05
	Section 3 – Monitoring	
11.	Te Ara Whakawaiora / Access (local indicator) – Dr Mark Peterson	4.20
12.	Annual Maori Health Plan Q2 – Tracee TeHuia / Patrick LeGeyte	4.25
	Section 4 – Reporting Committees	
13.	Imaging Guidelines in the Secondary Care Environment – Dr Mark Peterson - Proposed Guidelines - National Criteria for access to Community Radiology http://www.hawkesbay.health.nz/about-us/hawkes-bay-clinical-council/clinical-council-meetings-2017/	4.35
14.	**Section 5 – Recommendation to Exclude the Public**	

PUBLIC EXCLUDED

Item	Section 6 – Routine	
15.	Minutes of Previous Meeting	
16.	Matters Arising - Review Actions	
	Section 7 – General	
17.	Maintaining the Radiology Service to Primary & Secondary Care (draft) Paula Jones and Andrew West	4.45
18.	Integrating GP Services in Wairoa (verbal) – Dr Mark Peterson and Chris McKenna	5.00
19.	Urgent Care Update – where to from here? (verbal) – Dr Mark Peterson	5.10
20.	Topics of Interest – Member Issues / Updates	5.15

NEXT MEETING - Wednesday, 9 March 2017

Interests Register
Feb 17

Hawke's Bay Clinical Council

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

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Advisory Committee)	Dr Bryn Jones employee of MoH	Husband	Role with Ministry of Health as Chief Advisor in Sector Capability and	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Report on CQAC meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Life Education Trust Hawke's Bay	Trustee		No	
	Dr Bryn Jones employee of MoH	Husband	Deputy Chief Strategy & Policy Officer (Acting)	No	
	Pacific Chapter of Royal NZ College of GPs	Secretary		No	
Andrew Phillips (Director Allied Health HBDHB)	Nil	Not Applicable	Not Applicable	No	Nil
Dr David Rodgers (GP)	Tamatea Medical Centre	General Practitioner	Private business	Yes	Low. Provides services in primary care
	Tamatea Medical Centre	Wife Beth McElrea, also a GP (we job share)	Private business	Yes	Low. Provides services in primary care
	Directions Youth Health	Wife Beth involved	Assisting youth in HB	No	
	City Medical	Director and Shareholder	Medical Centre	Yes	Low. Provides services in primary care
	NZ Police	Medical Officer for Hawke's Bay	Provider of services for the NZ Police	No	
	Health Hawke's Bay (PHO) initially - from 1 July 2015 under HB District Health Board	Collaborative Clinical Pathways development	Was the Champion for the initial work, however on 1 July this moved under the HBDHB umbrella (with a community focus).	No	
	Advanced Care Planning	Steering Group member	Health and Wellbeing	No	
	Urgent Care Alliance	Group member	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues around the development of urgent care services.
	National Advisory Committee of the RNZCGPs	Member	Health and Wellbeing	No	
	Health Hawke's Bay (PHO)	Medical Advisor - Sector Development	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues in this area relating to the PHO.
Debs Higgins (Senior Nurse)	The Hastings Heatlh Centre	Practice Nurse Family Violence Intervention Coordinator	Delivery of primary health care - General Practice and training of Clinicians in family violence intervention.	No	
	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
	LIVE (Local Initiative for Violence Elimination)	Member of management Committee	Network of agencies that provide family violence intervention services.	No	
	Eastern Institute of Technology (EIT)	Lecturer - Nursing	Education.	No	
Anne McLeod (Senior Allied Health Professional)	Aeotearoa NZ Association of Social Workers	Member		Yes	Low
	HB DHB Employee Heather Charteris	Sister-in-law	Registered Nurse Diabetic Educator	Yes	Low
	Directions Coaching	Coach and Trainer	Private Business	Yes	Low: Contracts in the past with HBDHB and Hauora Tairawhiti.
Dr Robin Whyman (Clinical Director Oral Health)	NZ Institute of Directors	Member	Continuing professional development for company directors	No	
	Australian - NZ Society of Paediatric Dentists	Member	Continuing professional development for dentists providing care to children and advocacy for child oral health.	No	
Dr Russell Wills	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	

**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, 7 DECEMBER 2016 AT 3.00 PM**

PUBLIC

Present: Chris McKenna (Chair)
Dr Kiri Bird
Dr John Gommans
Dr Russell Wills
Dr Robin Whyman
Dr David Rodgers
Dr Andy Phillips
Debs Higgins
William Allan
David Warrington
Julie Arthur
Anne McLeod (arrived 3.20 pm)

In Attendance: Ken Foote, Company Secretary
Kate Coley, Director - Quality Improvement & Patient Safety
Tracy Fricker, Council Administrator and EA to DQIPS

Apologies: Dr Mark Peterson and Dr Caroline McElnay

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Chris McKenna (Chair) welcomed everyone to the last Clinical Council meeting for the year and thanked members for their valued input to meetings, the discussions and work completed during the year.

The Chair commented that there is one vacancy which is being worked through and congratulated David Warrington that he had been confirmed for a further three year term as a member of Clinical Council.

On behalf of the Clinical Council the Chair congratulated Dr Caroline McElnay on her new appointment as Director of Public Health at the Ministry of Health (MoH). Caroline has been a member since the establishment of the Clinical Council and has provided a very strong contribution. It was confirmed that Caroline's Successor as Director of Population Health will be an appointed member of Council

Apologies were noted as above.

Action: Letter of thanks to be sent to Dr Caroline McElnay.

2. INTERESTS REGISTER

No conflicts of interests for agenda items. David Warrington advised he will provide an updated list for the register.

Action: Interests register to be updated when changes received.

3. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the meeting held on 9 November 2016, were confirmed as a correct record of the meeting. One typo to be changed on page 5 “depravation” to deprivation.

Moved and carried.

4. MATTERS ARISING, ACTIONS AND PROGRESS

Item 1: **RMO Strike Update**
No strike action taken in November. *Item can be closed.*

Item 2: **Clinical Council Annual Work Plan 2016/17**
Not yet completed.

Item 3: **Resignation of Clinical Council Member**
Robyn O’Dwyer resigned from the Clinical Council. Letter of appreciation for service sent to Robyn. Replacement of Senior Nurse Representative underway.

Item 4: ***Clinical Governance and Committee Structures***
Work in progress.

Item 5: ***Laboratory Services Committee***
Review of terms of reference (ToR) to come to Clinical Council for sign off.

Item 6: ***Palliative Care and Advanced Care Workshop***
Following the workshop there have been a number of changes which will be presented back to Council in due course.

5. CLINICAL COUNCIL WORK PLAN

The work plan was included in the meeting papers for information. It was noted that there are some presenters in the work plan for March and June who are leaving the DHB and these topics will need to be reallocated.

Julie Arthur advised that she will be the lead for the Maternity Clinical Governance Group update in March.

SECTION 2: FOR DECISION

6. LONG TERM CONDITIONS REPORT

The Clinical Council noted the contents of the report presented by Leigh White, Portfolio Manager – Long Term Conditions and Jill Garrett, Strategic Services Manager – Primary Care.

Key points:

- The framework is based on the “Four Aka” roots *(Person-Family-Whanau Centred Care, Person centred systems and processes, Workforce development and enablement and Risk identification and mitigation)*. It is not diseased based
- Each of the Four Aka have four contributing dimensions
- The document is strategic and high level. There will be a simplified version developed for the general public which will be available early next year
- A service review matrix has been designed as well as a consumer evaluation tool so the consumer perspective can be captured

- A snap shot tracer audit from a number of consumers is being completed to inform the finalisation of the framework i.e. what can be removed and what needs strengthening
- Business Intelligence and Contracting teams worked on the financial assumptions. These are designed on specifications from the MoH on what services should be provided and aligning a financial figure to that. The aim is for a reduction on demand for resources of 4%. It is not the intention to remove budget from services, it is to reduce the demand on those services as the framework is focused on early intervention and prevention.

Following discussion it was noted that the paper needs to be clear that reduction of demand from patients with long term conditions has the potential to reduce demand in acute care in the hospital. The references to budget reductions in acute care should be removed. A social return on investment approach was recommended in demonstrating benefit. There is a need to ensure that our services for people with common mental health conditions and long term conditions are aligned. Also that our services need to change to provide better outcomes for people with multiple long term conditions. It was emphasised that our services will need to transform in order to achieve this, and this will be challenging. The importance of communication with clinical leaders in developing this work was emphasised Council members commended the excellent work so far.

The Long Term Conditions Framework was endorsed by the Clinical Council subject to amendments described above.

SECTION 3: PRESENTATIONS

7. GASTRO OUTBREAK UPDATE

Kate Coley, Director – Quality Improvement & Patient Safety (DQIPS) provided an update on the Gastro Outbreak.

The presentation included an outline of the purpose and methodology; key learnings; summary; recommendations; Inquiry update and next steps. The DQIPS tabled a diagram entitled "Responsibility for Drinking Water under the Health Act 1956 and the DHB Contract' which listed the starting point, business as usual and issues of non-compliance.

Document management is an issue. Work is currently underway collating all of the information generated during the outbreak (approximately 30,000 records). In future we need to look at better ways of saving information centrally.

It was noted that monthly and random testing of the bore head was being conducted by the Hastings District Council (HDC). Robust and regular testing is occurring with the hospital bore.

The Inquiry has been delayed due to the action being taken against the HDC by the Hawke's Bay Regional Council (HBRC). The Inquiry will sit to discuss Issue 8 (how we turn the bore back on) on 12 December. The Inquiry will begin in January and the findings will be presented by the end of April 2017.

Dr John Gommans advised that a research project outside of the inquiry is being conducted and Dr Nick Jones is co-ordinating locally for the DHB.

Concern raised on how we treat our environment locally and the impact this has on health. Legislatively we are not supported to comment on this outside of the safety of the water.

8. QUALITY IMPROVEMENT PROGRAMME

The Chair advised there is still work to be completed. This item will be included on a future agenda.

9. RELATIONSHIP CENTRED PRACTICE

Dr Andy Phillips, Chief Allied Health Professions Officer (CAHPO), Anne McLeod, Allied Health Educator and Laurie Te Nahu, Programme Administration Officer, Maori Health provided a presentation to the Clinical Council on Relationship Centred Practice.

Key points included:

- HBDHB values "HEART" (He Kauanuanu – Respect; Akina – Improvement; Raranga Te Tira – Partnership and Tauwhiro – Care)
- The Nuka System of Care
- Person and Whanau Centred Care
- Relationship Centred Practice Framework
- Timeline

As part of the presentation a video clip was played "Introducing Relationship Centred Practice". Anne McLeod advised that the video will be re-edited to include a more local flavour and examples in the future.

The Chair thanked the team for their presentation. The Clinical Council endorsed the progression of this work and noted that clinicians and the people we serve will need to continually engaged in its development.

SECTION 4: FOR INFORMATION

10. ANNUAL MAORI PLAN – QUARTER 1: JULY TO SEPTEMBER 2016

Tracee Te Huia, General Manager, Maori Health (GM, MH) advised that the annual plan, which included a summary dashboard was included in the papers for information only.

The GM, MH advised that work had been done to clean up the indicators on the dashboard to what the MoH requires, work is also underway to move the Maori Plan, Pacific Plan and Regional Services Plan into one 30 page document and to ensure that everything reported on is broken down by ethnicity. The service level measures being developed by primary care also need to be included in the dashboard.

The Chair commented that there is still a lot of red on the dashboard. The GM, MH advised that this is quarter one and there is a lot of development going on which includes how we get equity built into our systems. There are discussions taking place on how we use the equity tool across the organisation. There has been agreement at executive level to move the HEAT tool into project methodology, and a lot of training on the use of this tool has occurred over the past year.

Dr Tae Richardson commended Maori Health on the plan, but noted that we need to look at a more powerful way to drive equity than just using the HEAT tool.

The GM, MH requested in future that these reports be taken out of "information only" and be a discussion item. The Chair agreed as this work is critical to the organisation and across the health sector. The GM, MH also thanked those Clinical Council members who attended the Nuka training last week, it was a very beneficial two days training.

11. COMPLEMENTARY THERAPIES POLICY

Dr Andy Phillips, Chief Allied Health Professions Officer (CAHPO) advised that this is the final version of the policy for information and approval. Dr David Rogers to discuss some concerns with the CAHPO outside the meeting. The Clinical Council approved the policy for sign-off.

SECTION 5: REPORTING COMMITTEES / MONITORING

12. CLINICAL ADVISORY & GOVERNANCE (CAG) COMMITTEE

The CAG report was not available at the time of the meeting and will be sent out with the meeting minutes.

13. COLLABORATIVE CLINICAL PATHWAYS UPDATE

Leigh White, Portfolio Manager, Strategic Services provided a quarterly update on progress. It was noted that 30 pathways have been completed and the use by GPs has increased. The team continues to socialise by visiting GP practices, providing training and a quarterly newsletter. Discussions are taking place with Auckland, Canterbury and MidCentral DHBs to link e-referrals to pathways. Leigh acknowledged the good support the team has had from Dr Mark Peterson and Dr David Rodgers.

The Chair acknowledged the good work completed to date, noted it is a culture change and the importance of integration, joining up primary and secondary care.

14. RECOMMENDATION TO EXCLUDE THE PUBLIC

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

15. Minutes of Previous Meeting (Public Excluded)
16. Matters Arising – Review of Actions (Public Excluded)
17. Member Topics of Interest

The meeting closed at 4.50 pm.

Confirmed: _____
Chair

Date: _____

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

Action No	Date issue raised	Action to be Taken	By Whom	By When	Status
1	12/10/16	Clinical Council Annual Work Plan 2016/17. • Review of the plan to take place between meetings (Mark Peterson, Chris McKenna, Andy Phillips and Russell Wills).			Review of progress against the draft plan on Feb agenda.
2	9/11/16	Resignation of Clinical Council member - replacement Senior Nurse representative on Council.	Co-Chairs		An appointment has been approved by CEO's of HBDHB and HHB Ltd Yet to go to the Boards
3	9/11/16	Clinical Governance and Committee Structures • Progress and Council representation on five committees and some advisory groups TBC • Timeline for the document in final form TBC	K Coley		
4	9/11/16	Laboratory Services Committee Review of TOR to come through Council for sign off.	K Bird		
5	9/11/16	Following on from the Workshop on Palliative Care and Advance Care Planning – where to from here?			Palliative Care final to March Meeting.
6	7/12/16	Resignation Clinical Council member - letter of thanks to be sent to Caroline McElnay.	C-Chairs	Dec	Actioned
7	7/12/16	Interest Register – Changes for David Warrington to be actioned when received	D Warrington / Admin	Feb	

OURHEALTH HAWKE'S BAY Whakawateatia

HB CLINICAL COUNCIL WORKPLAN 2016-2017

Meeting Dates	Papers and Topics	Lead(s)
8 Mar 17 **1pm start TBC**	Quality Dashboard Concept Paper Travel Plan Update Draft Annual Plan New Investment bids – prioritisation ***Monitoring*** HB Integerated Palliative Care (Final) Maternity Clinical Governance Group Update (6 monthly) Falls Minimisation Committee Te Ara Whakawaiora / Breastfeeding (national indicator) Laboratory Services Committee Radiology Servcies Committee Health & Social Care Networks (6 monthly) CAG	Kate / Russell Wills Sharon / Andrea Beattie Tim / Carina Burgess Tim / Peter Kennedy Mary Wills Chris McKenna Chris McKenna Nicky Skerman Kiri Bird Mark Peterson Tracee / Belinda Sleight Tae Richardson
12 Apr 17	Quality Dashboard Concept Paper – revised for FRAC's viewing in April ***Monitoring*** Collaborative Clinical Pathways HB Nursing Midwifery Leadership Council Update & Dashboard 6mthly Te Ara Whakawaiora / Cardiology (national indicator) CAG	Kate / Russell Mark / Leigh White Chris McKenna John Gommans Tae Richardson
10 May 17 **1pm start**	ICU Learnings Report – Action Plan update (qtly) Best Start Healthy Eatng Plan *yearly review" Final Draft Annual Plan 2017 ***Monitoring*** HB Clinical Reasearch Committee Update (6 monthly) Infection Control Committee (6 monthly) CAG	Kate Coley TBC (previously Caroline) Carina Burgess John Gommans Chris McKenna Tae Richardson
14 Jun 17	Youth Health Strategy Update for information Alcohol Position Statement Update Quality Improvement Programme (6 monthly) Youth Health Strategy Update for information Suicide Prevention Postvention Update against 2016 Plan ***Monitoring*** Te Ara Whakawaiora / Oral Health (national indicator) CAG	Nicky Skerman Rachel Eyre Andy Phillips Andy Phillips Kate Coley Robin Whyman Tae Richardson

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

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

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

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

@BCL@5804CE70

HAWKE'S BAY District Health Board Whakawāteatia	**Learnings from ICU Review 2013 – Progress Update**
	For the attention of: **HB Clinical Council and the Finance Risk & Audit Committee**
Document Owner: Document Author:	Kate Coley, Director Quality Improvement & Patient Safety Kate Coley, Director Quality Improvement & Patient Safety
Reviewed by:	Executive Management Team; HB Clinical Council
Month:	February, 2017
Consideration:	For Information

RECOMMENDATION

That HB Clinical Council and the Finance Risk & Audit Committee:

1. **Note** the contents of this report.

EXECUTIVE SUMMARY

At the end of 2015 an urgent request was made to the Executive Management Team (EMT), HB Clinical Council and the Finance, Risk and Audit Committee (FRAC) to support a Business Case to appoint further senior consultants to ICU due to significant risks being identified in regards to SMO resourcing and an unsustainable and unsafe roster for the medical team.

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

Also attached is a second spreadsheet identifying the outstanding Recommendations of the ICU 2013 review, and progress against those that are outstanding.

ATTACHMENT(S)

A. ICU Action Plan/Progress
B. Incomplete Recommendations

A. ICU Action Plan

Action	Responsibility	Implementation deadline	Progress Update
A documented job sizing process needs to be established and agreed between the DHB and ASMS with clearly defined roles and responsibilities with an agreed timescale, with a maximum of 12 months for the work to be completed	John Gommans, Colin Hutchison + Craig Sidoruk	Dec-16	ICU SMO job sizing in progress. Further discussions and considerations and options to be negotiated and worked through. Hope is to finalise this piece of work fully by end November 2016.
Undertake a full review of the current ICU SMO rostering practices.	Colin Hutchison	Sep-16	ICU SMO job sizing in progress. Further discussions and considerations and options to be negotiated and worked through. Hope is to finalise this piece of work fully by end November 2016 with a new roster to follow thereafter.
Develop systems to ensure nurse staffing ratios are appropriate for both ICU and HDU patients	Ian Elson/Chris McKenna	Nov-16	Draft paper being prepared for HSLT. CCDM project will be utilised to understand the issues and resourcing requirements. Expected that the results of this will be completed by March 2017.
Review all recommendations from the 2013 Review, consider and implement any that are still relevant and outstanding	Paula Jones, Colin Hutchison, Ian Elson	Nov-16	Please see separate worksheet for an update.
Development of a TOR Guideline & process document	Kate Coley	Jul-16	Complete
TOR Template developed	Kate Coley	Jul-16	Completed
TOR Checklist developed	Kate Coley	Jul-16	Complete
HBDHB is to investigate the most time effective method for effectively and efficiently reviewing and approving SMO timesheets to ensure they accurately record actual hours worked and leave taken	John McKeefry - Now Kate Coley	Aug-16	Piece of work to be undertaken as part of the DRs Unit transition following the reconfiguration in Health Services.
Undertake a full audit of "actual hours worked" not necessarily contracted hours to determine whether SMOs / RMOs are working a significant number of hours over and above contracted hours	John McKeefry - Now Kate Coley	Aug-16	Pilot underway mapping SMO Timetables in Acute & Medical Services - actual hours worked versus contracted hours. Once pilot completed a full rollout will be undertaken as part of the DRS Unit transition.
Dependent on the results from the above audit consider and make a recommendation to EMT as to whether the DHB needs to consider ongoing tracing of actual hours worked and establishing a mechanism for identifying and escalating issues to senior leaders so that this issue is better managed.	John McKeefry - Now Kate Coley	Sep-16	Will form part of the DRS Unit transition following analysis of results of the pilot.
Each Directorate will be required to develop an annual service plan to reduce the risk of 'crises' occurring in the future	Sharon Mason	Jul-16	Completed and performance reporting provided on quarterly basis to identify any issues and risks. It will take 12 months to establish the reporting cycle.
Establish effective mechanisms for escalation of risks to relevant governance bodies in a more consistent and transparent manner.	Kate Coley	Immediate	Complete.
Monthly meetings set up with HS Directorate teams to review directorate risks & identify any actions, escalation that needs to occur	Kate Coley	Immediate	Complete
Risks identified that are significant to be discussed with HSLG and escalated to EMT/Clinical Council/FRAC as necessary	Sharon Mason	Immediate	Complete
Implementation of a new event system so that we will be able to triangulate information and allow us to understand where a risk is developing before it becomes critical	Kate Coley	Jan-17	Business case under development to be endorsed by year end. Implementation and upgrade to follow in first 6 months of 2017.

B. Incomplete Recommendations (as at end October 2016)

Report Recommendation (Feb 13)	Status - May 2016	Current Plan	Lead / Responsible	By When	July Update
1. ICU level					
1.8. Consideration should be made towards using the registrar more effectively. Where registrars are junior, support should be provided to enable them to manage a proportion of calls (within their ability) and to escalate others.	At time of 2013 report, majority of ICU registrars were PGY2. After accreditation - advanced trainees, now aiming for PGY3 or above. Service is now budgeted for 7 Registrars (vs 6 in 2013)	Increase in SMO numbers to support both clinical and non-clinical activity. Once new roster agreed then the support for the registrars will become more formalised.	John Gommans, Colin Hutchison & Craig Sidoruk	Sep-16	ICU SMO job sizing in progress. Further discussions and considerations and options to be negotiated and worked through. Hope is to finalise this piece of work fully by end November 2016.
1.9. ICU specialists should consider whether preservation of the current arrangements are of such importance that reduction of other resources (such as bedside nurses) is a preferred alternative in the case of present or future funding shortfall.	This is not the decision of ICU SMO team. Additional nursing resources not approved in recent business case. Potential review of ICU technician roles and allocation will be reviewed once flight review completed.	Will align with flight review implementation re technician support for ICU	Service Director with ICU Leadership	Oct-16	Discussions with HSLT and HR - plan to align implementation of flight review and hospital reconfiguration, alongside CCDM rollout into the ICU area to inform resourcing requirements. Expected completion March 2017.
1.11. Determine the level of care provided to groups of patients with likely poor outcome to enable best utilization of resources	Admission / discharge criteria implemented 2015	Gain consensus amongst SMO team. Support of PAR Team implementation Continue to push need for Goals of Care program at HBDHB	ICU - HoD	**COMPLETE**	Appointment made awaiting individual joining organisation.
1.17. Early discussion with colleagues around discharge plans for specific patients may reduce tension between the ICU and wards and facilitate a smooth discharge and care plan for the patient going forward.	Improved discharge planning within ICU underway including MDT meetings. Relationships between ICU and primary teams/wards improving.	Medical CD and HoD involvement in discussions with physicians group around patient care planning.	Medical Director HoD - ICU	**COMPLETE**	Undertake audit to ensure discharge planning being undertaken.
2. Hospital Level					
2.1. Continue to develop the MET team and CRN ward team to support care of the higher acuity patient on the ward.	EWS process reviewed and Rapid Response Team approach established in 2015. Additional RN fte approved in 15/16 new investment process. Business Case developed and signed off by Transform & Sustain Steering Group	Proceed with PAR Team recruitment. Work closely with ICU SMO team and Ward teams about model. Support available from ICU SMO team will be determined by outcome of ICU job-sizing. Paper for implementation of ALERT training prepared for CNO. Rapid Response Team now well established.	Nurse Director and ICU Leadership Team.	**COMPLETE**	
2.2. Current concerns about risk that appear to be driving a proportion of HDU admission could be addressed by a functional, integrated deteriorating patient response and supportive outreach service. Given the limited ICU medical resource, consideration should be made to making the first responder of an outreach service an experienced RN. Most services in other hospitals are based in ICU (this facilitates positive interaction between ICU and wards). Hawke's Bay should consider such a model. Further education is required to explain the basis of the deteriorating patient response system.					

Report Recommendation (Feb 13)	Status - May 2016	Current Plan	Lead / Responsible	By When	July Update
2.3. Develop an organisational approach to discharging the ICU/HDU during office hours.	As for 1.17. Ability to transfer during hours is largely influenced by ward bed availability.	Monitor and analyse ICU exit block and out of hours discharge rate.	HoD & CNM - ICU	**COMPLETE**	
3. Management					
3.1. HB Hospital need to consider value of a quality ICU service to quality care delivery at HB and maintenance of specialist surgical services	ICU SMO establishment increased. The rate limiting step in ICU is the number of RNs per shift. Bid made in new investment process for 16/17 for additional ICU RN resourcing.	Organisation clinical services plan to determine the philosophy of care for Hawkes Bay Hospital and HB ICU that determines level of service provision for Hawkes Bay. The model of care for the Hospital After Hours is still unresolved.	ICU Ops Team	Aug-16	CNM & HoD ICU to manage the day to day demands. Initiation of CCDM process in ICU with expectation of results March 2017. Aspects will inform Clinical Services plan which is expected to be completed by May 2017. The Integrated Ops Centre and IOC manager will work with the Directorate leadership team around patient flow and capacity.
3.2. HB Hospital should clearly identify funded bed capacity and devise clear operational guidelines for when ICU reaches funded capacity. This requires administrative responsibility and should not be left to the medical and nursing staff to resolve alone.	The current level of resourcing is clear and explicit. The challenge is understanding adequacy of current resource and future impact of increased elective surgery.	As 3.1	ICU Ops Team	Aug-16	
3.3. Review number of physical beds required to meet population need and the type of service the organization wishes ICU to provide.	As 3.1 & 3.2	As 3.1 & 3.2	ICU Ops Team	Aug-16	
3.5. Serious consideration should be made to reconfigure medical cover to ICU within a structure of safe working hours and reasonable roster	Recruitment of additional Intensive Care Physician position in 2015/16	SMO job sizing under way to be completed July 2016	John Gommans, Colin Hutchison & Craig Sidoruk	Aug-16	ICU SMO job sizing in progress. Further discussions and considerations and options to be negotiated and worked through. Hope is to finalise this piece of work fully by end November 2016.
3.7. Significant positive change has occurred and continuing. Administration take care to facilitate positive change and beware of applying excessive financial strain during a time of transition and transformation	ICU SMO establishment increasing as a result of ICU SMO business case approval. ICU SMO job sizing process to be completed to ensure safe and sustainable rostering.	Job sizing under way. Await outcome of job sizing project	John Gommans, Colin Hutchison & Craig Sidoruk	Aug-16	ICU SMO job sizing in progress. Further discussions and considerations and options to be negotiated and worked through. Hope is to finalise this piece of work fully by end November 2016.

Report Recommendation (Feb 13)	Status - May 2016	Current Plan	Lead / Responsible	By When	July Update
3.8. Develop systems to ensure minimum nurse staffing standards are adhered to. This will ensure there is a supernumerary nurse coordinating each shift, a 1:1 nurse patient ratio for ventilated patients and a 1:2 patient ratio for HDU patients	ICU RN establishment permits 8 RN per shift. Maintaining safe staffing within this number requires occupancy to be below maximum (11 beds) and have a favourable HDU to ICU case mix. When clinical demand exceeds 8 RN/shift there is either the option to source additional RN (extra shifts or casual) or reduce clinical demands (prematurely discharge, decline elective work, defer admissions or flight critically ill people out) CNM reports monthly on casual nursing staff usage, extra shifts worked and nursing overtime in report to directorate leadership.	A new investment bid submitted to increase RN establishment. Nurse staffing shortages are recorded in event reporting system and raised with directorate leadership. Trendcare shift variance shows this in a regular report.	A&M Directorate Leadership and ICU - CNM	Aug-16	Initiation of CCDM process in ICU with expectation of results March 2017.
3.9. Fill vacant ACNM position immediately to bring it back up to 3.5 FTE	Prior attempts to reinstate 4th ACNM unsuccessful	Only half of all shifts able to be staffed by ACNM due to budgeted establishment.	ICU Ops Team	Jun-16	Initiation of CCDM process in ICU with expectation of results March 2017.
3.11. Review out of hours ward medical and nursing resources to enable better support for the deteriorating patient	Pending AIM 24/7 implementation of 'managing the deteriorating patient' work stream. PAR nurse (working during the day) will identify the at risk patients to be monitored after hours.	PAR nursing resource approved. Negotiating with ICU SMO about the level of senior medical support available.	HoD & CNM - ICU	**COMPLETE**	
3.12. ACNM office days be rostered and acknowledged as essential time to enable the team to achieve service goals, develop nursing practice and manage nursing staffs' professional development. At these times the ACNM should not routinely be pulled onto the floor for meal reliefs or to take admissions or discharges. Thus a planned roster must enable them to be completely off the floor and away from the day to day running of the unit	3 part-time ACNMs not adequate to cover 24/7 roster and provide leadership and support to clinical team. Attempts to reinstate 4th ACNM unsuccessful - not budgeted but actually need 6 fte to function effectively.	Budget application 2015/16 to reinstate 4th ACNM was not prioritised. Therefore non clinical ACNM hours are unable to be rostered due to clinical duties taking priority. When able, non-clinical time is rostered. CNM frequently trying to roster non clinical as able.	HSLT	Ongoing	Initiation of CCDM process in ICU with expectation of results March 2017.
4. Anaesthetic Technicians and Flight					
Reduction or loss in Anaesthetic Technician cover will leave a large gap which could lead to equipment failures and shortages, increased complications, a reduction in nursing resource and increased number of flights by third party operators (at much greater cost). At present there are not enough ICU trained flight nurses to cover a 24/7 transport service. There must also be back up transport nurse/AT for times when urgent, time sensitive, transfers are required (e.g. Neurosurgical, cardiac and vascular patients).	A unique arrangement exists where ICU has a role for anaesthetic techs who also provide patient transport assistance to ICU medical team. ICU clearly needs dedicated technical support and a functional flight retrieval system	Start untangling this situation when recommendation	A&M Directorate and ICU Leadership Teams.	Oct-16	Discussions with HSLT and HR - plan to align implementation of flight review and hospital reconfiguration.

OURHEALTH HAWKE'S BAY Whakawateatia	collaborative clinical pathways **Collaborative Pathways (CP)**
	For the attention of: **HB Clinical Council**
Document Owner: Document Author(s):	Mark Peterson, Chief Medical Officer Primary Care Leigh White, Portfolio Manager Strategic Services
Reviewed by:	Paul Malan, Strategic Services Manager Integration; Mary Wills, Head of Strategic Services and the Executive Management Team
Month:	February 2017
Consideration:	For Approval

RECOMMENDATION

That HB Clinical Council

- Note the enclosed document – NexxT Proposal for HBDHB, in particular pages 9-12 with regards working relationship for proof of concept.
- Support proof of concept implementation. Spend $35K of the $124K that is "on hold" from the 2016/17 budget round.

EXECUTIVE SUMMARY

As noted in previous papers, the Map of Medicine tool used for the development of Collaborative Pathways does not provide us with integrated interface functionality. Feedback from clinicians is that they want to track a person's journey and have connectedness with secondary care. e.g. E-referral.

A small group of personnel led by Chief Medical Officer (Primary Care), have been seeking ways to develop the required functionality so that the static tool becomes dynamic. Discussions have been held with:

- Map of Medicine (MoM) UK, however, they don't see our request as a priority and are slow to respond (as per previous experience with single sign on).
- Canterbury DHB who have built a generic electronic form that enables pathway referencing from within that electronic form. This would require us to abandon MoM and E-Referral system and change to HealthPathways, which was not the decision when first presented as an option for pathway development in HB.
- Healthlink, who are the vendors of our E-referral system. To date their responses have been slow and they seem to lack the motivation to make changes to a product that has been primarily developed for Auckland DHB.

- NexxT (Pathway Navigator Limited), who facilitated a workshop in Hawke's Bay in early November 2016 to consider our requirements. NexxT have provided us with a proposal that is attached. It must be noted that the first proposal was priced at $64,350 but with renegotiation and agreement for a initial proof of concept, the latest quote is $35,000. See attachment one for a summary of the proposal from NexxT.

RECOMMENDATION

Currently, $124,000 that was included in the 2016/17 budget for Collaborative Pathways is "on hold". It is proposed that we use $35,000 of that money to trial a proof of concept with Nexxt (Pathway Navigator Limited). See attachment two for budget summary.

RISKS

- New Vendor with no proven track record
- Nexxt relationship with other Vendors with regard to integration/timeliness/actions to address e.g. Medtech/Healthlink
- Financial loss - $35K if not successful

OPPORTUNITY

- Nexxt committed to succeed
- Nexxt solutions are compatible with Medtech/My Practice (currently MoM interfaces with Medtech only)
- Nexxt are making significant investment to get into the market
- A structured trial like this should remove a lot of the grey area
- Ground breaking (nationally and maybe globally) – HB in partnership leading in innovation.

Attachment Two

COLLABORATIVE PATHWAYS BUDGET – For next 6 months

		Option 3
Bid $375k (Change as of June 2016)	**Comments/Internal**	**Programme Costs**
Leadership and Management		
Clinical Pathways Project Lead	1.0 FTE	
Internal Staff Support & Other Costs	As required	6,500
GP Champion (0.1 FTE) (Outsourced)	**ON HOLD– CMOs take the lead**	**24,000**
Project Support Costs		5,000
		35,500
Maintenance		
Editing (0.2 FTE)		26,991
Editing (outsourced)		38,400
External Facilitator/Editor (Fee for Service)		8,000
Ongoing Training		3,500
		76,891
Infrastructure		
Map of Medicine Licence Fees	Licence Expires July 2017	60,000
Publishing Fees		26,250
Publishing Fees with Midcentral	MOU expires July 2017	
Software changes (Med Tech/My practice)	Potential to change or add	45,000
		131,250
Clinical Engagement		
Pharmacy, Allied Health, ARC	MDT – Support committed pathways	23,063
Hospital Staff		
Facilitation & Catering		**3,750**
Venue Hire	Hosp or Community	
Education and Socialisation		5,000
		31,813
Innovation		
Redesign, service development, Coordinated Primary Options discharge pathways, diagnostics to support pathway implementation*	**ON HOLD**	100,000
		100,000

TOTAL	**Budget Bid 2016/2017**	**347,000**
	ON HOLD	**124,000**
	COMMITTED	**223,000**

Major risks: Implications of lack of buy-in GPs/ Labour intensive administration and editing requirements/Tool fails requirements.

HAWKE'S BAY District Health Board Whakawāteatia	**13-17 Year Old Primary Care Zero Fees Subsidy Project**
	For the attention of: **HB Clinical Council and Finance Risk and Audit Committee**
Document Owner: Document Author(s):	Tim Evans (General Manager Planning Informatics and Finance) Jill Garrett (Strategic Services Manager Primary Care)
Reviewed by:	Patrick Le Geyt (Programme Manager Māori Health) and Executive Managment Team
Month:	February 2017
Consideration:	For Information

RECOMMENDATION

That HB Clinical Council and Finance Risk and Audit Committee:

Note the contents of this report with specific reference to the evaluation framework

OVERVIEW

The 13-17yrs zero fees co-payment subsidy is a HBDHB initiative to support general practices across Hawkes Bay to become 'youth friendly' and provide 'no cost access' to GP consultations. The proposal is an 'opt-in' approach and targeted towards those practices with high Māori and Pasifika enrolled populations. The zero fees subsidy, however, will be made available to all 13-17 year olds enrolled within the practices. General practices will be expected to work together in locality based clusters and develop service plans that address youth health issues. HBDHB aim to work closely with general practices from January 2017 and start preparing for implementation from March 2017.

BACKGROUND

Extensive consultation was undertaken with Youth, Youth priovider services and Primary care to determine the parameters of the proposal.

What Youth Have Told Us They Want

- No cost primary health services
- Integrated (health services) with youth social services and offer 'practical' support and not just quick advice
- Telehealth care
- Pre-appointment options need to be offered more fully
- Walk in clinic options (virtual or face to face)
- Self-selection menu of services (electronic or tick box) should be offered at reception
- Consultation times need to be more generous
- Clinic locations closer to where they live
- Staff that specialise in youth health, are younger and from a variety of cultural backgrounds
- Staff need training to be more friendly, responsive and accommodating for youth

Target Population Group:

- High need Māori and Pasifika Population Groups
- Note that ALL (13-17yr) Youth registered with U18s practices are eligible for funding

Target Practices[1]

- Practices with a registered 13-17yr youth population of either ≥30% and/or ≥ 100 enrolled (Māori and Pasifika youth)
  - **Napier:** The Doctors Napier, Tamatea Medical, Maraenui Medical
  - **Hastings:** Hastings Health Centre, The Doctors Hastings (incl. Gascoigne St), Medical and Injury, Totara Health, Hauora Heretaunga
  - **Wairoa (Alliance):** Wairoa Medical, Queen Street Medical, Health Care Centre Ltd
  - **CHB:** Tukituki Medical, The Doctors Waipawa

THE PROPOSAL INCLUDES

Funding:

a) Consults:

Co-payment subsidy is $53.75 per annum for every enrolled 13-17 year old within each identified general practice.

The co-payment subsidy is based on an average utilisation rate of 1.72 GP consults per annum, plus an additional 25% for potential increases, totalling 2.15 consultations per annum.[2] The 2.15 consultation rate has been multiplied by a $25.00 co-payment fee to reach the $53.75 co-payment annual subsidy rate.

- See Table 1.0 for indicative practice funding paid directly to general practice based on an utilisation rate of 2.15 visits p.a.
- Quarterly on presentation of invoice to DHB
- First payment made on completion of approved cluster plan3. Paid quarterly thereafter on completion of reporting.

b) After Hours Care Provision:

Based on an after- hours consult subsidy of $40.00 per visit, and an utilisation rate of 0.26 visits p.a. Payment structure and mechanism per cluster to be determined by the cluster.

c) Pharmacy:

Pharmacy – subsidy of $5.00 per item, per general practice consult

- Bulk payment paid to each Pharmacy with 6 monthly reconciliations
- Napier and Hastings are working on electronic system, in line with Whanau Wellness system for invoicing
- Invoice directly to DHB

[1] Grouped in proposed clusters

[2] In 2015, the average GP consultation utilisation for 13-17 year olds was 1.72 consults per annum. The subsidy is based on GP consultations only and does not include Nurse consultations

[3] The cluster plan would be developed and agreed to by member practices then approved by the DHB.

APPROACH

- Practices cluster together in their geographical area under a cluster agreement (MOU)
- The focus of the program is to enhance outcomes for Māori, Pasifika and High needs Youth.[4]
- The Cluster develops **a single cluster plan which will include all of the following**;
  - Activities in response to findings from the individual practices RNZGP Youth Friendly Primary Care Assessment Tool
  - Activies that focus on enhancing outcomes for the target population – Māori, Pasifika, High Needs Youth 13-17yrs
  - Recommendations from the youth advisory group that the cluster practices consult and engage with
  - Collective and individual practice commitments to improving youth access to primary care *(See evaluation framework page 3 below)*
  - Referral and health navigation processes to and from Youth related services that focus on promoting Positive Youth Development[5]
  - Evaluation by YOUTH will be one of the measures of success in effective delivery of service.

EVALUATION FRAMEWORK

Quarterly Reporting Schedule

2016-17	Q3	Q4
DHB	**Cluster baseline data**	**Outcomes**
PHO	**Cluster base line data**	**Outcomes**
Cluster	**Cluster formation and Cluster Plan completion**	**Outcomes**

2017-18 (ongoing)	Q1 Outputs Report	Q2 Outcomes Report	Q3 Outputs Report	Q4 Outcomes report
DHB PHO Cluster	**Quantitative data**	**Progress against outcomes**	**Quantitative Data**	**Annual Plan based on findings**

Definitions:

MoPs points	Attendance (Educations) credits for medical officers
QIPs	Quality Improvement Patient Safety
CQI	continuous quality improvement
AoD	Alcohol and or Drugs
ED	Emergency Department
DNA	Did not attend
PHN	Public Health Nurse

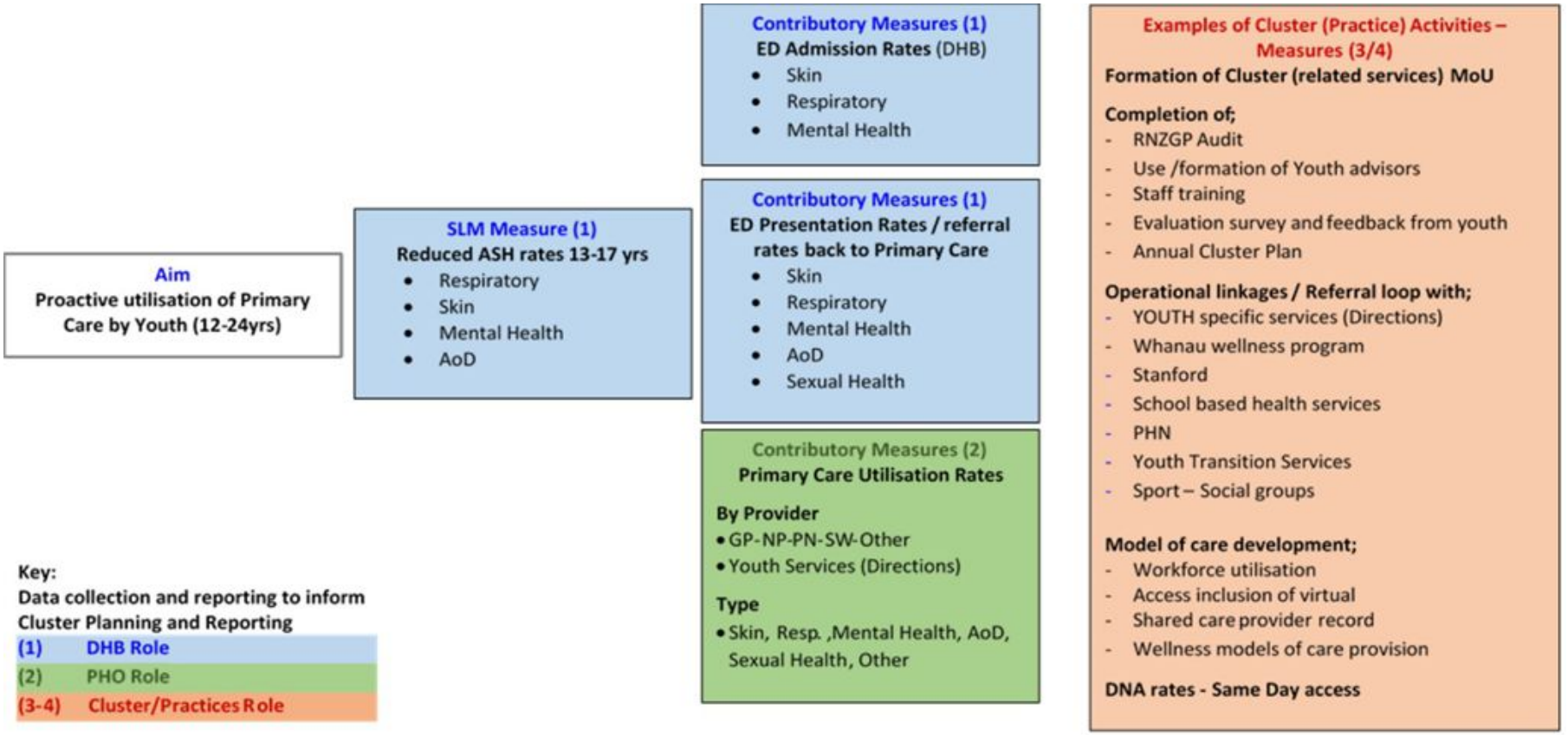
[4] Note that ALL youth within the practices that engage in the proposal are eligible for free fees
[5] This aligns with the HBDHB Youth Strategy

EVALUATION MEASURES AND REPORTING:

DHB-PHO-Cluster will all contribute to the planning and reporting cycle.
The evaluation framework links to work that is already being undertaken by the sector through; system level measures, contributory measures , ED7+ cluster work, Cornerstone accreditation, and links to MOPS points for CQI

This initiative sets the ground work for;

- The 2017-18 System Level Measure - Youth and Patient (customer) experience
- The HBDHB Youth Strategy – creating an environment for positive youth development
- Working in a locality orientated system wide approach



HAWKE'S BAY District Health Board Whakawāteatia	**Orthopaedic Review – Phase 2 (Draft)**
	For the attention of: **Maori Relationship Board, HB Clinical Council and HB Health Consumer Council**
Document Owner:	Andy Phillips and Mark Petersen
Document Author(s):	Carina Burgess, Patrick Le Geyt, Tae Richardson and Andy Phillips
Reviewed by:	Executive Management Team
Month:	February 2017
Consideration:	For Information

RECOMMENDATION

That the Maori Relationship Board, HB Clinical Council and HB Health Consumer Council

- Note the approach to the Second Phase of redesigning our musculoskeletal and orthopaedic pathways
- Note the three redesign goals for :
  Community Care: Addressing health inequities using Whanau ora approach delivered through Mobility Action Programme
  Primary Care: Ensuring that GPs and patients have appropriate expectations delivered by introducing dynamic hip and knee pathways
  Secondary Care: Improving patient outcomes and experience of elective surgery by fully implementing Principles of Enhanced Recovery After Surgery.

SITUATION

This paper gives a brief overview of the proposed approach to redesigning services for people within our community who have pain and disability resulting from Musculoskeletal and Orthopaedic conditions

BACKGROUND

It is evident that there are a large number of people in the community living with pain and disability caused by musculoskeletal conditions. This number is expected to rise as the population of Hawke's Bay ages and the incidence of osteoarthritis increases.

The redesign of Musculoskeletal and Orthopaedic services was set out in three phases. The first phase, now complete involved increasing surgical capacity and making conservative treatment options available. The second phase involves the co-design of a new pathway. The third phase will now be carried out within the Clinical Service Plan to effectively manage demand and align capacity over two to five years and address 'third horizon' issues over ten years that will require innovative approaches. The initiatives completed in the first phase included:

- Implementing non-surgical treatment options by increasing physiotherapy and other allied health resource.
- Implementing a new pathway for back pain patients offering an alternative non-surgical treatment option.
- Improved patient communication and collaborative services within the DHB.
- Reducing wait times throughout the pathway.
- Setting thresholds for surgery based on data for orthopaedic scoring and Oxford score.
- Increasing surgical capacity to deliver on the major joint replacement target.
- Building a partnership between HBDHB, Health Hawkes Bay PHO and Iron Maori to gain MoH funding and deliver a Mobility Action Programme

The Principles

The redesign of the pathway will deliver on the New Zealand triple aim

- Improved health and equity for all populations.
- Improved quality, safety and experience of care.
- Best value for public health system resources.

Within this broad purpose, the pathway redesign will be consistent with Hawkes Bay DHB vision and values

Our vision is *"healthy hawke's bay*", *"te hauora o te matau-*a*-maui" which means* excellent health services working in partnership to improve the health and well-being of our people and to reduce health inequities within our community.

Our values and behaviours are articulated as

he kauanuanu – showing respect for each other, our staff, patients and consumers
akina – continuously improving everything we do.
raranga te tira – working together in partnership across the community
tauwhiro - delivering high quality care to patients and consumers

These values and behaviours will be delivered for hip and knee pain by redesign using the following principles :

1. Equity based care, treating greatest need first
2. Do no harm
3. Doing only what is necessary to achieve the desired outcomes
4. Choosing wisely, openly together with the patient
5. Consistently apply evidence based and knowledge based clinical practice
6. Staff co creating health with the public, patients & partners.

Within these principles, the redesign will consider reliable delivery of high quality services by improving value to patients and the DHB. Value is defined as outcomes relative to costs, it encompasses efficiency. The design will consider issues such as decision making criteria and thresholds for different interventions in the context of minimising harm, waste and unwarranted variation.

There will be three clear goals of this work namely:

Community Care:	Whanau ora approach delivered through Mobility Action Programme. The first patients are expected to be enrolled by 1st March 2017 with the programme completing by 30th June 2018
Primary Care:	Dynamic hip and knee pathways to ensure GPs and patients have appropriate expectations. The learnings from this work will be disseminated by 30th June 2017.
Secondary Care:	Ensure that best practice is delivered through fully implementing Principles of Enhanced Recovery After Surgery. It is anticipated that this work will be completed by 30th June 2018

ASSESSMENT

During a workshop on the 8th of November, a group of primary and secondary care clinicians identified current problems and challenges arising during a patient's journey related to the management of Osteoarthritis.

1. **Appropriate referral**
   a. High demand vs availability - The threshold is a reflection of capacity.
      Varies by month and depends on budget cycle. Formula constantly changes, lack of consistency.
   b. Location of scoring in secondary care results in unnecessary referrals to orthopaedics and a longer queue.
   c. GPs not well informed so unable to manage patient expectations
   d. Ensuring appropriate patient selection, i.e. people who will have quality of life after surgery and not life-limited after surgery.
   e. Limited capacity in allied health and surgical services to meet demand
   f. Patient's condition deteriorating while on a waiting list
   g. GPs need confidence systems work and that there is an integrated system and communications.
   h. What happens with inappropriate referral – providing management advice for primary care
2. **Communication between services**
   a. No communications from specialty services to primary care
   b. Breaking down silos
   c. Transparency of information about services offered. E.g. Joint school
   d. Disconnect with involvement of aged residential care
3. **Patient expectations (also patient literacy)**
   a. Perception that they won't get care or referred (may have heard stories from friend's experience's)
   b. Expecting surgery as the only treatment option. Patient not aware that they could be on a physio instead of a surgical pathway
   c. Patient disappointment
   d. Patient's not seeking help until they are in severe discomfort or disability.

4. **Cost to patient**
    a. Costs for appointments and alternative therapy
    b. Support and management for patients that don't meet criteria
5. **Management of patients who aren't appropriate for surgery**
    a. Decreased or poor access to treatment options
6. **Pain management**
    a. Delays in pain management
    b. No pain services – ensure this is managed
7. **Future planning** of patients on a hip or knee pathway – know who is in early stage so they will have an idea of what future funding and services are required.
8. **Coding** - Clarity and consistency around coding (eg. SNOMED)
9. **Management of comorbidities**
10. **Monitoring outcomes** e.g. post op infection, readmission rates, quality of life, supporting data, cross reference social metrics

ELEMENTS OF THE NEW PATHWAY

The pathway will be built on a Whānau Ora model of care. It will be specifically designed to address health inequities experienced by Māori, Pacific and quintile 5 consumers, and will be designed to meet the needs of both the working age and elderly population. The model will serve people with previous or current employment in heavy labouring jobs and those with barriers to paid work, training or caring for whānau due to musculoskeletal conditions.

The model will include self-referral (including walk in), referral by any health practitioner and invitation using MSD database matching of consumers fulfilling entry criteria. The model will include raising awareness through both informal (community) and formal (publically funded health and social services, NGOs, Pacific Churches and community centres, workplaces) networks.

Outcome/exit measures will support Whānau Ora outcomes including reduced pain, improved function, increased social and cultural participation and increased local capacity. The model will be constructed specifically to address NZ Triple Aim outcomes with particular emphasis placed on a reduction in unmet need, reducing the need for GP consultations and unnecessary referral to secondary care.

A co-design approach will build on the strengths of existing services and address access and other barriers. The model will include delivery in local communities therefore reducing the need for transport. Services will be culturally responsive and flexible around people's lifestyle e.g. work and training commitments, child care etc. The pathway will include workplace clinics for Hawke's Bay's key unskilled labour employers such as horticulture, food processing, meatworks, forestry and shearing.

A specific focus of the model will be to increase local community capacity to ensure sustainability with appropriate ongoing PHO and DHB support. The pathways will be fully aligned with Hawke's Bay Health Sector's Transform and Sustain strategic framework.

A key deliverable will be improving patient experience, clinical outcomes and value for money. Growing evidence tells us that consumer experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers, and consumer and family-centred care have been linked to improved health, clinical, financial, service and satisfaction outcomes.

The pathway will ensure a consistent approach to collection, measurement and use of consumer experience information on a regular basis including measures of communication, partnership, co-ordination and physical and emotional needs.

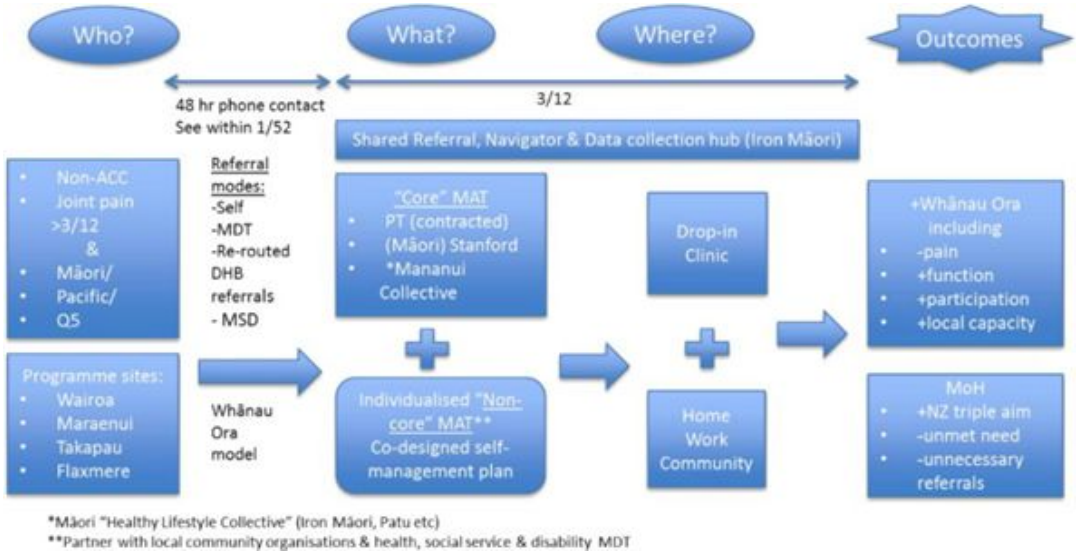
The pathway will address education and training needs of staff including relationship centred practice and cultural competency. Verbal and written communication will be in a consumer's preferred language (using translators if necessary). A health literacy "universal precautions" approach to communications will be implemented, given our understanding of health literacy levels in NZ, particularly for Māori. The system will support health literacy with services being easily accessible and navigable. The Whānau Ora model of care requires a partnership approach between consumer and service. In a Whānau Ora model of care, experience of care extends beyond supporting physical and emotional needs to cultural ones. The Stanford and Whariki Long Term Condition programme will further enhance consumer experience by developing, amongst other things, the person's own communication and decision making skills as well as dealing with the physical and emotional needs of their condition. The programme covers long term conditions in general therefore the pathway has the potential to improve the management of coexisting morbidities as well as musculoskeletal pain and disability.

Clinical outcomes will be enhanced not only by improved consumer experience of care, but also by a reduction in unmet need and inequity and through an emphasis on early intervention. It is recognised that early intervention for prevention and treatment is very important, especially around maintaining physical activity, as activity itself is evidenced to be beneficial for osteoarthritis.

As experience of care, quality (clinical effectiveness) and equity are cross cutting dimensions of the NZ Triple Aim, it can be argued that value for money cannot be achieved without them. The pathway will deliver value for money by equitable and improved health outcomes due to early intervention, and by a reduction in unnecessary referral to orthopaedic clinic. This will obviously free up orthopaedic outpatient capacity to focus on those most likely to benefit from this resource. Improved economic contributions would also be expected as people become able / better able to participate in work/ training and social obligations. These contributions are likely to be considerable given that musculoskeletal conditions are the leading cause of disability in NZ. With a wider lens, inequity itself has an uncontested effect on economic growth with evidence suggesting that in the decade 1990-2010, NZ experienced the largest impact of inequality on GDP growth of any OECD country.

The pathway will comprise physiotherapy, Stanford and Whariki Long Term Condition programme and a Māori Lifestyle Collective (a suite of kaupapa Māori healthy lifestyle services including Iron Māori and Patu programmes). In addition, the pathway will include an individualised, co- designed self-management programme and all existing publically funded health, social service and disability services and those provided by local community organisations.

The pathway will build on the Mobility Action Programme pathway shown above as well as existing hip/knee pathways.



ESTABLISHING A 'DYNAMIC' PATHWAY

At its meeting of 10th January, EMT agreed to work in partnership with NEXXT to develop dynamic pathways. Subsequently a sub-group agreed that dynamic hip/knee pathways would be the exemplars for this development. The purpose will be to develop a Patient Centric journey that encourages;

- the sharing of information
- the delivery of consistent best practice care and
- the measurement of outcomes.

The Key Benefit Areas will be:

- The generation and communication of appropriate referrals
- Improved communication and transparency of information between providers across both primary and secondary care
- The systematic collection of information to assist in planning and funding and to understand gaps in patient care.
- To identify in advance from the condition of the existing patients on chronic care pathways, if there is a likely to be an increase or decrease in demand
- Supporting patient literacy
- Reducing ASH rates

The hip and knee osteoarthritis pathways provided in both primary and secondary care settings will:

- Allow scoring or aspects of scoring in primary care to prevent inappropriate referrals
- Provide guidance when a patient's condition does not meet the threshold for a referral - management, in particular physiotherapy

- Provide the ability to build a moving threshold aspect into the pathway
- Facilitate and manage the criteria for appropriate patient selection
- Deliver transparency between health providers as to who is doing what and how long the patient has been managed for
- Enable the coordination of services and health care providers involved in patient care, e.g. GP, hospital orthopaedic team, physiotherapy, allied health

This will increase provider efficiency by reducing inappropriate referrals, improving communication and speeding up the delivery of care for patients.

Non-surgical management/checklists will be monitored and reviewed, pre and post op, according to the point the patient is at within a pathway, for example: pain management,

This will help to set the right patient expectations and help them to feel their on-going care is being managed. This will lead to better patient outcomes.

Possible inclusion of patient questionnaires to monitor their wellness, mental health, outcomes and social factors.

This will provide an insight into the wider well-being of the patient, allowing for appropriate care to be referred, leading to an overall better patient outcome.

Monitoring outcomes for hip or knee replacement surgery.

This will provide background data that can be used to optimise the care delivery and assistance provided to patients. Over time this will lead to better patient outcomes and a more effect use of resources.

Data on hip and knee osteoarthritis pathways will guide future planning and funding of services or points of low or high demand.

Data will be provided that can be used to forecast forward demand by patients. Over time this will lead to a more effect use of resources and a more consistent service for patients.

CO-DESIGN OF THE COMMUNITY/PRIMARY CARE PATHWAY

It has been agreed that this work will be undertaken by the Collaborative Pathways group. A partnership will be agreed with NEXXT to design the dynamic pathway. A steering group of primary and secondary care clinicians will be established. Initial work will be undertaken to describe the approach which will be discussed with a variety of stakeholders including patients with musculoskeletal conditions, patient groups such as greypower, primary and secondary care clinicians. Learnings from these discussions together with an initial design will be presented by the end of June 2017.

SECONDARY CARE PATHWAY

There has already been much work done in secondary care in HBDHB to implement the best practice principles of surgery to acute and elective orthopaedic pathways. Enhanced recovery after surgery ensures that patients : -

- Are in the optimal condition for treatment
- Are better informed about their care
- Are exposed to extensive pre-habilitation

- Experience a more streamlined, standardised care pathway
- Are exposed to evidence-based methods of enhancing care
- Experience optimal post-operative rehabilitation

The work will ensure that for each patient:

- Patients receive extensive Pre-Op Information
- Joint School is delivering appropriate patient expectation and preparation
- Anaesthetic Regime is optimised
- Pain Relief is provided without using opiates wherever possible
- Appropriate early mobilisation is provided
- Staff have appropriate expectations of patient early recovery

The aim of the next phase of this work will be to:

- Improve Patient Experiences
- Deliver standardised treatment pathways for all patients, all of the time
- Deliver Process Improvement resulting in Outcome Improvement

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Access (ASH Rates 0-4 & 45-64 years)**
	For the attention of: **Māori Relationship Board, HB Clinical Council and HB Health Consumer Council**
Document Owner:	Dr Mark Peterson, Chief Medical Officer - Primary
Document Author(s):	Mary Wills, Head of Strategic Services; Jill Garrett, Strategic Services Manager – Primary Care; Nicky Skerman, Population Health Strategist, Women, Child & Youth
Reviewed by:	Executive Management Team
Month:	February 2017
Consideration:	For Monitoring

RECOMMENDATION

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

Note the contents of this report.

OVERVIEW

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

UPCOMING REPORTS

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

Priority	Indicator	Champion	Reporting Month
Access *Local Indicator*	Reducing acute admissions of Ambulatory Sensitive Hospitalisations (ASH): 1. 0-4 year olds - dental decay, skin conditions, respiratory and ear, nose and throat infections 2. 45-64 year olds - heart disease, skin infections respiratory infections and diabetes	Mark Peterson	February 2017

MĀORI HEALTH PLAN INDICATOR:

This report provides an update on programmes related to Ambulatory Sensitive Hospitalisations (ASH) for 0-4 and 45-64 years of age in Hawke's Bay.

Ambulatory Sensitive Hospitalisations (ASH) reflect hospital admissions for conditions which could potentially be prevented by early access to treatment in care. In many countries ASH is used as a means to assess the performance of primary care and to identify potential barriers to access.
However, while ensuring early access to effective primary care is still likely to be of considerable value in reducing ASH, in countries such as New Zealand, where large socioeconomic and ethnic disparities in child health exist, a greater emphasis may need to be placed on addressing those factors, often outside of the health sector, which drive the underlying burden of disease (e.g. household income, housing, nutrition, exposure to second hand cigarette smoke). This is because, even with optimal access, the ability of a general practitioner to prevent a paediatric pneumonia admission after the first crucial hours may be limited, but the opportunities available for a DHB to prevent paediatric respiratory infections via e.g. healthy housing projects and parental smoking cessation programmes may be considerable.

The Hawke's Bay DHB is committed to non-differential targets and significant inequality is seen in this indicator. Our work programmes focus on targeting vulnerable populations to reduce hospitalisation, improving the home environment and improving consistency of practice and early access to primary care programmes and reducing inequities.

WHY IS THIS INDICATOR IMPORTANT?

System Level Measures
The Introduction of the System Level Measures; targeted performance measures, came into effect beginning 2016-17. The measures include some previous health targets included in the Integrated Performance Incentive Framework and a set of newly introduced, nationally agreed performance measures. Ambulatory Sensitive Hospitalisation (ASH) rates are included in two System Level Measures.

- ASH 00-04yrs is reported against under the SLM-Ambulatory Sensitive Hospitalisation (ASH)
- ASH 45-64yrs is reported under the SLM-Acute Hospital Bed Days.

Each ASH band for total population is divided into; Māori, Pacific, Other[1]. Targets are derived from the DHB ASH rates for the Māori population. The base line rates for the DHB will be compared with national total population rates and targets set accordingly. These are expressed in rates per 100,000.

The Hawke's Bay District Health Board recognises that comparing Māori against national-total population data masks the equity gap. Therefore all Māori and Pasifika data reported against for ASH will include ……. vs Other to adequately examine the equity gap.

Targets are to be set to work towards eliminating the gap within a 2-5 year period dependent on the base line. Using the base line as a measure, reducing the equity gap by half each year. If below 10% the aim is to eliminate the gap. Rates within 5% would be considered equitable (e.g. HBDHB Māori ASH rates to be at or below national total population rates) [2]

To September 2016, the Top Three ASH conditions for Māori in the 0-4 year age group were; Dental Conditions, Asthma and Respiratory Infections- Upper and ENT.

For the 2017 year the contributory measures regarding the System Level Measure of Reduced ASH rates for 0-4 years as agreed by Health Hawkes Bay and the Hawke's Bay DHB are:

[1] MoH-System Integration SI1: Ambulatory sensitive hospitalisations.
[2] MoH-System Integration SI1: Ambulatory sensitive hospitalisations.

- Paediatric respiratory training
- Increased Immunisation Health Target
- Oral Health Initiative

45-64 years
As of September 2016 the Top Three conditions contributing to the ASH rate for 45-64yrs were; cardiac conditions, respiratory (including COPD and Pneumonias) and Cellulitis.

For the 2017 year the target areas as identified in the SLM-Improvement Plan will be;

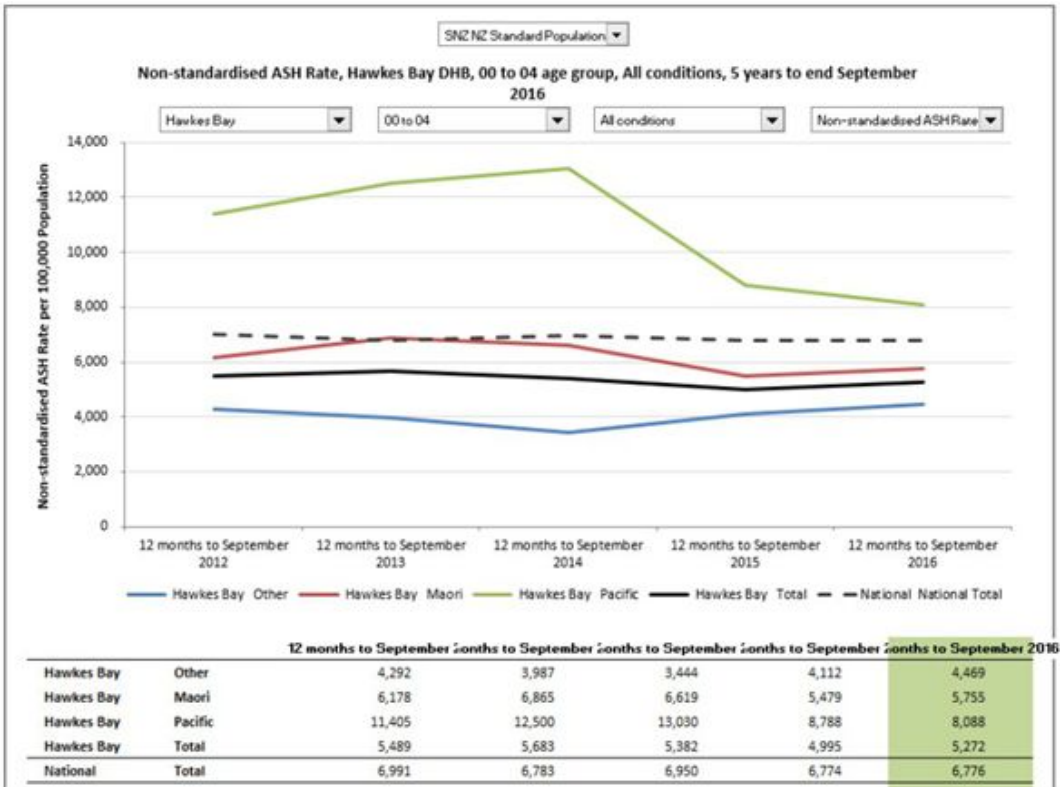
Acute Hospital Bed Days (SLM)

Contributory Measures
- ASH rates 45-64yrs
- Collaborative (Clinical) Pathways implementation for Cellulitis and Congestive Heart Failure
- Ed Admission rates; Cellulitis and Congestive Heart failure

HAWKE'S BAY DISTRIBUTION AND TRENDS

TARGET 0-4 YEAR AGE GROUP

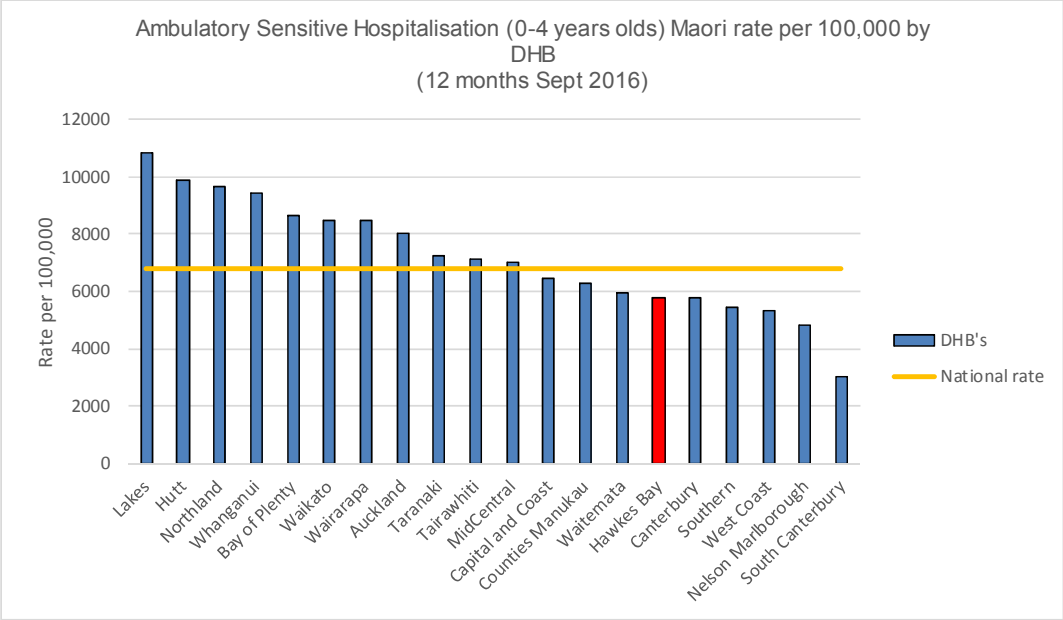
Hawke's Bay Māori ASH rates 0-4 year age group – 12 months to end Sept 2012-2016



		12 months to September	2013	2014	2015	2016
Hawkes Bay	Other	4,292	3,987	3,444	4,112	4,469
Hawkes Bay	Maori	6,178	6,865	6,619	5,479	5,755
Hawkes Bay	Pacific	11,405	12,500	13,030	8,788	8,088
Hawkes Bay	Total	5,489	5,683	5,382	4,995	5,272
National	Total	6,991	6,783	6,950	6,774	6,776

As at September 2016 Hawke's Bay tāmariki have lower rates of ASH compared to national rates for Māori and similar rates of ASH compared to national non-Māori. There has been a reduction in the gap between the Māori ASH rate and the national rates with a slight increase in the 12 month period to September 2016.

Māori ASH rates 0-4 year age group by DHBs – 12 months to end Sept 2016

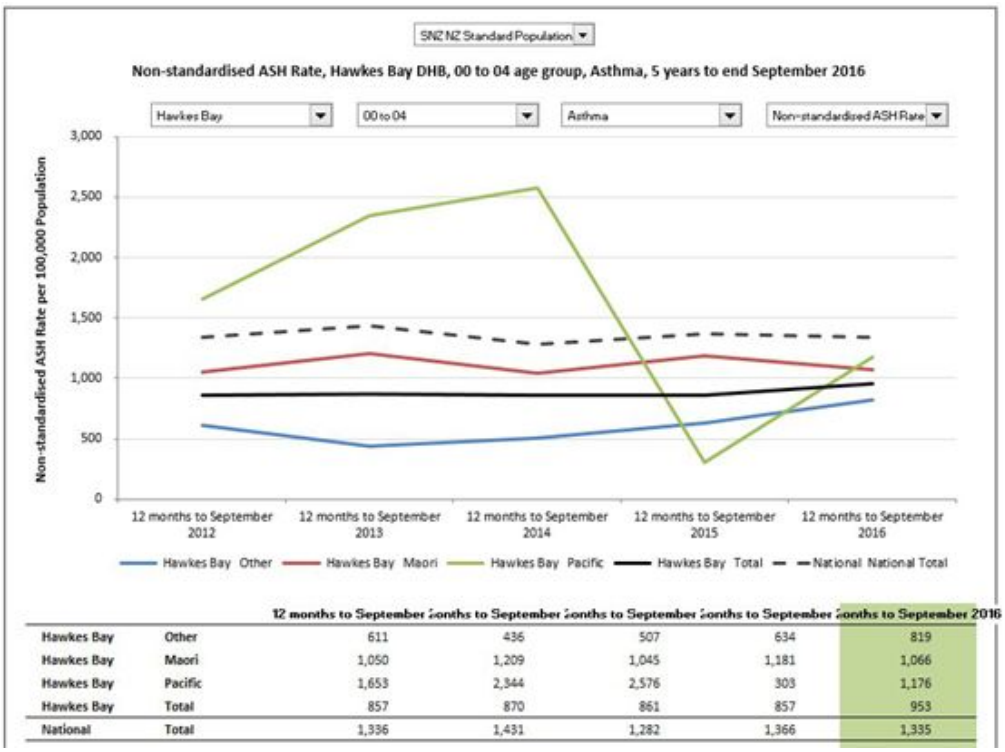


In the 12 months to September 2016 the Hawke's Bay Māori rate was 84.9% of the national rate and Hawke's Bay DHB was the 6th best performer of all DHBs with Māori rates substantially lower than national rates in this age group.

In 2016 the largest differences between Hawke's Bay Māori rates and national rates in the 0-4 year age group are in the conditions Cellulitus and Asthma - improvements have been made in the rates for Asthma over the last 12 months but there has been a decrease in the performance for Cellulitus.

Hawke's Bay Māori ASH rates 0-4yrs - improving

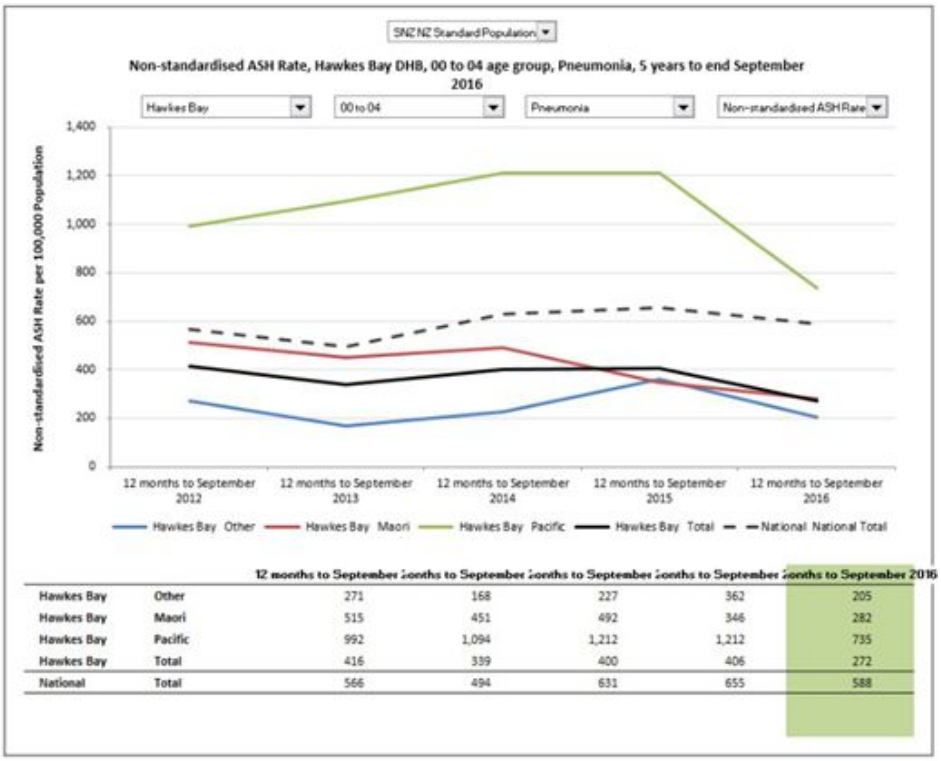
Asthma



		12 months to September 2012	12 months to September 2013	12 months to September 2014	12 months to September 2015	12 months to September 2016
Hawkes Bay	Other	611	436	507	634	819
Hawkes Bay	Maori	1,050	1,209	1,045	1,181	1,066
Hawkes Bay	Pacific	1,653	2,344	2,576	303	1,176
Hawkes Bay	Total	857	870	861	857	953
National	Total	1,336	1,431	1,282	1,366	1,335

Asthma is the 2nd ranked ASH condition for Māori 0-4 years yet rates have decreased slightly compared to the end of September 2015. There is also a reduction in the gap between Māori and non-Māori. By 12 months to end of September 2016 Māori rates were 23 % higher than rates for Other.

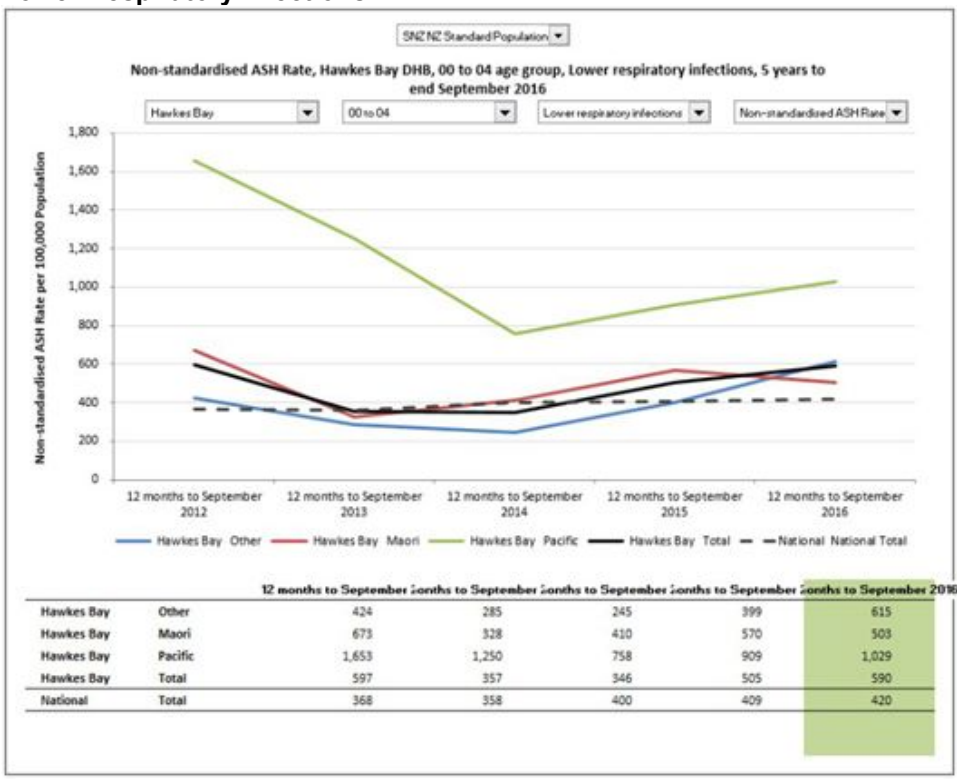
Pneumonia



		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	271	168	227	362	205
Hawkes Bay	Maori	515	451	492	346	282
Hawkes Bay	Pacific	992	1,094	1,212	1,212	735
Hawkes Bay	Total	416	339	400	406	272
National	Total	566	494	631	655	588

Pneumonia rates in the 0-4 years have decreased in the last two years. The Hawke's Bay Māori 0-4 year rate is half the national rate.

Lower Respiratory Infections

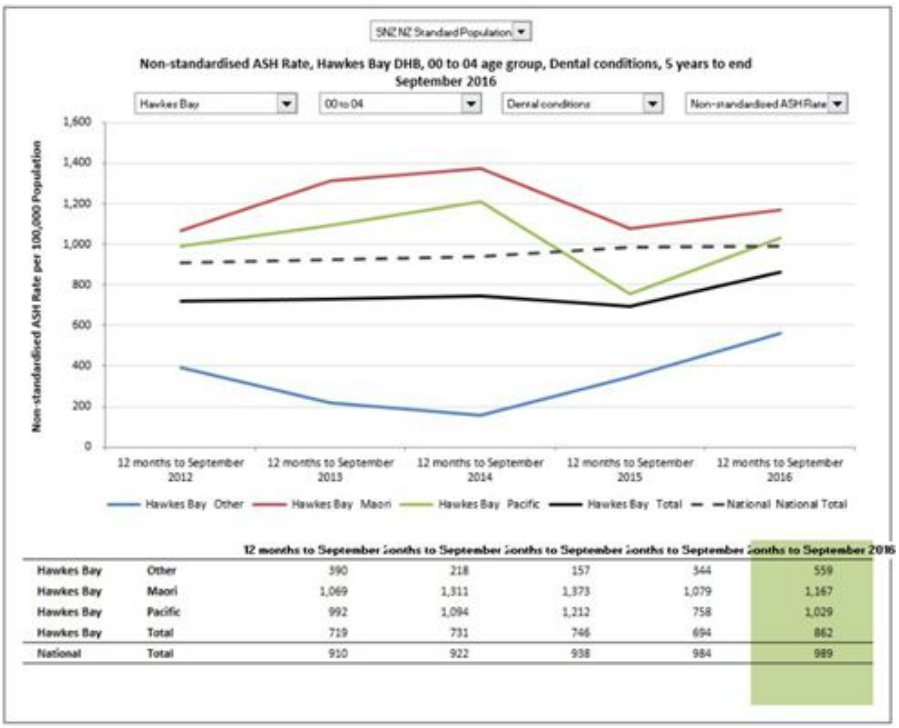


		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	424	285	245	399	615
Hawkes Bay	Maori	673	328	410	570	503
Hawkes Bay	Pacific	1,653	1,250	758	909	1,029
Hawkes Bay	Total	597	357	346	505	590
National	Total	368	358	400	409	420

Lower Respiratory Infections are 1.2 times the total national rate. In Hawke's Bay Māori 0-4 year olds are now the best performing ethnicity and is also below the rate for Hawke's Bay Other.

Hawke's Bay Māori Ash Rates 0-4yrs - Not Improving

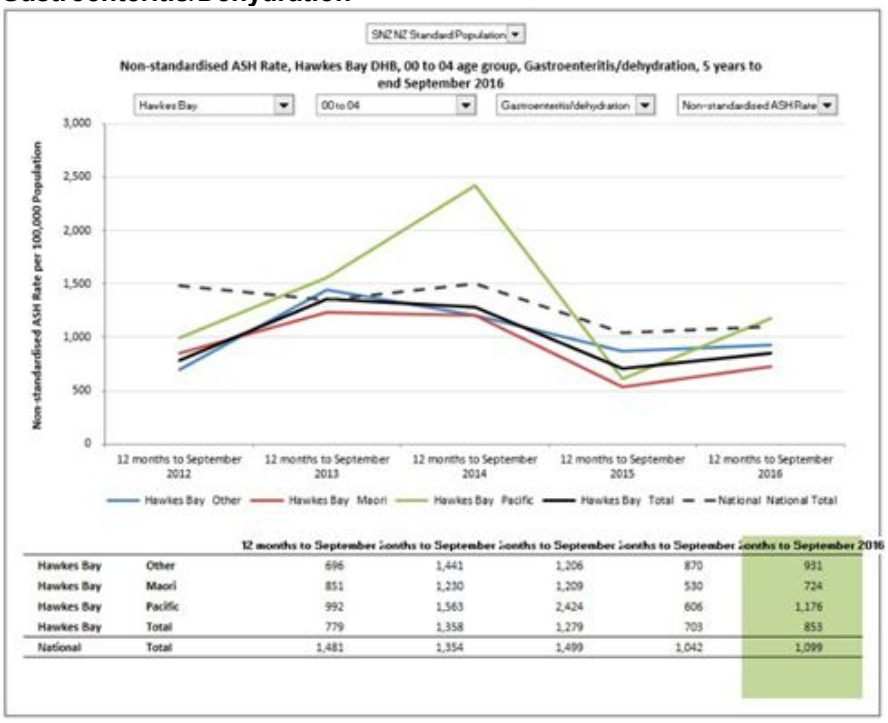
Dental



		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	390	218	157	344	559
Hawkes Bay	Maori	1,069	1,311	1,373	1,079	1,167
Hawkes Bay	Pacific	992	1,094	1,212	758	1,029
Hawkes Bay	Total	719	731	746	694	862
National	Total	910	922	938	984	989

Dental is the top ranked Māori ASH condition in the 0-4 year olds. Rates have increased in the last 12 months to September 2016 and Hawke's Bay Māori rates are 2 times the Hawke's Bay rate for Other and 1.2 times the total national rate.

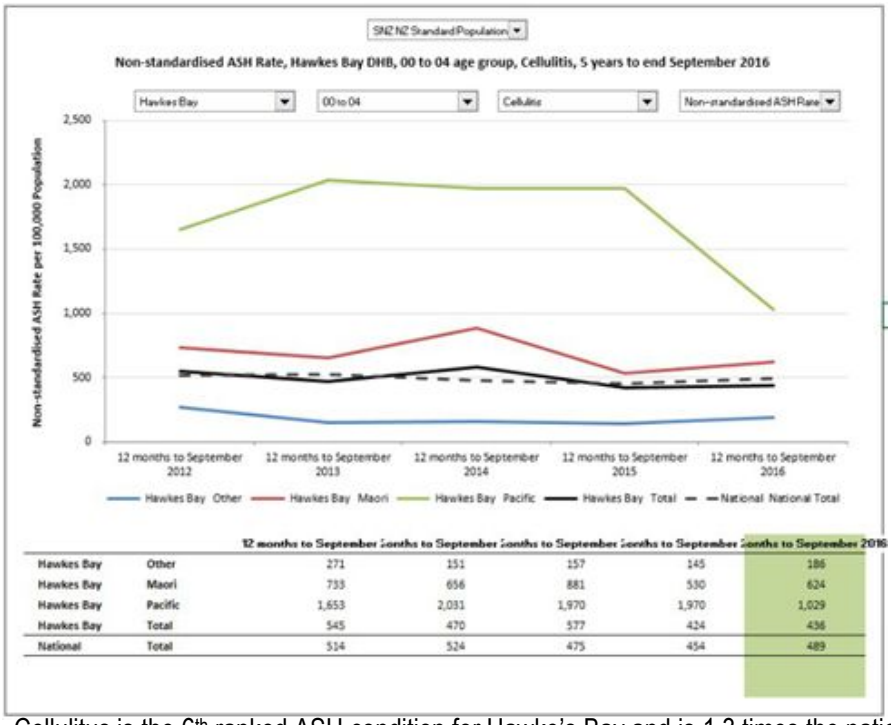
Gastroenteritis/Dehydration



		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	696	1,441	1,206	870	931
Hawkes Bay	Maori	851	1,230	1,209	530	724
Hawkes Bay	Pacific	992	1,563	2,424	606	1,176
Hawkes Bay	Total	779	1,358	1,279	703	853
National	Total	1,481	1,354	1,499	1,042	1,099

Ranked 4th for ASH conditions for Hawke's Bay Māori 0-4, Gastroenteritis/Dehydration increased over the current period 12 months to September 2016. Māori rates are lower than the Hawke's Bay non-Māori and below the national rates for total and Māori.

Cellulitis



		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	271	151	157	145	186
Hawkes Bay	Maori	733	656	881	530	624
Hawkes Bay	Pacific	1,653	2,031	1,970	1,970	1,029
Hawkes Bay	Total	545	470	577	424	436
National	Total	514	524	475	454	489

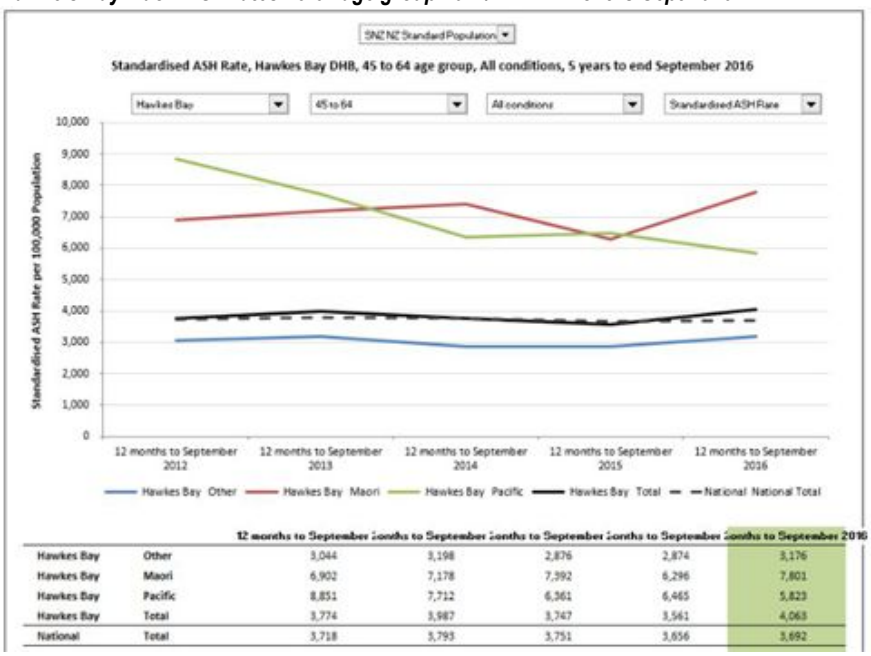
Cellulitus is the 6th ranked ASH condition for Hawke's Bay and is 1.3 times the national rate. There has been an increase from 530 per 100,000 for the period 12 months to September 2015 to 624 per 100,000 for the period 12 months to September 2016. It is also 3.4 times higher than the rate for Hawke's Bay Other.

ASH RATES 45-64 AGE GROUP

The expectation for ASH 45-64 is that there will be a minimum reduction by half of the equity gap between Māori and national total population base line data over a period of 2.5 years. Within 5% would be considered equity.[3]

Hawke's Bay Distribution and Trends

Hawke's Bay Māori ASH rates 45-64 age group 2011/12 – 12 months Sept 2016



		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	3,044	3,198	2,876	2,874	3,176
Hawkes Bay	Maori	6,902	7,178	7,392	6,296	7,801
Hawkes Bay	Pacific	8,851	7,712	6,361	6,465	5,823
Hawkes Bay	Total	3,774	3,987	3,747	3,561	4,063
National	Total	3,718	3,793	3,751	3,656	3,692

In period Sept 15-Sept 16	Increase in ASH rates Sept 15-Sept 16	Decrease in ASH rates Sept 15-Sept 16
Māori	1505	
Other	303	
Pasifika		642

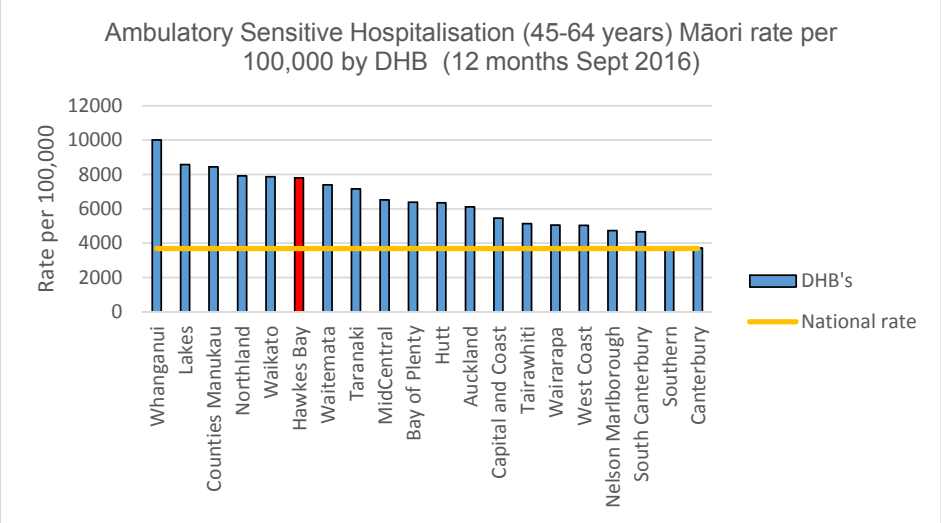
The top 3 ASH conditions for Māori in this age group are; Cardiac Conditions (Angina, Chest Pain, Myocardial Infarction), Respiratory (including COPD and Pneumonias) and Cellulitis.

There has been a decline in Hawke's Bay ASH rates in the 45-64 year age group in both Māori and non-Māori. In the 12 months to September 2016 the Hawke's Bay Māori rate was 1.9 times the Hawke's Bay non-Māori rate and 2.1 times the national rate.

The gap between the Hawke's Bay Māori rate and the Hawke's Bay non-Māori rate has widened between 2012 and 2016.

[3] As indicated by the MoH specifications for ASH rates.

Māori ASH rates 45-64 year age group by DHBs – 12 months to end Sept 2016

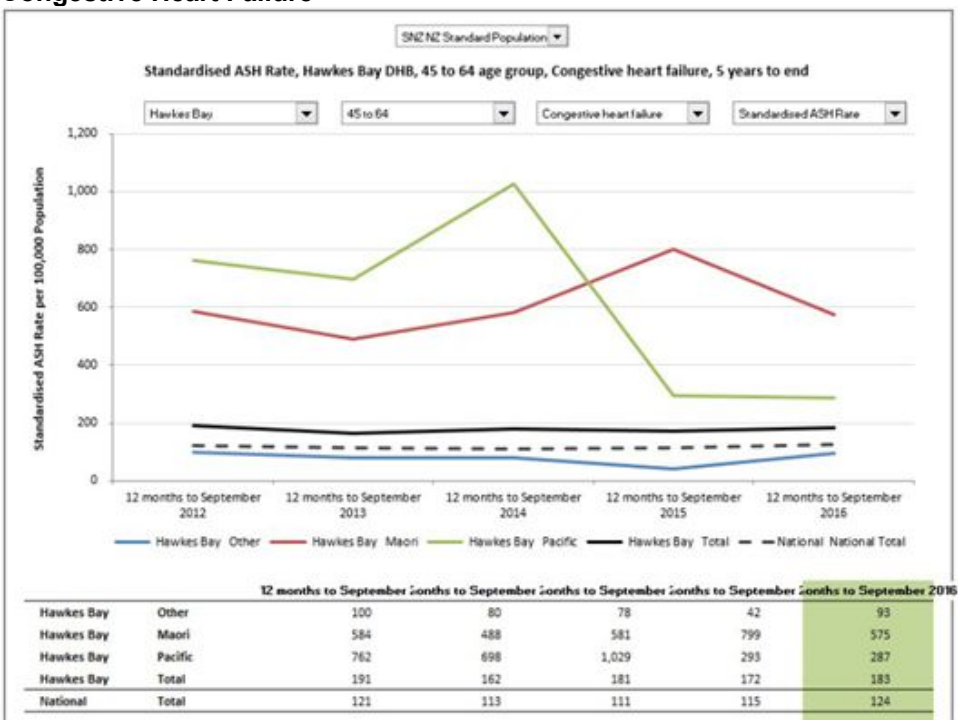


In the 12 months to September 2016 the Hawke's Bay Māori rate was 90% higher than the national rate and Hawke's Bay DHB is ranked 15th out of 20 DHBs. Māori rates are substantially higher than national rates in this age group across the majority of DHBs.

The largest differences in Māori rates and national rates by ASH condition in this age group are Congestive Heart Failure and Respiratory infections-COPD.

Hawke's Bay ASH rates 45-64yrs - conditions where Māori rates are - improving

Congestive Heart Failure

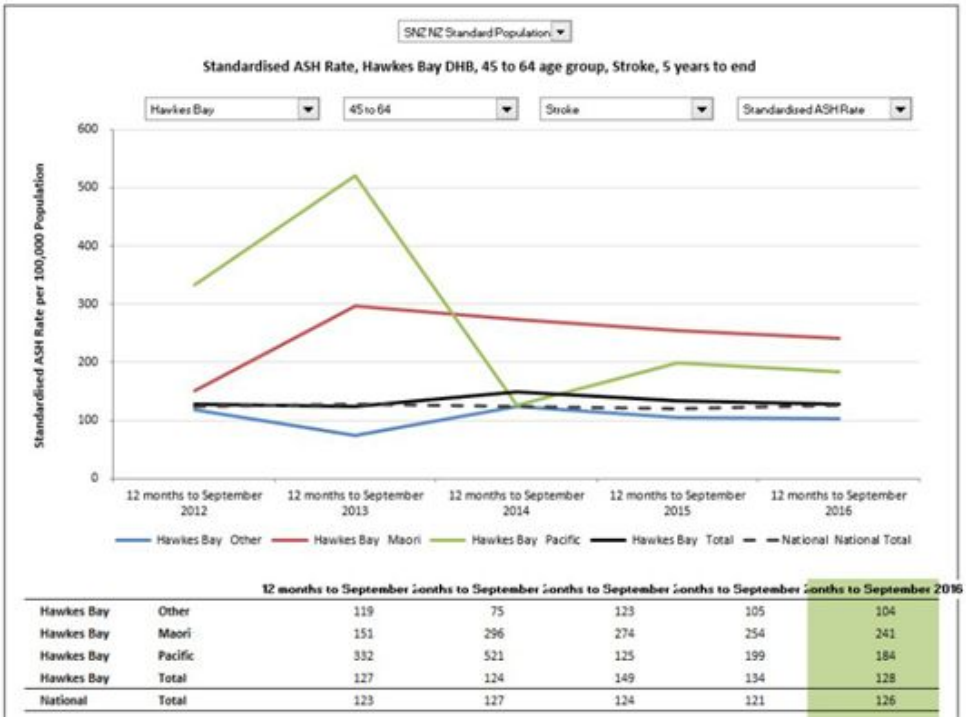


		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	100	80	78	42	93
Hawkes Bay	Maori	584	488	581	799	575
Hawkes Bay	Pacific	762	698	1,029	293	287
Hawkes Bay	Total	191	162	181	172	183
National	Total	121	113	111	115	124

Ranked 5th for ASH conditions Congestive heart failure has improved over the period 12 months and is now 0.3 times lower than 2015.

There is still a substantial gap between Hawke's Bay Māori and Hawke's Bay Other with the Māori rate being 6.1 times higher.

Stroke

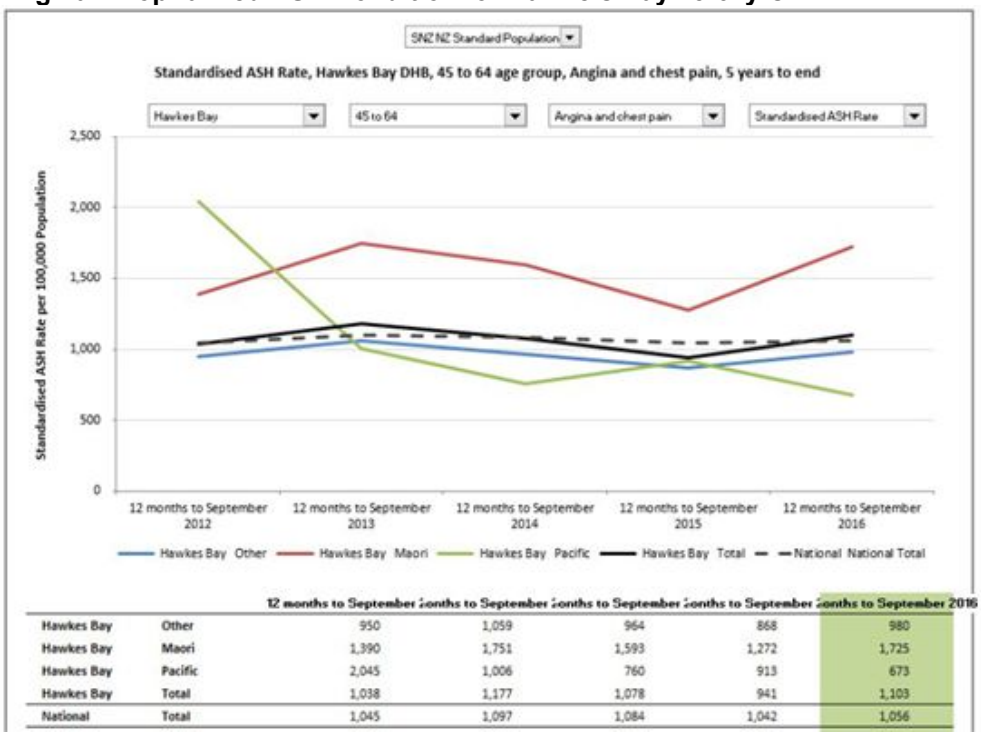


		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	119	75	123	105	104
Hawkes Bay	Maori	151	296	274	254	241
Hawkes Bay	Pacific	332	521	125	199	184
Hawkes Bay	Total	127	124	149	134	128
National	Total	123	127	124	121	126

Stroke has improved slightly over the period 12 months to September but is currently 1.9 the total national rate.

Hawke's Bay ASH rates 45-64yrs - conditions where Māori rates are - not improving

Angina – Top ranked ASH Condition for Hawke's Bay 45-64yrs

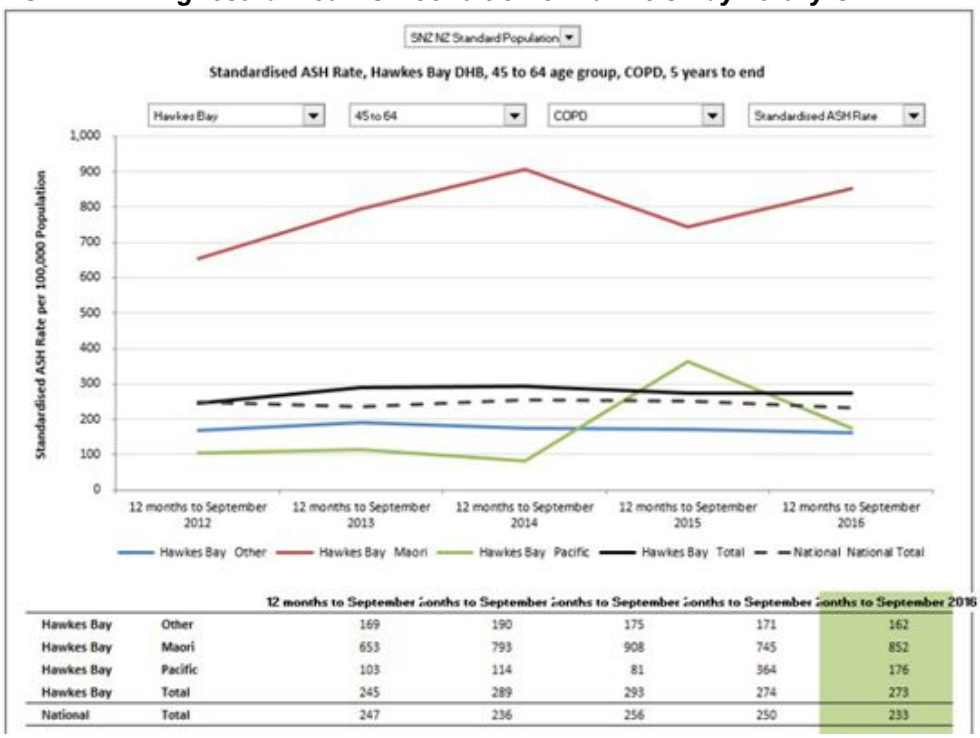


		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	950	1,059	964	868	980
Hawkes Bay	Maori	1,390	1,751	1,593	1,272	1,725
Hawkes Bay	Pacific	2,045	1,006	760	913	673
Hawkes Bay	Total	1,038	1,177	1,078	941	1,103
National	Total	1,045	1,097	1,084	1,042	1,056

Angina and chest pain is the top ranked ASH condition for Hawke's Bay Māori 46-64 and it has increased at a rate of 1.3 from the period 12 months to September 2015.

The rate is currently 1.6 times the national rate and 1.8 times the rate for Hawke's Bay Other.

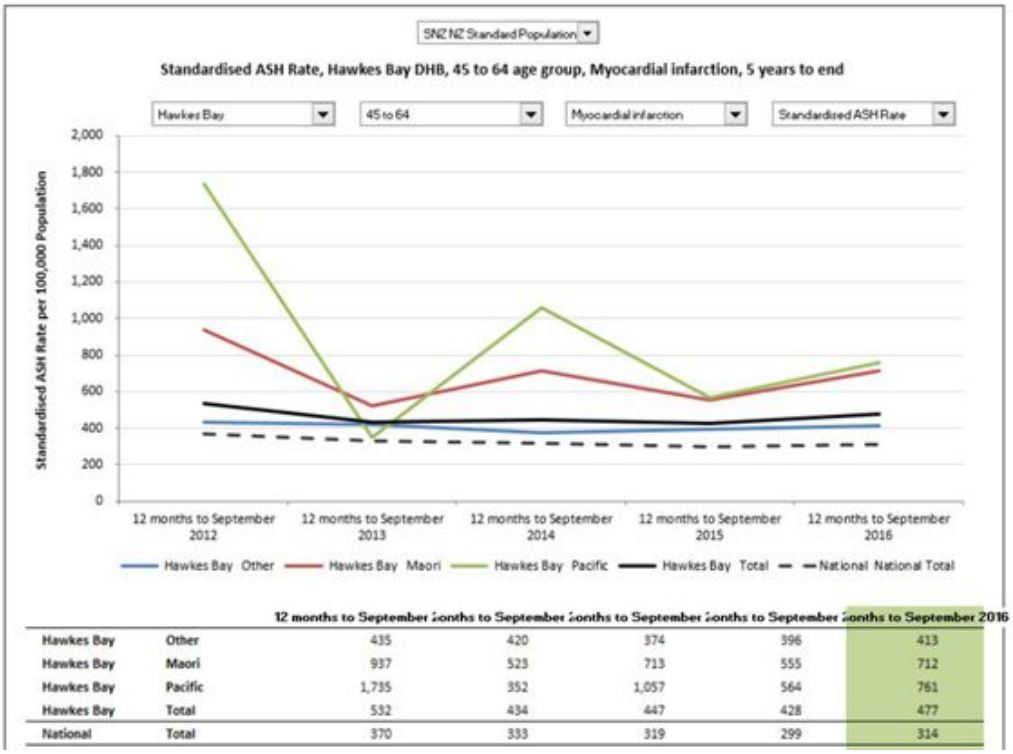
COPD – *2nd Highest ranked ASH condition of Hawke's Bay 45-64yrs*



		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	169	190	175	171	162
Hawkes Bay	Maori	653	793	908	745	852
Hawkes Bay	Pacific	103	114	81	364	176
Hawkes Bay	Total	245	289	293	274	273
National	Total	247	236	256	250	233

COPD is ranked 2nd for ASH conditions for Hawke's Bay Māori in the age group 45-64 years. There has been a 1.1 increase in the rate compared to the period 12 months to September 2015. Of greater signficance however is that the Māori rate currently sits 5.3 times higher than the rate for Hawke's Bay Other.

Myocardial Infarction - 3rd Highest ranked ASH condition of Hawke's Bay 45-64yrs



		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	435	420	374	396	413
Hawkes Bay	Maori	937	523	713	555	712
Hawkes Bay	Pacific	1,735	352	1,057	564	761
Hawkes Bay	Total	532	434	447	428	477
National	Total	370	333	319	299	314

Myocardial Infarction is ranked 3rd for ASH condition for Hawke's Bay Māori in the age group 45-64 years. The rate has increased at a rate of 1.2 in the period 12 months to September 2016 and has also widened against Hawke's Bay Other.

It is currently 1.7 times higher than the Hawke's Bay rate for Other.

REVIEW OF CURRENT AND PLANNED ACTIVITY RELEVANT TO SUPPORT THESE INDICATORS

0-4 YEAR OLDS

Paediatric respiratory training for Practice Champions

Paediatric respiratory training underway, 13 nurses from nine practices have currently completed. Health Hawkes Bay are working on a communication strategy out to general practice. Two further respiratory training sessions are scheduled.

The existing respiratory pathway has been modified to include children and a process is in place to support notification through to Practice Champions by CNS Paediatric Respiratory of all paediatric patients that have been admitted to hospital for asthma and wheeze.

Increased immunisation Health Target

Focus is on the measure: % of eight month olds who will have their primary course of immunisation (6 weeks, 3 months and 5 month immunisations events) on time. Hawke's Bay achieved target throughout the 2016 year. Concentrated efforts continue to ensure a targeted outreach service, provision of alternative venues and opportunistic immunisations in secondary services. Critical to the continued success of achieving the measure is a well-functioning NIR database which shares information between various child health databases.

Oral Health Initiative

The recommendations and findings report on 'Improving access to Community Dental Services for Tāmariki Māori' initiated by Population Health Service, Community Dental Service and Māori Health Service was released in July 2016. Key recommendations included; reinvesting resources with Well Child/Tāmariki Ora providers to manage children who are failing community dental appointments, introducing a patient focused booking system and revision of the 'hub and spoke' model of care.

Healthy Homes Programme

Hawke's Bay DHB and Health Hawkes Bay continue to fund a programme providing insulation and a range of interventions for households living in low socioeconomic areas who have significant health need. The greatest percentage of referrals into the Healthy Homes programme are for Māori and Pacific whānau. The MoH has expanded the criteria (and funding out to 2020) for the Healthy Homes Initiative which now includes pre-schoolers hospitalised for an indicator condition, at risk pregnant women/new mothers, and priority families with pre-schoolers for whom at least two of the following risk factors apply: CYF finding of abuse or neglect; caregiver with a Corrections history; mother has no formal qualification; and long-term benefit receipt

Work in Kohanga Reo

The re-establishment of DHB service provision within Hawke's Bay kohanga reo is now fully operational and enables the provision of education and advice to whānau, tamariki and kohanga around the management and treatment of skin conditions. As a result of a successful budget bid and investment, a new public health nurse was employed at the end of 2016, to continue to expand this programme.

The 'Clean it, Cover it, Treat it, Love it' skin resource has been translated for use in local Kohanga. This supports parents and Kaiako around best practice in recognition and management of skin issues. This aims to lead to earlier recognition and treatment of skin infections, avoiding the need for admission. Currently building feedback mechanisms for use of the resource into the action plan for 2017.

45-64 YEAR OLDS

Collaborative Pathways

Health Hawke's Bay and Hawke's Bay DHB are developing collaborative pathways across a range of conditions to improve practice by promoting the integration of services so that patients experience timely and consistent quality care that is coordinated in its approach within Hawke's Bay and reflects care that would be experienced elsewhere nationally.

Measuring the efficacy of the pathways is twofold. Firstly through analytics that would detail the current uptake and use of pathways within clinical practice and individual patient care and secondly through clinical patient / population health indicators.
Without both components, measuring the contribution that pathways make to patient outcomes is unreliable. The current platform on which the pathways are hosted does not currently provide this level of analytics.

An interactive application is going to be trialled with the anticipation that a fully interactive pathway can be developed. This would map how a pathway is being used by individual providers, link directly to patient information and ultimately be able to demonstrate the causal link between use of pathways to improve patient and population health outcomes.

Two pathways are being developed for a proof of concept. The cost of 35K has been approved by EMT (January 2017). The findings from the trial will be evident in June 2017 at which time the decision to extend to further pathways will be made by clinical council and EMT. It is anticipated that if the trial is successful all current pathways developed will be provided with the interactive function.

To date 30 pathways have been developed and GPs are increasing their use. From anecdotal evidence we can estimate that the most accepted pathways to date have been Respiratory (COPD), Dementia, Cellulitis and Last days of Life.

The new cellulitis pathway is reducing medication prescribing. This pathway was published and implemented into General Practice in November 2016 with the intent to change prescribing practice e.g. prescribe oral antibiotics and less use of intravenous antibiotics. However, if intravenous is required it is now a once daily administration rather than previous management which was twice daily – this saves the person time and cost to travel e.g. instead of two visits per day can be one. This pathway has been mirrored with slight changes and will be implemented into the Emergency Department, published date for February 2017. Consultants and nursing staff have received education and the change management is being led by the IV Clinical Nurse Specialist. Having this pathway in both primary and secondary care will endorse consistency of practice across both sectors.

The Congestive Heart Failure pathway aims to lead to improvements in consistency of practice not only in general practice but in aged residential care in the attempt to reduce and avoid hospital admissions. This is a very detailed prescribed pathway led by one of our dedicated Cardiologist and since publication has been reviewed with changes made due to national changes. This demonstrates the support from Clinical leads to ensue pathways are current within practice.

Promotion of all pathways is led by a small team that continues to socialise by visiting individual practices, promotion at CME/CNE training and quarterly newsletters.

Continuation of the Nurse-Led Respiratory Program

(Responding to Māori COPD rates-5.3 times the rate of Other)
Nurse led respiratory (including asthma and Chronic Obstructive Pulmonary Disease-COPD) clinics have been operating in General Practice since Sept 2014. Significant improvement and stabilisation of COPD rates for Pasifika and Other has been achieved.

This has not been the same for Māori, which currently sit at 5.3 time that of other with an annual increase of 1.2

Funding has been approved for the continuation of the pilot into a program of work that includes joint funding commitments from PHO and DHB. The focus of the program in its continued form will be addressing the high COPD rates of Māori

The service specifications are being developed currently and are being designed to intensify the focus on Māori outcomes and diversify the approaches whilst still repeating the proven work achieved with Other and Pasifika. The program methodology will follow and outcomes based framework.

Outcomes to date have seen decreases in ED presentations, hospitalisations and length of stay.

These outcomes can be attributed to the following key elements within the program:

- Emphasis on co-ordination and streamlining of client healthcare, with a strong Primary Health Care ethos focusing on early detection and timely management of chronic conditions at the primary care level.
- Nurse-led clinics are effective in co-ordination and self-management.
- Focus on Q4 and 5 patients representing 45% Māori accessing from quintile 5, and 65% Pacific) reflecting improved access to healthcare for high-needs clients
- Increased autonomy of nursing workforce with strengthened career pathway to CNS and Nurse Practitioner levels of competency
- Working in tandem with first line emergency services and pharmacy to provide patient management that reduces ED presentations for stabilisation.

Newly introduced elements to improve Māori Health outcomes are:

- Greater focus on whānau wellness vs the individual, supported by referral by Respiratory Clinical Nurse Specialist (R-CNS) to the whānau wellness program (PHO)
- Shift of emphasis on review rather than initial diagnosis allowing more people to be seen and more concentrated follow up
- The R-CNS to work with practice nurse champions alongside Māori health workers to improve capacity within the sector of specialist knowledge – management of respiratory conditions
- The R-CNS is working with exercise and health literacy teams to provide expert advice to improve program delivery and information
- Direct liaison by St John service with primary care for the management of patients instead of being transported to ED

Challenges:

- Disinvestment in secondary services with expectation of primary care to meet patient needs has not been accompanied by equivalent resources
- Non integration of primary and secondary service IT Patient Management Systems hinder real time transfer and visibility of clinical notes

The respiratory service will be used to trial the newly developed Draft Long Term Conditions Framework and the evaluation tool that has also been developed to support services in their planning reporting and implementation activities. The service has been selected to its focus on whānau based care, self-management focus and improved health outcomes for Māori.

Sharing Primary Care Practice Information

Business Intelligence has produced reports for a selection of general practices on their ED presentation and admission rates for consumers who had been identified as presenting 7+ times.
The pilot initiative was set up to help determine the causative factors. Initial findings have demonstrated a range of influences and the most informative was that the patients identified in the trail were both high users of ED and General Practice, with high to complex needs and or awaiting surgical intervention.

Sharing of practice level data – pertaining to consumer utilisation of hospital based services has proven to be effective in identifying opportunities for service integration and coordination of patient centred care.

The initiative is continuing and work is underway to extend to additional data sharing with an ever greater number of general practice involvement with the appropriate oversight for a confidentiality and IT governance perspective.

RECOMMENDATIONS FROM TARGET CHAMPION

As the Champion for the TAW ASH rate report there were two things that stood out for me.

1 For ASH rates 0-4 we are doing well, both with national comparisons and with the closing of the equity gap. We are now well in the lower half of the league table of DHB ASH rates in this age group and, pleasingly, the gap between the Maori rates and the total population is small and closing. Dental admissions is the one issue that does need to be highlighted were the rates are still high, however the work done with getting younger children engaged with the dental service should lead to improvements over the next 1-2 years.

2 For ASH rates in the 45-64 age group the HBDHB is at the wrong end of the league table with rates higher than the national average and some very large discrepancies between Maori and non-Maori. COPD and Heart Failure stand out as issues that need to be addressed.

CONCLUSION

There is significant work with COPD by the Respiratory Pilot which has now become BAU and for CHF the appointment of a CNS to work between primary and secondary care should help with this. It is interesting that CVD rates are much closer to the national average and have a much lesser equity gap. This could represent a time gap with improvements in primary prevention still to come through but could also indicate an treatment gap where Maori are not being treated as successfully for their CVD and therefore going on to develop CHF.

Dr Mark Peterson
Chief Medical Officer - Primary

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Māori Health Plan Q2 (October - December 2016)**
	For the attention of: **HB Clinical Council and HB Health Consumer Council**
Document Owners:	Tracee Te Huia, General Manager Māori Health
Document Author(s):	Patrick Le Geyt, Programme Manager Māori Health Justin Nguma, Senior Health & Social Policy Advisor Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Executive Management Team
Month:	February 2017
Consideration:	For Monitoring

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RECOMMENDATION

That the Clinical and Consumer Councils:

Note the contents of this report.

OVERVIEW

The purpose of this paper is to providing MRB, HB Clinical Council, HB Consumer Council and the HBDHB Board with exception report for Quarter 2 on the implementation of the 2016 – 2017 Annual Māori Health Plan. A quick reference summary dashboard will be supplied prior to the meeting which shows our position as at the end of Quarter 1 for all indicators. The dashboard uses traffic light methodology with detailed information and symbols for all indictors. For example, in a situation where the performance of the indicator for the current quarter is higher than the previous quarter this symbol '▲' will be used to show an upward trend while an opposite symbol '▼' will be used to show a downward trend. In cases where the variance to the annual target for the indicator is greater than 0.5% this symbol **'U'***(indicated on the dashboard in red)* will be used to indicate unfavourable trend and 'F' for favourable trend*(indicated on the dashboard in green colour)*toward the annual target *(see the table below).*

KEY FOR DETAILED REPORT AND DASHBOARD

Baseline	Latest available data for planning purpose
Target 2015/16	Target 2016/17
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target
Trend direction ▲	Performance is improving against the previous reporting period or baseline
Trend direction ▼	Performance is declining
Trend direction -	Performance is unchanged

2016-2017 ANNUAL MĀORI HEALTH PLAN QUARTER 2 PERFORMANCE HIGHLIGHTS

Achievements

1. Access to referral services for alcohol and other drugs for 0-19 year old Māori within 3 weeks has slightly decreased from 81.6% in Q1 to 80.5% in Q2, but still tracking positively above the expected target of ≥ 80%.

Areas of progress

1. Immunization rates for 8 months old Māori for Q2 has remained unchanged from 94.6% in Q1, tracking positively towards the expected target of ≥ 95%. This rate lowers the disparity gap between Māori and non- Māori from 2.1% in Q1 to 1.8 in Q2.

2. The number of Māori enrolled with HHB PHO increased slightly from 96.6% in Q1 to 96.8% in Q2 and trending positively towards the target of ≥ 100%. This brings the disparity gap between Māori and non- Māori for Q2 to less than 1%. Currently HBDHB ranks 4th among all DHBs in the country for Māori PHO enrolments

3. The ASH rates for Māori 0-4 year old group has dropped from 91.7% in Q1 to 84.9% in Q2 and trending positively towards the expected rate of ≤ 83%. This lowers the disparity gap between Māori and non- Māori from 11.4% in Q1 to 7.1% in Q2. HBDHB ranks 3rd among the best DHBs in the country for ASH rates among the 0-4 year olds.

4. Cervical screening for 25-69 year old Māori women for Q2 is 72.8% up slightly from 72.7% in Q1 with a disparity gap of 6% between Māori and non- Māori compared to 5% recorded in Q1. Nonetheless, this indicator continues to trend positively towards the target of ≥80% putting HBDHB ahead of all other DHBs in the country.

5. Māori Workforce grew by less than 1% from 12.5% in Q1 to 13% in Q2 trending towards the expected target of 13.8% or 22 employees to the target of 409 Māori staff.

6. Access to referral services for alcohol and other drugs for 0-19 year old Māori within 8 weeks has increased slightly from 91.7% in Q1 to 93.6% in Q2, tracking positively towards the expected target of ≥ 95%. This lowers the disparity gap between Māori and non- Māori from 1.1% in Q1 to 1% in Q2.

Challenges

1. Acute hospitalization for Rheumatic Fever has steadily remained at 7.3% from Q1 and tracking more than 20% away from the expected target of ≤1.5.

2. Māori under Mental Health Act compulsory treatment orders (CTO) has decreased from 183.9 per 100,000 population in Quarter 1 to 179.9 per 100,000 population in Q2. However, the indicator is tracking behind the target of ≤ 81.5 with a disparity gap of 117.8.between Māori and non- Māori in Q2 compared to 94.2 in Q1.

3. ASH rates for Māori 45-64 years went up slightly to 211.3% in Q2 from 196% in Q1 trailing behind the target of ≤ 123% with a significant disparity gap of 101.3% between Māori and non-Māori.

4. Breast screening for 50-69 Māori women dropped from 67.1% in Q1 to 64.7% in Q2 tracking positively towards the target of ≥ 70%. This rate presents a disparity gap of about 11% between Māori and non- Māori compared to 7.4% in Q1.

5. The Māori staff cultural competency training shows some slight increase from 78.8% in Q2 to 80.7% in Q2. While the numbers of staff training across professions went up slightly across the service, the number of staff training among the medical staff dropped by 2.2% from 39.9% to 39.7% in Q2.

National ranking by Trendly.

Please note:

- Unless otherwise stated the results presented in this dashboard are for Māori.
- The approximated gap to achieving target numbers stated may only be one of a range of possible values that could deliver the targeted level/result.

ANNUAL MĀORI HEALTH PLAN, QUARTER 1 SEPTEMBER – DECEMBER 2016 DASHBOARD REPORT

Immunisation

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Immunisation at 8 Months (3m)	92.6%	94.4%	94.4%	96.2%	≥ 95%	-2		↑
65+ Influenza (3m)	68.0%	56.5%	Update available in Q4		≥ 75%	-		↑

Rheumatic Fever

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Total	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Hospitalisation rate (6m)	2.48	7.3	7.3	2.48	≤ 1.5	-1		↓

Breastfeeding

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Total	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
QIF Data (6m)								
At 6 Weeks	58.0%	67.0%	Update available in Q3		≥ 75%	-		↑
At 3 months	46.0%	39.0%			≥ 60%	-		↑
At 6 months	46.0%	48.0%			≥ 65%	-		↑

SUDI

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Rate per 100,000 (12m)	2.09	2.1	Update expected Q4		≤ 0.4			↓
Caregivers given SUDI Prevention Info (12m)	72.8%	72.8%			≥ 100%			↑

Oral Health

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Pre-school enrolment rate (3m)	65.3%	74.1%	Update available in Q3		≥ 95%	-		↑
% Caries Free at 5yrs (3m)	36.0%	36.0%			≥ 67%	-		↑

Tobacco

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Smokefree 2 weeks postnatal (6m)	53.0%	65.6%	Update expected Q3		≥ 95.0%	-		↑

Mental Health & Addictions

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Mental Health Act community treatment orders (per 100,000) (3m)	196.0	183.9	179.9	62.1	≤ 81.5	-		↓

Access to Care

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
PHO Enrolment (3m)	97.2%	96.6%	96.8%	97.5%	≥ 100%	-1310		↑

The number in brackets identifies the frequency at which data is updated:
(3m) 3 months
(6m) 6 months
(12m) 12 months

ASH Rates

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
0-4 years (6m)	82.1%	91.7%	84.9%	77.8%	≤ 83%	-145		↓
45-64 years (6m)	172.0%	196.0%	211.3%	110.0%	≤ 138%	-2706		↓

Cancer

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Cervical screening (25-69 yrs) (3m)	74.1%	72.7%	72.8%	78.9%	≥ 80%	-656		↑
Breast screening (50-69 yrs) (3m)	68.4%	67.1%	64.7%	75.0%	≥ 70%	-93		↑

Maori Workforce

Indicator	Baseline	Prior period result	Actual to date Maori	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	2.9%	3.4%	4.2%	≥ 13.8%			
Management & Administration	16.5%	16.5%	17.2%	≥ 13.8%			
Nursing	10.6%	10.8%	11.3%	≥ 13.8%			
Allied Health	12.6%	13.2%	13.5%	≥ 13.8%			
Support Staff	28.2%	27.4%	28.2%	≥ 13.8%			
Māori staff - HBDHB (3m)	12.3%	12.5%	13.0%	≥ 13.8%	-		↑

Cultural Responsiveness

Indicator	Baseline	Prior period result	Actual to date	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	19.2%	39.9%	37.7%	≥ 100.0%			
Management & Administration	79%	87.0%	88.4%	≥ 100%			
Nursing	70%	82.9%	85.4%	≥ 100%			
Allied Health	77%	86.2%	89.2%	≥ 100%			
Support Staff	36%	63.3%	64.9%	≥ 100%			
HBDHB (3m)	66%	78.8%	80.7%	≥ 100%	-		↑

Obesity

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Referred for Nutrition (3m)	30%	26%	44%	40%	≥ 95%	-		↑
Bariatric Surgery (3m)	7	0	0	0	-	0.00		-

Alcohol and Other Drugs

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
% of 0-19 year olds seen within 3 weeks of referral (3m)	91%	81.6%	80.5%	81.1%	≥ 80%	Numbers available in Q3		↑
% of 0-19 year olds seen within 8 weeks of referral (3m)	100%	91.7%	93.6%	94.6%	≥ 95%			↑

HAWKE'S BAY District Health Board Whakawāteatia	**Imaging Guidelines in the Secondary Care Environment**
	For the attention of: **HB Clinical Council**
Document Owner:	Dr Mark Peterson, Chief Medical Officer – Primary
Reviewed by:	Radiology Services Committee
Month:	February 2017
Consideration:	Decision

RECOMMENDATION

That HB Clinical Council:

Endorse a) Imaging Guidelines in the Secondary Care Environment and b) the National Criteria for Access to Community Radiology.

BACKGROUND

The Radiology Services Committee is a sub-committee of the Clinical Council. Its role is to advise Clinical Council on matters relating to radiology across the Hawkes Bay DHB.

Part of this role is to advise on referral criteria for the range of imaging. For community radiology the Radiology Committee has endorsed the Ministry of Health paper "National Access Criteria for Access to Community Radiology" and for secondary care a paper "Imaging Guidelines in the Secondary Care Environment".

These papers provide guidelines to referrers about the clinical use of imaging and if endorsed by Clinical Council will empower the DHB Radiology Department to accept or decline referrals based on the clinical information provided.

The aim is to enhance the use of imaging services, using the right examination to answer the clinical question. Radiologists will be able to discuss with the referrer if there is a preferred imaging technique to the one requested, or possibly decline the referral.

It is not intended that there will be any financial savings but that we make better use of the scarce radiology resource

ATTACHMENTS:

- Proposed Guidelines
- National Criteria for access to Community Radiology

If not attached, please refer to the website under Clinical Council papers February 2017

http://www.hawkesbay.health.nz/about-us/hawkes-bay-clinical-council/clinical-council-meetings-2017/

OURHEALTH
HAWKE'S BAY
Whakawateatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

15. Minutes of Previous Meeting (Public Excluded)

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

17. Drafting Maintaining the Radiology Service to Primary & Secondary Care

18. Integrating GP Services in Wairoa (verbal)

19. Urgent Care Update (verbal)

20. Member Topics of Interest

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

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