HB Clinical Council
Monthly & Annual Meeting

Date: **Wednesday, 9 August 2017**

Lunch: **12.30 pm**

Meeting: **1.00 pm to 4.30pm**

Venue: **HBDHB Board Room**

Council Members:

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

Apologies: Dr John Gommans

In Attendance:

Dr Kevin Snee, Chief Executive Officer, Hawke's Bay District Health Board
Kate Coley, ED People and Quality
Ken Foote, Company Secretary
Tracy Fricker, Council Administrator and EA to ED People and Quality
Graeme Norton, Chair HB Health Consumer Council
Kerri Nuku, Māori Relationship Board Representative

MONTHLY MEETING

Public Meeting

Item	Section 1 – Routine	Time (pm)
1.	Apologies / Welcome	**1.00**
2.	Interests Register	
3.	3.1 Minutes of Previous Meeting (combined with Consumer Council) 3.2 Minutes of Previous Meeting (Clinical Council)	
4.	Matters Arising – Review Actions	
5.	Clinical Council Workplan	
	Section 2 – Discussion / Updates / Decision	
6.	Ka Aronui Ki Te Kounga / Focussed on Quality (Draft) Kate Coley & Jeanette Rendle	**1.20**
7.	Te Ara Whakapiri Hawke's Bay - Mark Peterson & Leigh White - Palliative Care Outcomes (raised in April 17) - Andy Phillips	**1.30**
8.	Learnings from ICU Review 2013 – Progress Update Kate Coley	**1.45**
	Section 3 – Monitoring for Information	
9.	Te Ara Whakawaiora / Mental Health – Sharon Mason, Justin Lee & Peta Rowden	**1.50**
10.	Annual Maori Plan Q4 Apr-June 17 / Dashboard - Tracee TeHuia & Patrick LeGeyt	**2.00**
	Section 4 - Committee Reports	
11.	Clinical Advisory & Governance Group Report (meeting held 25 July 17)	**2.10**
12.	**Recommendation to Exclude the Public**	

Public Excluded Meeting

Item	Section 5 – Routine	Time (pm)
13.	Minutes of Previous Meeting	**2.15**
14.	Matters Arising - Review Actions	
15.	Health Awards - Anna Kirk (Communications Manager)	
16.	Investment Prioritisation - Tim Evans (ED Corporate Services) & Ashton Kirk (Finance)	
17.	Member Topics of Interest	
	AFTERNOON TEA (20 minutes)	**2.55**

NEXT MEETING - Wednesday, 13 September 2017

ANNUAL MEETING

Public

Item	Section 6 – Annual Meeting	Time (pm)
18.	Welcome and Opening	**3.15**
19.	Apologies Received	
20.	Minutes of Previous Annual Meeting held 10 August 2016 20.1 AGM Workshop Outcomes	
21.	Matters Arising from Annual Meeting - nil	
22.	Annual Information: 22.1 Review last 12 months (2016-17) Year in Summary 22.2 Attendance over the prior 12 months 22.3 Tenure	
23.	Review HB Clinical Council Terms of Reference	
24.	Quality Annual Plan – Annual Review 2016/17 – Kate Coley	
25.	Clinical Governance Structure: 25.1 Clinical Governance Committee Structure Update (since August 2016) Verbal – Russell Wills, David Warrington, David Rodgers and Andy Phillips 25.2 Final Clinical Governance Committee Structure	
26.	Review of Clinical Council's Annual Workplan 2016/17 (past year)	
27.	Development of Council's Annual Workplan for 2017/18	
28.	Election of Chair / Co-Chairs 2017/18	

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE

NEXT MEETING - Wednesday, 13 September 2017

Interests Register

3 July 2017

Hawke's Bay Clinical Council

Name **Clinical Council Member**	**Interest** **eg Organisation / Close Family Member**	Nature of Interest **eg Role / Relationship**	Core Business **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
Chris McKenna (Director of Nursing)	Hawke's Bay DHB - Susan Brown	Sister	Registered Nurse	Yes	Low - Personal - family member
	Hawke's Bay DHB - Lauren McKenna	Daughter	Registered Nurse	Yes	Low - Personal - family member
	Health Hawke's Bay (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
Dr Mark Peterson (Chief Medical Officer - Primary Care)	Taradale Medical Centre	Shareholder and Director	General Practice - now 20% owned by Southern Cross Primary Care (a subsidiary	Yes	Low
	Royal New Zealand College of General Practitioners	Board member	GP training and standards	Yes	Low
	City Medical Napier	Shareholder	Accident and Medical Clinic	Yes	Contract with HBDHB
	Daughter employed by HBDHB from November 2015	Post Graduate Year One	Will not participate in discussions regarding Post Graduates in Community Care	Yes	Low
	PHO Services Agreement Amendment Protocol (PSAAP)	"Contracted Provider" representative	The PHO services Agreement is the contract between the DHB and PHO. PSAAP is the negotiating group that	Yes	Representative on the negotiating group
	Health Hawke's Bay Limited (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
	Council of Medical Colleges	Royal New Zealand College of General Practitioners representative and Council of Medical Colleges Executive	May impact on some discussions around medical training and workforce, at such times interest would be declared.	Yes	Low
Dr John Gommans (Chief Medical Officer - Hospital)	Stroke Foundation Ltd	Chairman of the Board of Directors	Provides information and support to people with a stroke. Has some contracts to the MOH	Yes	Low
	Internal Medicine Society of Australia and New Zealand (IMSANZ)	Immediate Past President and a current Director of IMSANZ	The IMSANZ represents the interests of specialist General Internal Medicine physicians throughout Australia and New Zealand	Yes	Low
	Royal Australasian College of Physicians (RACP), Adult Medicine Division Committee (AMDC)	Member and Chair elect of NZ Committee	RACP represents Physicians in all Adult Medicine specialties across Australasia; the NZ AMD representing those based in NZ	Yes	Low
Jules Arthur (Midwifery Director)	National Midwifery Leaders group	Member	Forum for national midwifery and maternity issues	No	
	Central Region Midwifery Leaders report to TAS	Member	Regional approach to services	No	
	National Maternal Wellbeing and Child Protection group	Co Chair	To strengthen families by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner.	No	
	NZ College of Midwives	Member	A professional body for the midwifery workforce	No	
	Central Region Quality and Safety Alliance	Member	A network of professionals overseeing clinical governance of the central region for patient quality and safety.	No	
Dr Kiri Bird (General Practitioner)	Te Timatanga Ararau Trust (Iron Maori)	Partner (Lee Grace) is a Trustee	Health and Wellbeing	Yes	Low - Contract with HBDHB
	Gascoigne Medical Raureka	General Practitioner	General Practice	Yes	Low
	Royal NZ College of General Practitioners	Member	Health and Wellbeing	No	
	Royal NZ College of General Practitioners	Lead Medical Educator in HB	Health and Wellbeing	No	
	Te Ora Board (Maori Doctors)	Member	Health and Wellbeing	No	
	Te Akoranga a Maui (Maori chapter for RNZCGP)	Member	Health and Wellbeing	No	
	Hawke's Bay Community Fitness Centre Trust	Trustee	Health and Wellbeing	Yes	Low - May potentially request funding from DHB
David Warrington (Nurse Director - Older Persons)	The Works Wellness Centre	Wife is Practitioner and owner	Chiropractic care and treatment, primary, preventative and physiotherapy	Yes	Low
	National Directors of Mental Health Nursing	Member		No	Low
Dr Tae Richardson (GP and Chair of Clinical Quality Advisory Committee)	Loco Ltd	Shareholding Director	Private business	No	
	Dr Bryn Jones employee of MoH	Husband	Role with Ministry of Health as Chief Advisor in Sector Capability and	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Report on CQAC meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Life Education Trust Hawke's Bay	Trustee		No	
	Dr Bryn Jones employee of MoH	Husband	Deputy Chief Strategy & Policy Officer (Acting)	No	
	Pacific Chapter of Royal NZ College of GPs	Secretary		No	

Name **Clinical Council Member**	**Interest** **eg Organisation / Close Family Member**	Nature of Interest **eg Role / Relationship**	Core Business **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
Andrew Phillips (Director Allied Health HBDHB)	Nil	Not Applicable	Not Applicable	No	Nil
Dr David Rodgers (GP)	Tamatea Medical Centre	General Practitioner	Private business	Yes	Low. Provides services in primary care
	Tamatea Medical Centre	Wife Beth McElrea, also a GP (we job share)	Private business	Yes	Low. Provides services in primary care
	City Medical	Director and Shareholder	Medical Centre	Yes	Low. Provides services in primary care
	NZ Police	Medical Officer for Hawke's Bay	Provider of services for the NZ Police	No	
	Health Hawke's Bay (PHO) initially - from 1 July 2015 under HB District Health Board	Collaborative Clinical Pathways development	Was the Champion for the initial work, however on 1 July this moved under the HBDHB umbrella (with a community focus).	No	
	Advanced Care Planning	Steering Group member	Health and Wellbeing	No	
	Urgent Care Alliance	Group member	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues around the development of urgent care services.
	National Advisory Committee of the RNZCGPs	Member	Health and Wellbeing	No	
	Health Hawke's Bay (PHO)	Medical Advisor - Sector Development	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues in this area relating to the PHO.
Debs Higgins (Senior Nurse)	Eastern Institute of Technology (EIT)	Lecturer - Nursing	Education.	No	
	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
Anne McLeod (Senior Allied Health Professional)	Aeotearoa NZ Association of Social Workers	Member		Yes	Low
	HB DHB Employee Heather Charteris	Sister-in-law	Registered Nurse Diabetic Educator	Yes	Low
	Directions Coaching	Coach and Trainer	Private Business	Yes	Low: Contracts in the past with HBDHB and Hauora Tairawhiti.
Dr Robin Whyman (Clinical Director Oral Health)	NZ Institute of Directors	Member	Continuing professional development for company directors	No	
	Australian - NZ Society of Paediatric Dentists	Member	Continuing professional development for dentists providing care to children and advocacy for child oral health.	No	
Dr Russell Wills (Community Paediatrition)	HBDHB Community, Women and Children and Quality Improvement & Patient Safety Directorates	Employee	Employee	Yes	Potential, pecuniary
	HBDHB employee Mary Wills	Spouse	Employee	Yes	Potential, pecuniary
	Paediatric Society of New Zealand	Member	Professional network	No	
	Association of Salaried Medical Specialists	Member	Trade Union	Yes	Potential, pecuniary
	New Zealand Medical Association	Member	Professional network	No	
	Royal Australasian College of Physicians	Fellow	Continuing Medical Education	No	
	Neurodevelopmental and Behavioural Society of Australia and New Zealand	Member	Professional network	No	
	NZ Institute of Directors	Member	Professional network	No	
Lee-Ora Lusis (Clinical Nurse Manager, Totara Health)	Totara Health and Choices Kahungunu Health Services	Employee	Clinical Nurse Manager	Yes	Potential, pecuniary
	Hawke's Bay Primary Health Nurse Practitioner Group	Member / Nurse Practitioner Intern	Professional network	No	
	Hawke's Bay Nurse Leadership Group	Member	Professional network	No	
	College of Nurses Aotearoa (NZ)	Member		No	
	Fusion Group Committee	Representative		No	
	ED High Flyers	Representative		No	
Dr Nicholas Jones (Clinical Director - Population Health)	NZ College of Public Health Medicine	Fellow	Professional network	No	
	Association of Salaried Medical Specialists	Member	Professional network	No	
	HBDHB Strategy & Health Improvement Directorate	Employee	Employee	No	
	National Information Clinical Leadership Group	Member	Professional network	No	
Maurice King (Community Pharmacist)	Napier Balmoral Pharmacist	Shareholder and Director	Community Pharmacy	Yes	Has various contracts with HBDHB to provide pharmacy based services. Low. Ensure position declared when discussing issues in this area.
	Pharmacy Guild of NZ	Member	Representative and negotiating organisation for Pharmacy	Yes	Negotiations on behalf of Napier Phamacy with HBDHB. Low. Ensure position declared when discussing issues in this area.
	Phamaceutical Society of NZ	Member	Pharmacy advocacy, profressional standards and training.	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Independent Advisor	No	

MINUTES OF THE COMBINED MEETING OF THE HAWKE'S BAY CLINICAL COUNCIL AND HAWKE'S BAY CONSUMER COUNCIL HELD IN THE "TAKARANGI" CONFERENCE ROOM, TE TAIWHENUA O HERETAUNGA, 821 ORCHARD ROAD, HASTINGS ON WEDNESDAY, 12 JULY 2017 AT 3.00 PM

PUBLIC

Present:

Clinical Council:
Chris McKenna (Co-Chair)
Dr Mark Peterson (Co-Chair)
Dr Tae Richardson
Dr John Gommans
David Warrington
Dr Andy Phillips
Lee-Ora Lusis
Debs Higgins
Jules Arthur
Dr Nicholas Jones
Maurice King

Consumer Council:
Graeme Norton (Chair)
Rosemary Marriott
Heather Robertson
Terry Kingston
Tessa Robin
Sami McIntosh
Deborah Grace
Olive Tanielu
Jim Henry
Malcolm Dixon
Sarah Hansen
Dallas Adams
Kylarni Tamaiva-Eria

In Attendance:
Ken Foote, Company Secretary (Co. Sec)
Tracee Te Huia, Acting Chief Executive Officer (Acting CEO)
Kerri Nuku, Maori Relationship Board Representative
Linda Dubbeldam, Health Hawke's Bay representative
Tracy Fricker, Council Administrator and EA to EDP&Q
Jill Garrett, Strategic Services Manager – Primary and Carina Burgess, Head of Planning *(Clinical Services Plan item only)*

Apologies:
Dr Russell Wills, Dr Robin Whyman, Dr David Rodgers, Dr Kiri Bird, Anne McLeod, Leona Karauira, Dr Dianne Mara, Jenny Peters and Rachel Ritchie

SECTION 1: JOINT DISCUSSION WITH HAWKE'S BAY CONSUMER COUNCIL

1. WELCOME AND INTRODUCTIONS

Graeme Norton (Chair of Consumer Council) welcomed everyone to the combined meeting of the Clinical and Consumer Councils. Tracee Te Huia, Acting CEO provided a Karakia.

Chris McKenna (Co-Chair of Clinical Council) welcomed the new member of the Clinical Council, Maurice King, Community Pharmacist who has been appointed Council while Billy Allen, Chief Pharmacist is seconded to the Health Quality & Safety Commission for six months.

Graeme Norton also acknowledged the two new members recently appointed to the Consumer Council, Deborah Grace who is in attendance today and Dr Diane Mara who starts next month.

2. CLINICAL SERVICES PLAN

Graeme Norton introduced David Moore and Tom Love from Sapere Research Group who were here to facilitate discussion on the Clinical Services Plan.

Graeme Norton introduced the topic he, Tae Richardson and Andy Phillips had prepared a short pre-reading paper as a warm-up for discussion on the topic.

Roundtable discussion took place, the feedback from which was captured by Sapere Research Group who will present back at future Clinical and Consumer Council meetings.

The Chair thanked everyone for their contributions.

3. SURGICAL EXPANSION PROJECT – CLINICAL AND CONSUMER ENGAGEMENT

Chris McKenna (Co-Chair) welcomed Rika Hentschel, Surgical Director and her team which included John Rose, Clinical Director, Anna Harland, Perioperative Unit Manger and Ben Duffus, Improvement Advisor to the meeting to present on the project.

Key points:

- Phase 1 – indicative business case approved by the Board in March 2017

- Phase 2 – workstreams for production planning capacity planning; delivery planning; capital works and detailed business case. Steering Group and Clinical Advisory Group established as well as stakeholder and user groups used for co-design, process reviews, model of care changes and floor space layout.

Questions / Feedback:

- Outsourced work to Royston, does that mean patients will not return to the hospital? Correct, these patients are screened and potentially do not need intensive care, short stays (1-2 days) and day cases.
- A lot of great work is going on with the partnership with Royston and our tertiary providers, day surgery rates, model of care work, outpatient procedures, changes to the model of care and changing practice by doing things outside of theatre which were previously done in theatre.
- How will this re-organisation impact on waiting lists? We are looking at our 4 month waiting time for first specialist assessment and to see if we can do better, we hope the changes being made will enhance this process as well. The changes will increase our capacity and we are also anticipating an increase in demand. It is hard to predict a waiting time for an individual because the increase in demand is developing as the population ages.

The Co-Chair thanked the team for their presentation and congratulated them on the work done so far.

4. COMMUNITY PHARMACY SERVICES AGREEMENT

The Co-Chair welcomed Di Vicary, Portfolio Manager to the meeting. Di provided an update on the community pharmacy services agreement contract which has been extended for 12 months to give certainty to the sector as a new contract is developed in readiness for 1 July 2018. The new contract will align with the other two national contracts for Aged Related Residential Care and Primary Health Organisation and will be consistent in delivering the key objectives of the New Zealand Health Strategy and the Pharmacy Action Plan. The contract extension includes additional funding for smoking cessation; workforce development and long term conditions for mental health.

It was acknowledged that the contract negotiations had been challenging but that they are trying to make the national contract be flexible regionally to reduce barriers and free up access for consumers. It is our opportunity to have a say on how this additional funding is spent in Hawke's Bay.

Please provide feedback on the draft terms of reference for Pharmacy Services in the Community Development Group to di.vicary@hbdhb.govt.nz.

5. 2017/8 BUDGET

The Co-Chair welcomed Ashton Kirk, Acting Finance Manager to the meeting. Ashton provided a presentation on the HBDHB budget for the 2017/18 financial year, pre and post receipt of the funding envelope from the MoH on 26 May 2017.

A breakdown summary was provided, and explanation given on scenarios regarding five options presented to the Board. At the Board Meeting on 28 June, option 5 was approved, being budget for $0.5 million surplus, $3.0 million contingency offset by a "risk reserve" of $0.6 million, and $0.3 million rising to $1.0 million investment. Also to maintain a universal savings target of 2.0%, writing off the bulk (77.6%) of "unidentified savings" accumulated in budget lines. The Board also requested a change to the word surplus to "new investment" or "capital investment fund".

The plan has been submitted to the MoH and we are waiting approval.

The Co-Chair thanked Ashton Kirk for the presentation.

The Co-Chair thanked the Consumer Council members for attending the joint meeting and brought the meeting to a close. The Clinical and Consumer Councils re-convened for their separate meetings.

The combined meeting closed at 5.40 pm.

Confirmed: _____
Chair

Date: _____

MINUTES OF THE HAWKE'S BAY CLINICAL COUNCIL MEETING
HELD IN THE "TAKARANGI" CONFERENCE ROOM, TE TAIWHENUA O HERETAUNGA,
821 ORCHARD ROAD, HASTINGS
ON WEDNESDAY, 12 JULY 2017 AT 5.40 PM

PUBLIC

Present:	Dr Mark Peterson (Co-Chair) Chris McKenna (Co-Chair) Dr Tae Richardson Dr John Gommans David Warrington Dr Andy Phillips Lee-Ora Lusis Debs Higgins Jules Arthur Dr Nicholas Jones Maurice King
In Attendance:	Ken Foote, Company Secretary (Co. Sec) Tracee Te Huia, Acting Chief Executive Officer (Acting CEO) Graeme Norton, Chair HB Health Consumer Council *(from 5.55 pm)* Kerri Nuku, Maori Relationship Board Representative Tracy Fricker, Council Administrator and EA to EDP&Q
Apologies:	Dr Russell Wills, Dr Robin Whyman, Dr David Rodgers, Dr Kiri Bird and Anne McLeod

6. APOLOGIES

The apologies were noted as above. An apology was also noted from Kate Coley, an attendee member.

7. INTERESTS REGISTER

No conflicts were noted for agenda items.

The interests for new member, Maurice King, Community Pharmacist had been received and added to the register.

8. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 14 June 2017, were confirmed as a correct record of the meeting.

Moved and carried.

9. MATTERS ARISING, ACTIONS AND PROGRESS

Item 1: Clinical Council Annual Plan 2016/17 Objectives
An update on development of model of care will be provided at the August meeting (which has been included on the work plan).

Item 2: **Joint Workshop**
Actioned. *Item can be closed.*

Item 3: **Mortality Rate Detail**
Actioned. *Item can be closed.*

10. CLINICAL COUNCIL WORK PLAN

The work plan was included in the meeting papers.

A reminder that the August meeting also includes the Annual General Meeting which is important for the election of the Co-Chairs. A lunch will be provided at 12.30 pm, prior to the start of the meeting at 1.00 pm. Chris McKenna advised she would be stepping down as co-Chair after six years.

Health Awards:

A brief discussion took place regarding the Health Awards. Clinical Council members assist with the short listing process for the judging and members are to be assigned to each category, as listed below:

1. Excellence in Provider Collaboration and Integration
2. Excellence in Innovation
3. Excellence in Service Improvement
4. Excellence in Clinical Practice
5. Outstanding Contribution to Improving Health in Hawke's Bay
6. Commitment to Quality Improvement & Patient Safety
7. Commitment to Reducing Inequities

The Chair requested that the list be sent out to all members and for them to email which categories they would like to lead/assist with shortlisting.

Action: ***List of categories to be sent out to members.***

SECTION 3: DECISION

11. LABORATORY GUIDELINES

Dr Mark Peterson (Chair) welcomed Dr Ross Boswell, Clinical Director, Laboratory to the meeting to talk to the draft Laboratory Testing Guidelines paper. He acknowledged that these guidelines had been worked on for some time by the Laboratory Committee and they need input from the Clinical Council to endorse this work.

Dr Boswell introduced himself and advised that he was a House Surgeon at Hawke's Bay Hospital in 1974 and for 40 years he has worked in laboratories in the UK and New Zealand. Currently he works at Middlemore Hospital and has been sub-contracted to work at Hawke's Bay for 2 days per fortnight.

The choosing wisely programme is an international programme and has been adopted by the Council of Medical Colleges in New Zealand.

The paper is in draft as they are still working up the costs for laboratory testing in Hawke's Bay. The sensible thing with laboratory testing is not necessarily ticking boxes on a form but to send fewer specimens to the laboratory. We need to persuade people to do the tests they need and to do them on as few specimens as possible because that is what is best for the patient, the doctors and the dollars. The document will come back to the Clinical Council when it has been finalised.

Feedback:

- Concern around the length of the document, 16 pages will it be used by staff
- To make it meaningful for clinical staff have a one pager test/why/cost
- Public Health would like to provide some input into the criteria of why a test would or wouldn't be done for clinical reasons around outbreaks and also how it fits into clinical pathways.
- It is a reference tool to help manage average practice, it can be used to train RMOs and to help SMOs and GPs. As a Clinical Council we have been delegated to make decisions on how public money is spent
- It is a tool for education, monitoring and to help us manage behaviour
- The choosing wisely programme is about rationalisation not rationing. It is being sensible in what we are doing, it's not saying do less, it is saying do the right thing
- An electronic 'order entry' system would be desirable for the guidelines to be fully effective in practice.

The intention of the document is to provide a guideline for practice and it is a useful resource to have for education purposes and gives the Laboratory Committee a tool that can be used consistently.

Following the discussion the draft Laboratory Guideline was **endorsed** and **approved in principle**. The final document will come back to Clinical Council for information.

SECTION 4: REPORTING COMMITTEES

12. HB RADIOLOGY SERVICES COMMITTEE

Dr Mark Peterson, Chair of the Committee advised that the last meeting was a brief one which looked at the Radiology Service business case approval.

Dr John Gommans highlighted for members that the Radiology Service has been under significant pressure for months with the recent SMO resignations, particularly that of the Head of Department. Locums are being used when available and two permanent Radiologists will be arriving in August. Some work is being outsourced. It is the ability to have a face to face conversation with a radiologist that is the challenge.

The Radiology Service was commended for the work it was doing with their current reduced resources.

13. HB LABORATORY SERVICES COMMITTEE

Dr Kiri Bird, Chair for the committee was not at the meeting to talk to the report which was included in the meeting papers.

Andy Phillips commended Dr Ross Boswell's work for the Laboratory Department and Laboratory Services Committee, he is adding considerable value.

Updates of other pieces of work:

- Laboratory results in discharge planning summaries sent to GPs – IS are looking at a solution to stop cutting and pasting of results from ECA into discharge summaries
- "Mark as read" policy review and responsibility for laboratory results - still a significant risk. All DHBs are struggling with the issue of getting the results to the right doctor and how results are documented as unread or un-acted upon is a risk. There are a whole lot of system issues being looked at. To complicate this further we are changing the IT clinical portal next year. Paper copies are still used as a back-up in most specialties. This costs money and is inefficient but we cannot stop this until we have a robust electronic system
- New automated identification and susceptibility testing system
- Technology solution for labelling to solve mislabelling issues

14. PHO CLINICAL ADVISORY & GOVERNANCE GROUP REPORT

It was noted that this group had not met for the past two months and therefore there was no report to be tabled. Chris McKenna advised that an extra ordinary meeting was held to endorse the PHO Annual Plan.

15. RECOMMENDATION TO EXCLUDE THE PUBLIC

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

16. Minutes of Previous Meeting (Public Excluded)
17. Matters Arising – Review of Actions (Public Excluded)
18. People Strategy Update

The meeting closed at 6.10 pm.

Confirmed: _____
Chair

Date: _____

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

Action No	Date issue raised	Action to be Taken	By Whom	By When	Status
1	08/03/17	***Clinical Council Annual Workplan 2016/17 Objectives***	Co-Chairs	Aug	August Agenda Item 26.
2	12/07/17	***Health Awards*** • Category list for shortlisting to be sent out to members. • Members to advise which category(ies) they wish to be part of for the shortlisting process.	Admin Members	14 Jul 27 Jul	Actioned Pending August Agenda Item 15.
3	12/07/17	***Laboratory Guidelines*** Approved in principle at July meeting. Guidelines document to be tabled for information at Clinical Council when finalised.	Dr Kiri Bird		Ongoing

OURHEALTH HAWKE'S BAY Whakawateatia

HB CLINICAL COUNCIL WORKPLAN 2017-2018

Meeting Dates	Papers and Topics	Lead(s)
9 Aug 17	**Ordinary Clinical Council Meeting followed by the Annual General Meeting** **Lunch at 12.30pm Venue : HBDHB Boardroom** **Meeting commences at 1.00pm**	
6 Sept 17	**HB Health Sector Leadership Forum – East Pier, Napier** **8.30am tea/coffee Commencing at 9am, concluding 3.00pm**	
13 Sep 17	Waioha Primary Birthing Unit - Benefits Realisation NEW Ka Aronui Ki Te Kounga / Focussed on Quality (final) NAME CHANGE Quality Annual Plan 2017/18 year Consumer Experience Results (March, **June**, Sept, Dec) Serious Adverse Events draft (p/excl) ED 6 Hours Update - NEW Trauma Service Presentation - NEW Social Inclusion Position on Reducing Alcohol Related Harm Metabolic (Bariatric) Survey in the context of a Healthy Weight Strategy for Adults - NEW ***Monitoring*** Te Ara Whakawaiora / Healthy Weight Strategy Te Ara Whakawaiora - Culturally Competent Workforce (local indicator) – FROM AUGUST Falls Minimisation Committee Maternity Clinical Governance Group PHO Clinical Advisory & Governance Committee	Chris McKenna Kate Coley Kate Coley Kate Coley Kate Coley Sharon Mason, Colin, Paula, David and John Sharon Mason / Albert Lo / Susan Hawken Tracee TeHuia Tracee TeHuia / R Ayre Tracee TeHuia /J Garrett Patrick LeGeyt / Shari Kate Coley Chris McKenna Chris McKenna Tae Richardson
11 Oct 17	Establishing Health and Social Care Localities Bowel Screening – NEW Collaborative Pathways Update Gastro Review – Progress Update 6mthly ***Monitoring*** Laboratory Service Committee Radiology Services Committee Infection Control Committee update HB Nursing Midwifery Leadership Council Update & Dashboard 6mthly PHO Clinical Advisory & Governance Committee	Tracee TeHuia Tracee TeHuia, Alan, Malcom Mark / Leigh White Kate Coley Kiri Bird Mark Peterson Chris McKenna Chris McKenna Tae Richardson

8 Nov 17	Tobacco Annual Update against plan Best Start Health Eating & Activity (6 monthly update) Quality Dashboard Quarterly *reporting commences* ICU Learnings Report – Action Plan update (qtly) Legislative Compliance 6 monthly update (FRAC action) Recognising Consumer Participation – Review Policy FROM AUGUST People Strategy update – next viewing in February 2018) Surgical Expansion Project - NEW ***Monitoring*** Annual Maori Plan Q1 July-Sept Dashboard HB Clinical Research Committee Update Te Ara Whakawaiora / Smoking TBC PHO Clinical Advisory & Governance Committee	Tracee TeHuia Tracee TeHuia / Shari Kate Coley Kate Coley Kate Coley Kate Coley / Jeanette Kate Coley Sharon Mason / Janet Heinz Tracee TeHuia John Gommans Patrick LeGeyt / Penny Tae Richardson
6 Dec 17	Consumer Experience Results Qtly (Dec – Mar 18) Clinical Pathways Committee ***Monitoring*** PHO Clinical Advisory & Governance Committee	Kate Coley Mark Peterson / Leigh Tae Richardson
2018 **14 Feb 18**	Quality Annual Plan 2017/18 – 6 month review People Strategy Clinical Services Plan Collaborative Pathways HB Laboratory Services Committee HB Radiology Services Committee Annual Maori Plan Q2 Dashboard ***Monitoring*** Te Ara Whakawaiora / Access 0-4 / 45-65 year (local indicator)	Kate Coley Kate Coley Tracee TeHuia / Carina Leigh White Kiri Bird Mark Peterson Tracee TeHuia / Patrick Mark Peterson
14 Mar 17	Establishing Health and Social Care Localities in HB (6mthly) Consumer Experience Feedback Q2 Falls Minimisation Committee Update ***Monitoring*** Te Ara Whakawaiora / Breastfeeding (national indicator)	Tracee TeHuia Kate Coley Chris McKenna Chirs McKenna

HAWKE'S BAY District Health Board Whakawāteatia	**Ka Aronui Ki Te Kounga Focussed on Quality (draft)**
	For the attention of: **Māori Relationship Board, Clinical and Consumer Council**
Document Owner:	Kate Coley, Executive Director People and Quality
Document Author	Jeanette Rendle, Consumer Engagement Manager
Month:	August 2017
Consideration:	For Endorsement

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Council:

- Endorse the new format of the Quality Accounts and provide feedback on layout and content.

OVERVIEW

The publication of the annual Quality Accounts was initiated in 2013, following the Health Quality & Safety Commissions (HQSC) guidance publication in July 2012 and the MOH's request that Quality Accounts should be produced annually. Since that time HB health sector has published four sets of accounts detailing our performance against both national and local quality and safety indicators.

The Quality Accounts are annual reports to the public from DHBs about the quality of services they deliver. As they are aimed at our community the aim is to keep them as short as possible, be visual, simple to read and understand, using photo's, images, stories, quotes, and examples to enhance the results and achievements.

The guiding principles are:-

- Accountability and transparency
- Meaningful and relevant whole of system outcomes
- Continuous quality improvement

FEEDBACK ON HB QUALITY ACCOUNTS 2016

Last year a working group was established to support the development and review of the Quality accounts publication for our community. It was a huge undertaking and presented multiple challenges. The link to last year's accounts as follows:
http://www.ourhealthhb.nz/assets/Publications/Our-Quality-Picture-2016-sml2.pdf

Previously the HQSC has reviewed all Quality Accounts providing annual feedback individually to DHB's and across New Zealand. From 2016, HQSC no longer provide feedback.

In 2016 around 400 publications and accompanying advertising posters were distributed across the community – to GP practises, health centres, public libraries, and community groups. The accounts were advertised in local newspapers and available on ourhealth website. It has been difficult to quanitify the level of readership. Feedback from the community was limited.

The feedback from stakeholders and community that we did receive resulted in the recommendation to have a smaller, more concise document this year with increased focus on the quality improvements that have come about from community feedback and consumer engagement. A ‘you said, we did” type format. Also, less emphasis on improvements and quality initiatives within services (which perpetuates the idea of working in silos) with increased emphasis on improvements as a result of working together across the sector; in particular more content from Primary care.

Recommendation:

The communications team have developed a template based on the recommendations and articles that have been gathered thus far. This is a starting point and provides a flavour for the document. We anticipate profiling another staff member (from PHO) and are waiting on content from Primary care which will include a day in the life of Te Mata Peak practise duting the gastro outbreak and will profile Totara and Choices new #whanau work.

I am looking for endorsement to proceed with this new tabloid publication and take any feedback on layout and content that will inform the final draft copy.

The final draft publication will come back to you next month before going to Board for endorsement in September.

KA ARONUI KI TE KOUNGA

FOCUSSED ON QUALITY

OUR QUALITY PICTURE 2017

Kia ora and welcome to the fifth edition of "Our Quality picture". This is a snapshot of how the health system is working to meet the needs of the Hawke's Bay community. People should be at the centre of health care and inside we focus on what we have done in the last year in response to feedback from our consumers and community.

We also recognise that providing healthcare is not without risks and sometimes people can be unintentionally harmed while undergoing care. Our aim is to reduce this harm and inside we outline our progress in this area, and how we measure up nationally against patient safety priorities and national health targets.

Kate Coley, Executive Director of People and Quality

Our Quality Commitment

Our commitment and pledge to you is:

That as individuals, and as a health sector, we continually improve the safety and quality of health care for all

To ensure that we have a blame free culture that embraces consumer involvement

That we put the patient at the centre of everything we do and focus on continuous improvement

That we ensure all of our teams are well supported and have the skills to deliver high quality and safe patient care, every time.

Ko ā koutou whakahokinga kōrero
Your feedback

We welcome and appreciate receiving feedback. To improve our services we need to hear your story. Whether compliments, comments, questions or suggestions, complaints or a mixture, your feedback is valuable. It helps us see where we are performing well and where we could improve.

You can give feedback in a number of ways:

- email us: feedback@hbdhb.govt.nz
- complete an online feedback form: www.ourhealthhb.nz
- Phone us: 0800 000 443
- complete a freepost feedback form which may be given to you when you visit, or which can be found in many areas across the DHB's sites.

You may receive a phone call or receive a request to complete a survey based on your experience. It is your choice to take part or not.

Ngā whāinga hauora ā-motu
National health targets

HEALTH TARGET	TARGET	OUR RESULT (04 2015/16)	TREND (since last year)	COMMENT
Shorter stays in Emergency Department	95%	Not achieved (93%)	↓	Hawke's Bay DHB continues to focus on improving flow through the Emergency Department. Additional staff are being employed to support this.
Improved access to elective surgery	100%	Exceeded (105%)	↑	This year we have continued to focus on Operation Productivity and increasing Hip and Knee surgeries to increase the number of people receiving surgery.
Faster Cancer Treatment	85%	Not achieved (63%)	N/A	This is a new national health target. The Faster Cancer Treatment team are working with improved processes to identify patients on the cancer pathway and we expect to see improvement in the coming year.
Increased immunisa	95%	Achieved	-	Hawke's Bay DHB remains one of the top performers in this Health Target. All immunisation service providers are working well together.
Better help for smokers to quit (Hospitals)	95%	Exceeded (99%)	-	Hawke's Bay DHB has achieved this target for the last three years.
Better help for smokers to quit (Primary Care)	90%	Not achieved (81%)	↓	Health Hawke's Bay continues to work with general practices to improve smokefree interventions.
More heart and diabetes checks	90%	Not achieved (88%)	↓	Health Hawke's Bay continue to focus on priority groups who are most at risk of heart disease and diabetes.

2015/16 DATA
NEW DATA TBC

KEY:

↑ Improved our performance against the health target.

↓ Our performance against the health target has declined

– Our performance against the health target has stayed the same.

You asked, we did

The following articles are examples of some of the things you told us through your feedback and what we are doing about it.

Youth Consumer Council

The Hawke's Bay Health sector has its own youth consumer council (YCC). The first of its kind in the country!

The formation of YCC was recommended as part of the youth health strategy that was finalised in July 2016. The development of this involved lots of consultation with health sector staff, community groups and youth in Hawke's Bay.

We learned that youth partnerships, leadership and collaboration across the health system was really important. YCC was initiated in late 2016 to help make this happen!

Aged between 12 and 24, the members of YCC ensure the youth voice is heard. They will also help the health system with ideas and concepts so it can be better connected with young people.

Charged with getting out and about, the council also meets with individuals in the community, other organisations and established youth groups so they can be well informed about what motivates young people to be proactive about their health. By engaging with youth face to face and interacting in different forums YCC were able to confirm their three priorities:

- Teen Suicide Awareness
- Drug and Alcohol culture
- Mental Healthcare Hawke's Bay

Dallas Adams, Chair off YCC and member Kylarni Tamaiva-Eria attend monthly Hawke's Bay Health Consumer Council meetings. Whilst they found it intimidating at first they have now made positive connections and feel confident they have a platform to voice youth opinion and influence decision making in the health system. "They encourage us to have a say and that makes us feel valued" says Dallas.

Did you know

There are 19,300 15-24 year olds in Hawke's Bay. This is 12% of the total population.

Around 2,019 (11%) youth live in rural areas and 15,984 live in urban areas (based on 2013 census)

YCC member Deveraux Short-Henare has enjoyed learning about the health system and how in his role he can influence changes to better meet the needs of youth. "I accepted the nomination because I honestly believe that youth need to be represented and have a say on what a 'youth' health system looks like and I think this group can enable that to happen". Deveraux and fellow member Tremayne Kotuhi recently represented YCC at Festival for the Future 2017. Hundreds of young innovators and influencers all gathered in Auckland to connect, explore issues, be inspired, and build ideas and skills to create the future. Tremayne came back motivated with new connections and ideas to test in Hawke's Bay.

The council has its own Facebook page, HB Youth Consumer Council ,where you can keep up-to-date with what they are up to.

Improving how we communicate with you

"He did not tell us what he was going to do. He went ahead without informing us or including us in the decision."

It is not uncommon for you to tell us, as health profesionals, that we could do better at listening to what you have to say, understanding what is most important to you and including you and your whanau in decisions about your care and treatment.

To support our staff in improving communication with consumers we started a training programme in March 2017 called "relationship centred practice" which has so far been delivered to over one hundred Allied Health Professionals (Physiotherapists, Occupational Therapists, Social Workers etc..). Online learning modules and face to face training workshops were developed with consumer involvement.

The training is a sustainable, skills based training package which is aimed at providing health professionals with practical methods and strategies to enhance their interactions with consumers and their whanau. This includes working in partnership, finding out what is important, what really matters to the consumer in terms of healthcare, and working together to come up with solutions.

This mana enhancing practice clearly puts the consumer and their whanau at the centre of their own healthcare - working in collaboration, building on strengths and being well supported to achieve the goals that are important in the context of their lives. It is focused on improving the connection and quality of interactions with consumers who in turn get greater engagement and thereby health outcomes are improved.

We have plans to roll this out to other health professionals in the hospital and communtty settings in 2017/18.

Staff have found this training valuable and it has allowed them to reflect on and improve their practise.

"I am much more aware of focusing on what the families want, how important it is to them and changing my approach to empower them more".

"The facilitator delivered the message effectively and simply and made me see how vital whakawhanaungatanga is, with every patient I see".

Health literacy – making healthcare easy to understand

Health literacy is about making sure healthcare is easy for people to find, understand and use so that they can look after their health and wellness.

To do this HBDHB has committed to changing the way we deliver health care to the people of Hawke's Bay. We have taken the first step by setting some rules around how we provide information such as pamphlets and letters, as well as how our health professionals talk to you about your health and wellness.

The next step is to make sure everyone working in the HBDHB is aware of the importance of making healthcare easy to understand. This involves working alongside our services and health professionals to help them make the changes that are needed to ensure this happens.

Ultimately, we want to make it as easy as possible for people to find the correct information or get to the right healthcare services, so they understand how they are best to take care of themselves.

Achieving this will take time, but people will progressively notice a difference in the way they receive information and healthcare services in Hawke's Bay.

To make this easier, we need the help of our consumers to tell us how we are doing throughout this journey and where we need to make improvements and changes. Feel free to email us at feedback@hbdhb.govt.nz with your thoughts.

This will go a long way in making sure healthcare is easy to understand to help you be well, get well and stay well.

National Patient Safety Priorities

The Health Quality and Safety Commissions (HQSC) key role is to publish information including targets about the quality of health care in New Zealand. By having a target we can monitor how we compare with other DHB's which will challenge us to do better. For more information look at the website www.hqsc.govt.nz.

The four main ways we can monitor how we compare with other DHBs are by:

- reducing the number of injuries from a fall while in hospital or residential care by assessing people and having a plan to look after them
- stopping people from getting an infection while in hospital or during surgery by having good hand hygiene and giving antibiotics before surgery
- preventing people from having more problems because of medication they require
- decreasing problems just from having surgery.

We know we are getting better at this because our results in the January to March 2017 quarter tells us that Hawke's Bay compared to other DHB's are in the top areas for three out of the four areas and we are working hard to improve the fourth area which is the safer surgery marker. The safer surgery marker compares how well surgical staff complete safety checklists and although we know they are doing it – we need to get better at proving it.

Staff and visitors participating in a Tai Chi taster class lead by Sport Hawke's Bay.

Our Falls Campaign across the whole region focused on improving balance and strength, we had a great month working with other providers and we ended up being recognised nationally for our work. This is something everyone can do to help themselves – as we age its harder to keep our balance and keep strong in our legs. But there are a lot of community programmes to help – staff and visitors tried Tai Chi this year – thanks to Sport HB. Look at their website for a list of programmes www.sporthb.net.nz

Other national programmes which are coordinated by the HQSC include:

- Recognising Detoriating Patients - Getting better at identifying when someone is getting sicker while in hospital and having a plan to help them faster;
- Medication Management - Helping people who are in pain and need strong medication to help them, which sometimes means they get constipated – ie. you can't have a 'poo' as often as you would normally, this is a problem so we are doing some things to stop this, for example: making sure if strong medication is needed, medicine to make you poo is also given.
- National Patient Experience Survey (in hospital) – this has been running for three years now and the feedback informs national improvement campaigns for example: medication safety. HBDHB are measured on four main domains – communication, coordination, partnership and physical and emotional needs. (insert table with our scores).

Let's Talk - Patient Safety Week

Patient Safety is top of mind every day in healthcare. "Let's Talk" was the theme at Hawke's Bay Hospital during Patient Safety Week in November 2016 when we highlighted better communication between patients, whānau and health professionals. We had displays to highlight the Let's Talk campaign making sure we got the attention of staff, patients and visitors to the hospital and our "what matters to you" whiteboards reinforced that whānau/family matters most.

Patient Safety Week is a Health Quality and Safety Commission initiative which we embrace every year. The theme for 2017 will be medication safety. This topic has been chosen because the in-patient experience survey question "Did a member of staff tell you about medication side effects to watch for when you went home?" consistently gets one of the lowest scores from consumers and there are a large number of medication errors in hospitals.

CEO Dr Kevin Snee checks out a display alongside Jane Bailey, Patient Safety Advisor and Jeanette Rendle, Consumer Engagement Manager.

How to keep yourself safe when in hospital – here are our top tips:

- **Talk** with your doctor and nurse and tell them what you know about your illness or injury.
- **Ask** questions to help you understand your treatment – why you are having it, the choices, what will happen and the risks and benefits.
- **Clean** your hands often to help stop infection, and ask your visitors to clean their hands.
- **Keep** a list of and learn the names of the medicines you are taking, the reasons you are taking them and when and how to take them.
- **Ask** for the results of any tests you have and what happens next.
- **Get** to know your ward and make sure the call bell is always within easy reach.
- **Before** leaving hospital, ask what you and your family/whanau need to do at home.

National Patient Safety Priorities **In hospital**

The Health Quality & Safety Commission is driving improvement in the safety and quality of New Zealand's healthcare through the national patient safety campaign 'Open for Better Care'. All of New Zealand's district health boards need to report on how well they are doing against key targets. These targets are about making sure consumers are not harmed from a fall when in our care, that we reduce the number of infections and that we make sure that when consumers have surgery they receive the necessary medicines, and that we work as part of a team.

This is how we are doing (results for Jan-Apr 2016 unless otherwise specified):

✓ **93%** **Falls prevention 1**: Older consumers assessed for risk.. Target 90%

✓ **94%** **Falls prevention 2**: Percentage of older patients assessed as at risk of falling who receive an individualised care plan addressing these risks. Target 90% (an increase of 8% from last year).

✓ **89%** **Hand hygiene:** Percentage of health professionals who clean their hands before and after having contact with a patient. Target 70%.

✓ **100%** **Surgical site infection 1:** Antibiotic administered in the hour before surgery. Target 100%

✓ **98%** **Surgical site infections 2:** Right antibiotic in the right dose. Target 95%

open FOR BETTER CARE Hāpai ake te toiora

Hand Hygiene

Hand hygiene is recognised worldwide as the single most effective way to prevent the spread of infection and improve the quality and safety of patients in our care. The 5 moments for Hand Hygiene is a programme developed by the World Health Organisation (WHO), and implemented across all New Zealand district health boards (DHBs).

HBDHB continues to achieve a high level of compliance with the 5 moments for Hand Hygiene when compared to other NZ DHBs. The quarter ending March 2017, HBDHB achieved a compliance rate of 88.7%, the highest in NZ.

On 5 May, HBDHB celebrated World Hand Hygiene Day. Wall displays across the hospital were created by enthusiastic staff members, an information board was created in the main entrance, and a competition 'guess the hands' was run that created a sense of fun and engagement with staff, patients, and visitors.

It was also a time to celebrate and thank the Hand Hygiene champions within the hospital for their passion and dedication to the programme and ultimately the positive impact it has on patient safety.

Go Well Travel plan

We know that prior to March 2017 our community were having real trouble finding car parking at Hawke's Bay Hospital – whether coming to an outpatient appointment, or visiting loved ones. In 2016 a lack of car parks was one of our top complaint themes.

"trying to find parking can take up to 30 minutes. I ended up missing my appointment".

"I had an appointment for my moko at 9am. I couldn't find a park. When I did find one we were 50 minutes late for his appointment…"

Feedback like this was not unusual. Missing an appointment is inconvenient for our patients, impacts negatively on their overall experience of care and doesn't allow us to best manage our time and resources.

We listened to you. The introduction of paid car parking in March 2017 and the promotion of alternative modes of transport has eased congestion. Patient and visitor parks are now freely available with about 30 spaces available at any given time. It is working well with plenty of positive feedback from people who are grateful to be able to easily find a park and this means a better overall experience, people attending appointments on time and less stress.

"I have used the car park twice this week for appointments, it was so nice to just be able to drive straight in and park without having to drive around endlessly. I was more than happy to pay the $1 each time for such an easy stress free arrival". (Lucy Billings, Facebook).

Tom Wihapi (pictured below), is our friendly parking officer overseeing the paid parking scheme. Tom averages 15km per day on the job and is only too happy to help visitors and patients with parking queries, lost car keys or machine issues.

"It has been going very smoothly, people are very understanding of the pay scheme and visitors especially are only too happy to be able to find a car parking space."

As well as paid car parking, we have also worked with GoBay to bring you other transport options. Outpatients are making the most of the free bus transport option, with 519 trips to attend their appointments at the hospital or Napier Health in May alone. That's a staggering 122% increase on May last year!

Tom (pictured right) says he enjoys catching the bus to his hospital appointments.

If you have an upcoming outpatient appointment at the hospital or Napier Health, you too can jump on the goBay network for free, together with a support person. Simply show your appointment letter or text reminder to the bus driver and you'll be on your way!

"It's completely hassle free, it's an easy way of getting across from Napier and I don't need to rely on anyone else."

Adverse events

Adverse Events are events which have resulted in serious harm to patients. This harm may have led to significant additional treatment, have been life threatening or led to a major loss of function or unexpected death.

Adverse events are uncommon but taken seriously. For each event we conduct a formal review which follows the patient's journey through the hospitals systems and processes.

What we learn from these reviews is important and we recognise that each event provides an opportunity to improve the care we provide.

Adverse events 2016/17

Data TBC

Learning from Adverse Events

Several reviews at HBDHB have led to significant improvements on the front line, examples are:

- The appointment of more senior doctors
- Reducing delays to reach definitive diagnosis
- Education opportunities
- Improvements to the transfer of care – communication information gathering tools have been developed.

"[we] would like to thank you for investigating [his] death and providing a clear report. My primary intention was to ensure any lessons that could be learnt from this tragedy would possibly prevent others having to experience this and to that end we were heartened to see the changes in DHB operating procedures.

…the family was happy to see that our concerns were taken seriously by the depth and openness of the DHB report and the remedial actions that have since been implemented".

Future Focus

The organisation has invested in a new integrated risk management system which is intended to be rolled out at the end of 2017. This new system brings new capabilities and allows the DHB to better monitor and manage its associated risks. We hope to bring the primary care sector on board with the system in 2018.

We value the input of consumers into decision making about our healthcare and improvement activities and as such in 2018 we intend to invite consumers and/or their whanau to be involved in the review process.

Staff profile

Wairoa's Rural Nurse Specialist Nerys Williams is relishing the opportunity to make a difference in people's lives by helping them in whatever way she can. Her experiences, she says, have reinforced the importance of her role in keeping people out of hospital and delivering care in the home for rural patients.

Wairoa people are benefitting by having the opportunity to reduce travel to Hastings for procedures that can be provided by Nerys in their own home.

One experience, in particular, has had a positive impact on Nerys and listening to her recount the story of two sons who cared for their terminally ill father is touching.

"It was their Dad's dying wish to return to his papakāinga (original home)," says Nerys, who was determined to try and make that happen. With Nerys' training, the sons were able to inject medication into their Dads muscle over a period of four to five days, being fully responsible for the drug application, and providing constant attention to their Dad in the comfort of their home.

"The training was robust and this was supported by phone calls and daily visits by me to ensure the sons and wider whānau were supported well," said Nerys.

"Just as important was coordinating the wider support network including district nurses, occupational therapists and Cranford Hospice and I am proud of how well everyone pulled together to do their respective jobs with very short notice."

Primary Care

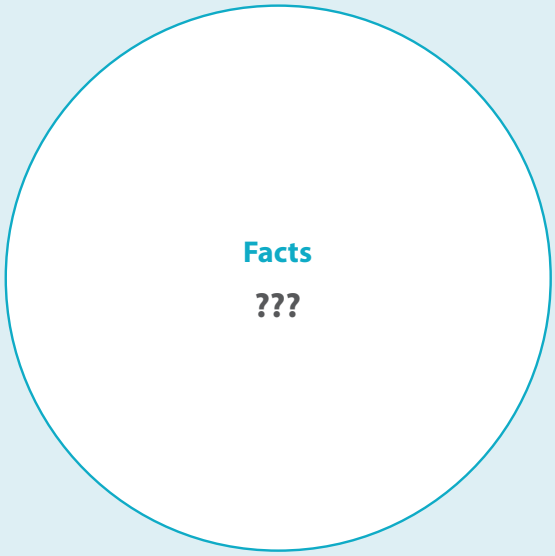
TBC

Heading

text

Gastro Outbreak

lText



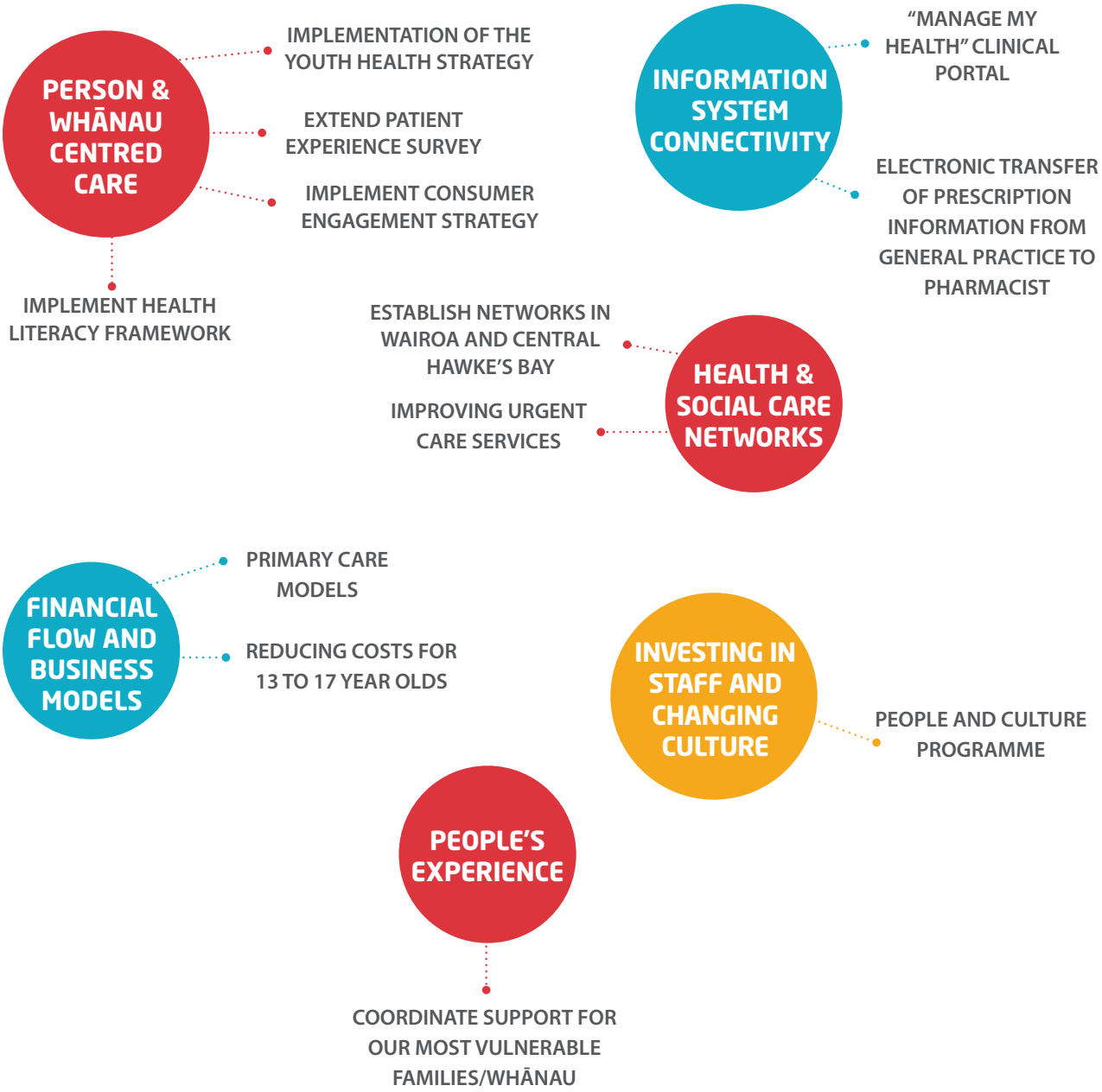
#whanau

Text

TŌ TĀTOU ARONGA MŌ ĀPŌPŌ
OUR FUTURE FOCUS

With the refresh of the New Zealand Health Strategy, we will be working to ensure that: **All New Zealander's live well, stay well, get well in a system that is people powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system.**

We have reviewed our 5 year strategy Transform and Sustain which aligns to the New Zealand Health Strategy. We will support the elimination of inequity and prepare our health services for more numbers of younger Māori and growing numbers of older people and people with chronic conditions. Over the next two years we will identify further projects to respond to the changes in our population. We have included examples under each theme. To meet the needs of the Hawke's Bay population we need to continue to improve what we do.



I MŌHIO RĀNEI KOE IA RĀ...
DID YOU KNOW THAT EVERY DAY...

3
children will receive one of their vaccinations

6
babies will be born

10
fragile babies will be cared for in the special care baby unit

16
people will get their free annual diabetes check

22
women will have a mammogram and a further 29 a cervical smear test

35
operations will be completed in one of Hawke's Bay Hospital's theatres

NEW DATA TBC

200
visits/appointments will be made to support people with mental health issues

209
visits will be made by district nurses and home service nurses

245
children will be seen for their free dental health check

1,454
people will see their family doctor

4,662
prescriptions will be filled out

5,680
laboratory tests will be completed

an orderly can walk on average of 15km

85
people will be admitted to Hawke's Bay Hospital

350
meals on wheels will be delivered

5,870
items of laundry will be delivered to the hospital

Icons made by Freepik from www.flaticon.com

OURHEALTH HAWKE'S BAY Whakawateatia	**Te Ara Whakapiri Hawke's Bay**
	For the attention of: **Māori Relationship Board, Clinical and Consumer Council**
Document Owner:	Mark Peterson, CMO Primary Care
Document Author:	Leigh White, LTC Portfolio Manager, Strategic Services
Reviewed by:	Executive Management Team
Month:	August, 2017
Consideration:	For Endorsement

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Council

1. Endorse roll out of Last Days of Life Care Plan and Toolkit
2. Support ongoing work

PURPOSE

The purpose of this document is for EMT to:

- Endorse roll out of HBDHB localised Care Plan and Toolkit for Last Days of Life into:
  - ✓ All HB ARC Facilities (note: we cannot make this compulsory with national corporates however we will encourage facilities to be in line with local development)
  - ✓ All HB Hospital Wards (staged approach)
  - ✓ Excluding Cranford Inpatient Unit (Care Plan has been analysed with components of Palcare).
- Support further work as we progress with roll out (enclosed action/work plan).

EXECUTIVE SUMMARY

An international and national review resulted in the phasing out the Liverpool Care Pathway (LCP), however many service providers providing palliative care report that there is still a requirement for a care planning tool for last days of life. It was noted in HB that tools are being used based on the "old" LCP framework and that these tools are not representative of: individualised care planning, not supported by education, quality review, or audit. In response to this, key stakeholders within Hawke's Bay drafted a localised care plan and toolkit.

In May 2016 HBDHB Executive Management (EMT) and respective Councils were presented with a proposal to review and endorse work as outlined below:

- A proposed proof of concept trial of the HBDHB Last Days of Life Care Plan and toolkit (Draft) in five nominated Aged Residential Care (ARC) Facilities, Cranford Hospice Inpatient Unit and a Medical Ward in HB Hospital.

- An evaluation of the proof of concept to be commissioned and completed by Cranford Hospice. Key to the evaluation was to measure the HBDHB tools against the national guidance document Te Ara Whakapiri and other national tools (Full report enclosed). Key findings were:
  - ✓ Overwhelming support from our trial sites and integrated working group that the HBDHB Care Plan and toolkit be adopted locally into all ARC Facilities and Medical Wards of HB Hospital. Note: we cannot insist ARC Facilities but we can encourage and we are supportive to share our local tools to ARC national bodies.
  - ✓ Feedback suggested some minor changes to the care plan and tool kit. These changes are currently being worked on with key members from the integrated working group and publisher. Note: there are no changes to the local medication prescribing tools that have been in place in General Practice for some years.

RECOMMENDATIONS

- This piece of work has been a truly integrative approach and it cannot go unnoticed of the work of the Integrated Advisory Group (inclusive of GP support), Cranford Hospice, Inpatient Specialist Palliative Care Team and ARC Facilities.
- Committed ongoing support , once endorsed by EMT and respective Councils:
  - ✓ Cranford Hospice will continue to roll out Care Plan and Toolkit to ARC Facilities.
  - ✓ Manager of Specialist Palliative Care Team in-hospital fully supported and has commenced planning to roll out.
  - ✓ LTC Portfolio Manager to seek funding for published tools
  - ✓ Socialise this work through Map of Medicine

SUCCESS FOR US IN HB

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

THIS PIECE OF WORK SUPPORTS TWO SIGNIFICANT DOCUMENTS:

1. Ministry of Health Palliative Care Action Plan: – Priority 3 action (2017): "Implement Healthy Ageing Strategy action: Support the implementation of the Te Ara Whakapiri Principles and guidance for the last days of life".
2. HBDHB Live well, stay well and die well, Palliative care in HB[i]: actions required: "Last Days of Life (Te Ara Whakapiri) pathway is developed and implemented across the region" with an **outcome** of "100% of ARC facilities and hospital wards implementing the Last Days of Life (Te **Ara** Whakapiri) supported by Specialist Palliative Care services".

June 2017: LW

Action planning for roll out of Te Ara Whakapiri (inclusive of Logic Model)

Brief Summary

Last days of life care planning is an integral component of care and management of people in their last hours to days of life. It is imperative that all health professionals are competent to provide care.

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

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

Outcomes:

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

What will show improvements

Health records will better reflect a holistic approach to care in the last days of life. This includes evidence of communication and consideration of the individual needs of the person and family/whanau.

It is expected that staff working with the document will show high level of confidence in planning and providing care. Having a consistent approach to the delivery and management of care will allow for effective evaluation and subsequent improvement to services provided through evaluation. This will be inclusive of the family/ whanau experience.

The journey thus far

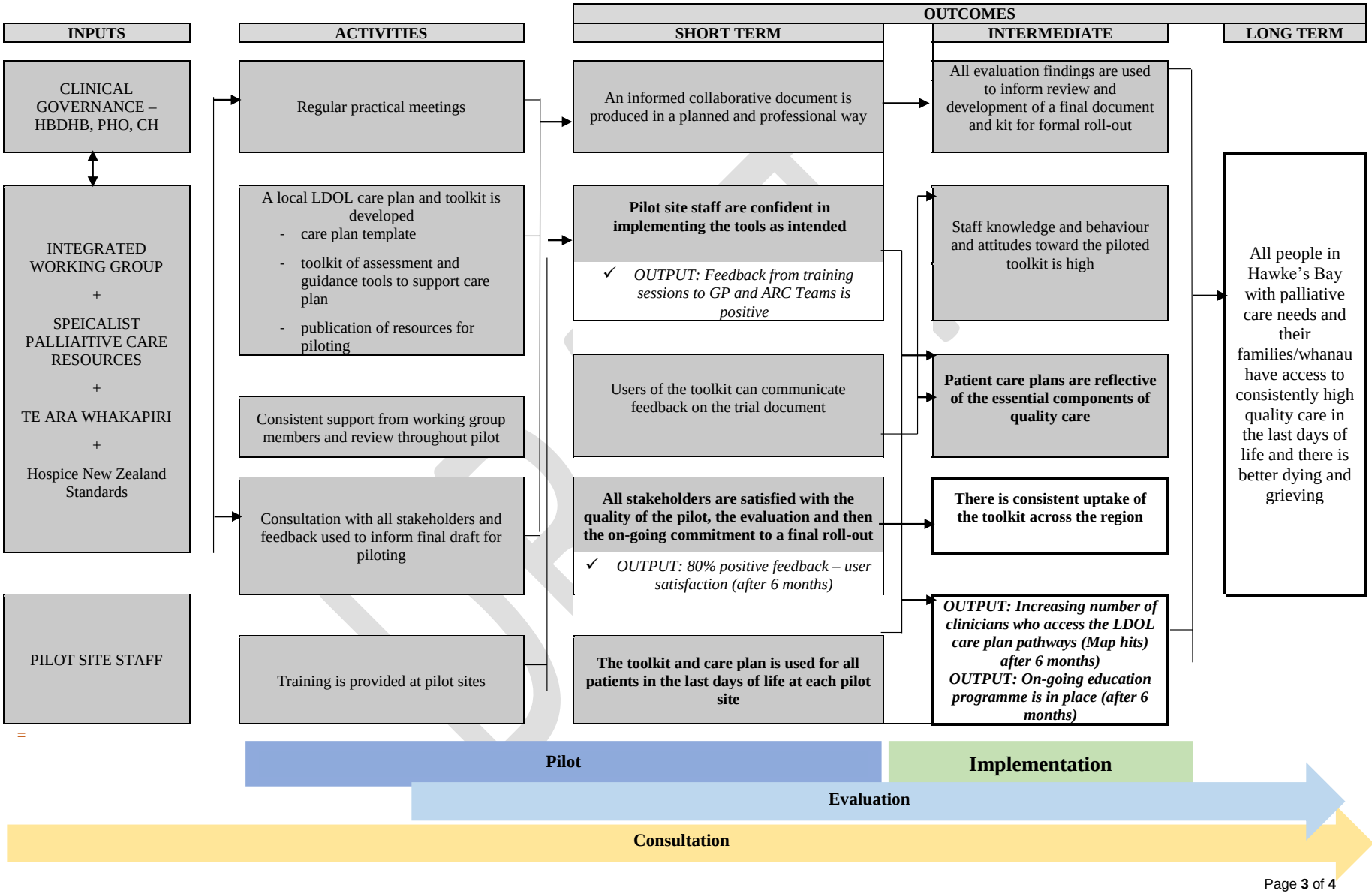
1. HBDHB Integrated Steering group was formed: Key purpose:
   - develop a Care plan and Toolkit unique for HB but aligns with the Te Ara Whakapiri document
   - note: half way through our HB process a decision was made to develop same nationally
2. Pilot the Care plan and Toolkit (enclosed document). GPs were kept informed of Pilot and progress:
   - ARC Facilities Piloted : Mary Doyle, Brittany, Masonic and Atawhai/Gracelands
   - GP support: Dr M. Peterson, Dr P. Henley, Dr L. Whyte and Dr J. Eames
3. Evaluation of the pilot (enclosed document)

Next steps

HBDHB Governance Committees to endorse the work and support implementation of the HBDHB Last Days of Life Care Plan document and toolkit as a replacement for LCP based on Te Ara Whakapiri: Principles and Guidance. The tool has similarities that are already embedded into Palcare the electronic tool used at Cranford Hospice. Note: Medication symptom Management for last days of life algorithms are currently well embedded into general practice and these will not change.

Milestones to date (Work to be done)	Names	To complete by August 2017
Tool and Toolkit		

1	**From Evaluation - make recommendations to change master** Planning for Last Days of Life Care Plan	Sarah Jo	Plan **Do** Done
2	Liaise with Publishing to gain costs for changes	Leigh	**Plan** Do Done
3	Changes Made with Publisher	Leigh	**Plan** Do Done
4	Implement changes into Map of Medicine.	Leigh	**Plan** Do Done
Advisory Committees			
1	Integrated Steering Group • Inform them of outcome and share Evaluation report	Leigh	Plan Do **Done**
2	Provide update to PHO Palliative Care Steering Group/ HB Governance Steering Group	Leigh	Plan Do **Done**
3	LTC Advisory Committee (Present: 15 July 2017) • Endorse roll out	Leigh	Plan **Do** Done
4	EMT (9/08/2017)	Leigh	**Plan** Do Done
5	Clinical Council (9/08/2017)/Consumer Council (10/08/2017)/ Maori relationship Board (9/08/2017)	Leigh	**Plan** Do Done
6	PHO Clinical Advisory groups (PHOLT 4/09/2017, CAG 12/09/2017)	Leigh	**Plan** Do Done
Roll out Planning – ARC by Cranford Hospice			
1	Confirm endorsement (Evaluation)	Leigh	Plan **Do** Done
2	Roll out to ARC – confirm with Cranford	Sarah/Jo	Plan Do **Done**
3	Date of Implementation and Socialisation to all ARC	Sarah/Jo/Leigh	**Plan** Do Done
4	QA audit processes – recommend a year post implementation	Sarah/Jo/Leigh	**Plan** Do Done
Roll out Planning – HB Hospital general wards and Rural Wairoa/Waipuk)			
1	Confirm endorsement – Agree Operational within budget	Leigh/Mandy Anne/Emma	Plan Do **Done**
2	Implementation planning – Meeting 11/07/2017 Operational	Leigh/Mandy Anne	**Plan** Do Done
3	Date of Implementation – Ann to Lead/Resource Nurse in wards/staff meetings/Meetings with CNM/Meeting with Education Department (25/07/2017) to script modules to Ko Awatea	Leigh/Mandy Anne	Plan **Do** Done
4	QA audit processes – recommend a year post implementation	Leigh/Mandy Anne	**Plan** Do Done
5	Rural Wairoa/Waipuk – link with Managers		**Plan** Do Done
Socialisation			
1	Link in with other DHBs – what are they doing? Link: Kate Grundy: Kate.Grundy@cdhb.health.nz, being socialised at Canterbury DHB		Plan Do **Done**
2	Educational workshops for ARC (Presented to ARC Forum 25/07/2017)	Sarah/Jo	Plan Do **Done**
3	Grand Round – Date confirmed 23/08/2017	Emma Mary	Plan Do **Done**
4	Update to Primary care	Leigh	**Plan** Do Done
5	Update Map of Medicine		**Plan** Do Done


INPUTS
ACTIVITIES
OUTCOMES
SHORT TERM
INTERMEDIATE
LONG TERM
CLINICAL GOVERNANCE – HBDHB, PHO, CH
INTEGRATED WORKING GROUP
+
SPEICALIST PALLIAITIVE CARE RESOURCES
+
TE ARA WHAKAPIRI
+
Hospice New Zealand Standards
PILOT SITE STAFF
=
Regular practical meetings
A local LDOL care plan and toolkit is developed
- care plan template
- toolkit of assessment and guidance tools to support care plan
- publication of resources for piloting
Consistent support from working group members and review throughout pilot
Consultation with all stakeholders and feedback used to inform final draft for piloting
Training is provided at pilot sites
An informed collaborative document is produced in a planned and professional way
Pilot site staff are confident in implementing the tools as intended
✓ OUTPUT: Feedback from training sessions to GP and ARC Teams is positive
Users of the toolkit can communicate feedback on the trial document
All stakeholders are satisfied with the quality of the pilot, the evaluation and then the on-going commitment to a final roll-out
✓ OUTPUT: 80% positive feedback – user satisfaction (after 6 months)
The toolkit and care plan is used for all patients in the last days of life at each pilot site
All evaluation findings are used to inform review and development of a final document and kit for formal roll-out
Staff knowledge and behaviour and attitudes toward the piloted toolkit is high
Patient care plans are reflective of the essential components of quality care
There is consistent uptake of the toolkit across the region
OUTPUT: Increasing number of clinicians who access the LDOL care plan pathways (Map hits) after 6 months)
OUTPUT: On-going education programme is in place (after 6 months)
All people in Hawke's Bay with palliative care needs and their families/whanau have access to consistently high quality care in the last days of life and there is better dying and grieving
Pilot
Implementation
Evaluation
Consultation

7.2

Hawke's Bay Last Days of Life Care Plan and Toolkit

Evaluation and Pilot Report April 2017

ABSTRACT

An integrated Hawkes Bay District Health Board Working Group, was given the task of designing, implementing and piloting a care plan and supporting documents for a person's last days of life. This plan and associated documents are based on Te Ara Whakapiri - The Principles and Guidance for the Last Days of Life. This evaluation report has been prepared to outline the findings of the pilot and inform future recommendations of implementation.

ACKNOWLEDGEMENTS

This report has been prepared by Sarah Nichol on behalf of the Cranford Hospice Leadership Team. This report was commissioned to evaluate the pilot trial of the Hawke's Bay Last Days of Life Care Plan and Toolkit implemented into five Aged Residential Care Facilities, Inpatient Unit Cranford and a Medical Ward in Hawke's Bay Hospital.

As the author of this report, I would like to thank all the people who have provided information and feedback for the purpose of this evaluation

Thanks to the members of the Integrated Working Group and to the areas that agreed to pilot these tools:

Integrated working group

- Leigh White (DHB)
- Karen Franklin (Cranford Hospice)
- Sarah Nichol (Cranford Hospice)
- Ann Gray (DHB/Cranford Hospice)
- Joan McAsey (Hastings Health Centre)
- Irene O'Connell (Eversley ARC)
- Jo Loney (Cranford Hospice)
- Sue-Mary Davis (Cranford Hospice)
- Liz Beattie (Masonic)
- Trish Freer (PHO)

Pilot Sites

- Cranford Hospice In-patient Unit
- HBDHB Ward A1
- Brittany House Residential Care
- Mary Doyle Life Care Trust
- Taradale Masonic Resthome
- Atawhai Lifestyle Care
- Gracelands Lifestyle Care

CONTENTS

EXECUTIVE SUMMARY

An integrated service working group consulted, designed, produced and after consultation, a Hawke's Bay "Last Days of Life Care Plan" and "Tools and Resources to Guide the Care of People in Their Last Days of Life" (collectively known as "Toolikit").

The toolkit was based on Te Ara Whakapiri – The Principles and Guidance for the Last Days of Life and are practical tools intended to support equal access to the best quality of care for all people with palliative care need regardless of setting. A key point of difference for the Hawke's Bay version is the inclusion of a planning tool section that involves taking the findings of an initial assessment to develop a plan of care that is individualised to the patient.

This evaluation was commissioned by the Leadership Team at Cranford Hospice, and the Integrated Hawkes Bay District Health Board (HBDHB) working group. The evaluation priorities were limited to short term outcomes, related to feedback on the usability, confidence and satisfaction with the document. The quality of actual care provision was outside the scope of the evaluation, however the level of documented evidence of care was reviewed.

Nursing and some medical staff (N26) that worked with the document during the trial period provided feedback via focus groups, informal written and verbal interview and in writing through communication journals. In addition, care plans (N19) and patient records were reviewed at each site using a consistent tool developed for in the evaluation.

The evaluation showed that the pilot was successful in achieving its short term goals. The above evaluation methods and data sources provided consistent findings and those key standards were:

- The peer review of the patient files showed that **most of the components of the documentation were completed** as instructed therefore providing evidence that the principles of quality care were applied.
- There were **some suggestions for improvement** to the tool which were mostly for user ease, with few that may have implications on patient care if not rectified.
- **Most of the staff that were involved in the use of the tool were supportive of the permanent use of the tool** as part of their organisational policy. This included 100% support for use in ARC settings; while there was a universal view that it was not suitable for continued use in the Cranford Hospice IPU. There was 100% support for its use in the HBDHB Ward that piloted the tool, however this finding should consider that the tool could only be used in one case.
- The pilot successfully achieved its outcomes within set timeframes apart from the unexpected delays in starting in the HDBHB and the resulting small data pool.

> *"it's straight forward, doesn't need instructions….and it is a refreshing stand-out colour"*
> *'worked well, leaves no ambiguity i.e. who to ring, what to do post passing away……"*

The integrated approach of the tools development, the implementation of the pilot and the evaluation have appeared to enhance relationships across services and provides an opportunity for on-going peer review and data benchmarking which has recently been identified as an outcome measure in the Hawke's Bay Regional Palliative Care Strategic Plan – Live Well Stay Well Die Well 2016-2026.

Recommendations

- A regional commitment to the consistent use of the localised version of the careplan and toolkit (presented with this report based on changes identified during evaluation)
- Continued resourcing and full 'roll out' in Aged Residential Care settings
- Cranford Hospice to discontinue use of the paper tool and consider alternatives
- Hawkes Bay District Health Board should consider continued use
- On-going integrated peer review and data analysis should be fostered.

INTRODUCTION

Background

An international and national review in 2013 resulted in the phasing out the Liverpool Care Pathway (LCP) , however many service providers providing palliative care reported that there is still a requirement for a care planning tool for last days of life. It was noted in HB that tools were being used based on the "old" LCP framework and that these tools are not representative of: individualised care planning, not supported by education, quality review, or audit. In response to this, key stakeholders within Hawke's Bay drafted a localised care plan and toolkit. In May 2016 HBDHB Executive Management (EMT) and respective clinical councils were presented with a proposal to review and consequently endorsed ongoing work as outlined below:

- A proposed pilot to trial the HBDHB Last Days of Life Care Plan and Toolkit (Draft) in five nominated Aged Residential Care (ARC) Facilities, Cranford Hospice Inpatient Unit and a Medical Ward in HB Hospital
- An evaluation review of the pilot was commissioned and to be completed by Cranford Hospice. Key to the evaluation was to measure the HBDHB tools against the national guidance document Te Ara Whakapiri and other national tools.

What are we wanting to achieve with the Pilot? (Appendix 1: Logic Model)

- That the HBDHB Last Days of Life Care Plan and Toolkit assists in achieving all the components of care outlined in Te Ara Whakapiri. Note: Outside this scope of evaluation is investigating the quality of care provision and the direct impact on service users was not evaluated.
- Gain learnings from providers and suggestions for improvement

Description of Pilot

This Pilot was trialled in Cranford Hospice In-patient Unit, HB Hospital Ward A1, Britany House, Mary Doyle Life Care Trust, Taradale Masonic, Atawhai Lifestyle Care and Graceland Lifestyle Care.

The pilot was undertaken by Cranford Hospice, with a key focus on providing education to the workforces on the purpose and the "how to" use the tool. In ARC support in practice was overseen by the Cranford Hospice ARC Liaison Nurses and in HB Hospital support was provided from Clinical Nurse Specialist.

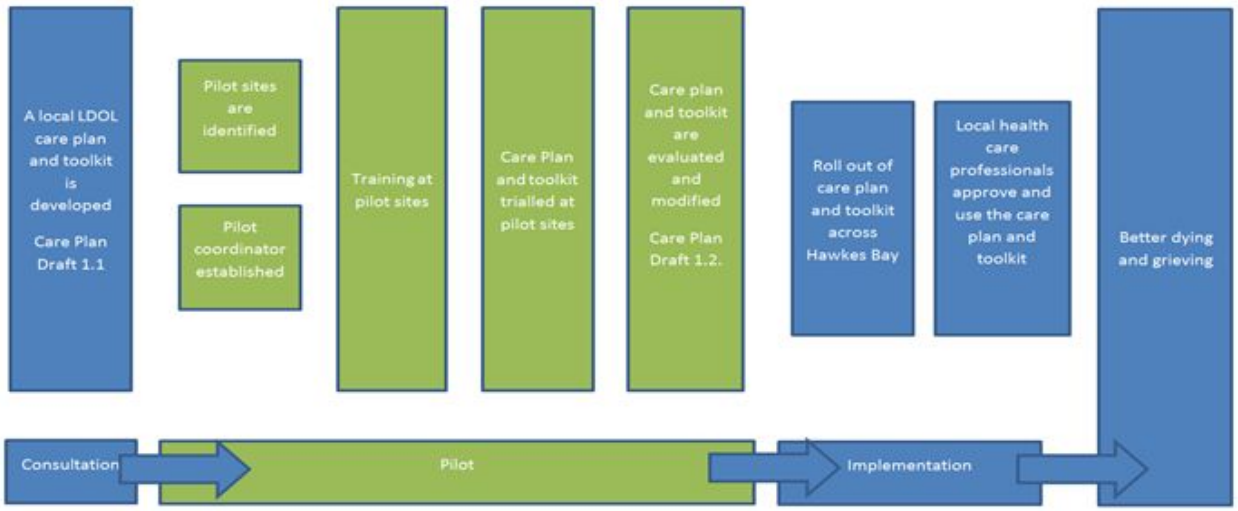


Figure 1: Demonstrates the pilot processes phases of: sites identified, co-ordinator established, training at sites and evaluation. (FROM ORIGINAL PILOT PLAN)

EVALUATION APPROACH

This evaluation was completed as part of the predetermined pilot plan, August 2016 (figure 1). Ultimately, the evaluation seeks to answer the questions:

Evaluation Question 1. How successfully did the pilot achieve its' outcomes?
Evaluation Question 2. How ready is the LDOL Care Plan and Toolkit for final roll-out?

During the project and evaluation planning stage, a logic model was developed (refer to Appendix 1) to illustrate the key project pilot activities and the intended outcomes This model was developed based on the HBDHB and PHO communication documents authored by Leigh White and; the Pilot and Draft Evaluation Plan developed by C. Dempers in August 2016. NOTE: Outputs included on the model link to the Map of Medicine LDOL Pathway Evaluation Plan outputs.

The pilot and evaluation schedule was effected by an unexpectedly low number of deaths in some sites and the medical strike and staffing issues at the HBDHB. Key short term outcomes from the logic model (highlighted in pink) were selected as priorities based on the need for useful data to inform further developments and roll out, and that is most practical to evaluate (Appendix 1). Table 1 shows the evaluation priorities and the methods for obtaining related evidence.

Table 1. Success definition table (criteria) – outlines the priorities for the evaluation

Priority	Criteria (what will a successful outcome look like?)	Sources of data	Methods
➢ Measure whether the care plan does indeed promote achieving the aims of the national guidance document Te Ara Whakapiri.	The care plan assists in achieving all the components of care outlined in Te Ara Whakapiri	Patient notes	Data analysis Documentation review
➢ Gather suggestions for improvement of the care plan and toolkit from the pilot users.	Site specific and generic suggestions for improvement are captured	Staff at pilot sites ARC Link Nurses	Interview
➢ Gauge support for the care plan and toolkit before roll-out.	Support for the care plan and tool kit is gauged		

Peer audit of patient files was completed by two to three members of the evaluation team using a pre-determined audit tool based upon the components of care outlined in Te Ara Whakapiri (see Appendix 2). Results were analysed as internal audits are using basic descriptive methods looking for trends.

Focus group discussions were facilitated using a discussion guide (see Appendix 2). The discussions at each site were minuted by an objective observer. The observer and facilitator met after each session to establish and record themes and key points from each focus group. The quality of actual care provision was outside the scope of the evaluation, however the level of documented evidence available was reviewed.

Criteria for success (Table 1) were defined by the evaluation team based on a predetermined merit rating rubric of Poor - Moderate - Good - Excellent and methods for obtaining evidence were aimed at measuring the level success – see table 2 below.

Evaluation Findings

Pilot sites were provided an opportunity to contribute to the evaluation via focus groups (Appendix 2), by informal written, verbal interviews and in writing through communication journals. A total of twenty-six nursing and medical staff that had worked with the documents during the pilot period provided feedback (figure 2). In addition,

nineteen care plans and patient records were reviewed at each site* using an audit tool specifically developed for the evaluation (Appendix 2). Note: during the trial period in the HB Hospital medical ward one person died, for this reason, the data related to the completion of the document was focused on the feedback from staff.

Table 2. Standards for determining merit (rubric) – conclusion (SHORE, 2015)

Rating	Explanation
Excellent	Peer audit of patient files shows almost all of components are achieved. There are very few suggestions for improvement of tool. All are in support of the care plan and toolkit.
Good	**Peer audit of patient files show most of components are achieved:** - completed documents provided evidence of the application of the principles of Te Ara Whakapiri. **Most are in support of the care plan and toolkit:** - 100% support for use in ARC settings - universal view that it was not suitable for continued use in the Cranford Hospice IPU. - 100% support for its use in the HBDHB Ward that piloted the tool (however this finding should consider that the tool could only be used in one case). - those involved in the pilot appeared engaged and committed to actively and critically use the care plan and toolkit in practice - care plan and toolkit enhanced their ability to plan care for patients in the last days of life **There are some suggestions for improvement of tool (user ease).** - Almost all the suggested improvements to the tool were repeated by multiple parties and the issues associated with the problems were also confirmed during the review of notes e.g. sections that were unclear were also often not completed fully. - feedback relating directly to the template and toolkit are detailed in Appendix 3. The use of this feedback will contribute to a continued sense of ownership for those using the tool and has the potential to greatly improve the quality of the document.
Moderate	Peer audit of patient files show at least half of the components are achieved. There is a significant amount of suggestions for improvement of tool. At least half are in support of the care pan and toolkit.
Poor	Peer audit show less than half the components are achieved. There is a significant amount of suggestions for improvement of tool. Few people are in support of the care plan and toolkit.

Focus groups were established and discussions were facilitated using a discussion guide (Appendix 2). A total of 14 ARC Nurses, 6 Cranford Hospice Nurses, 3 secondary care nurses and 2 medical staff and 1 GP participated in face to face feedback sessions or provided written feedback.

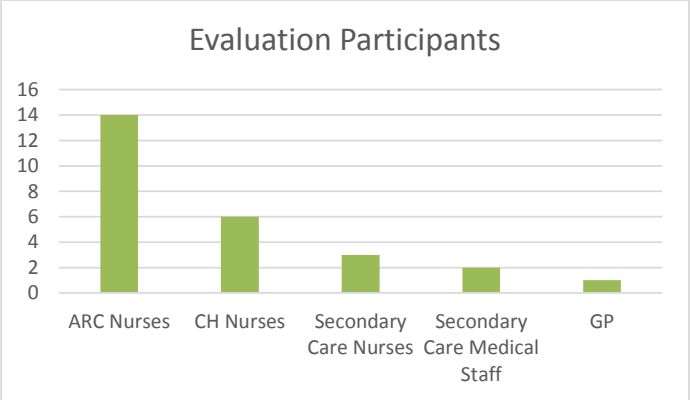


Figure 2: Illustrates breakdown of evaluation participant sources

The discussions were documented and later, themes and key points from each focus group were agreed by the three working groups members present at each session. Each site was also provided a communication journal to provide feedback and these were collected and collated.

*Current staff from Brittany House did not participate in the focus groups. The Clinical Lead in place at Brittany House during the pilot moved to another participating facility and provided feedback.

7.2

Evaluation Question 1: How successfully did the pilot achieve its' outcomes?

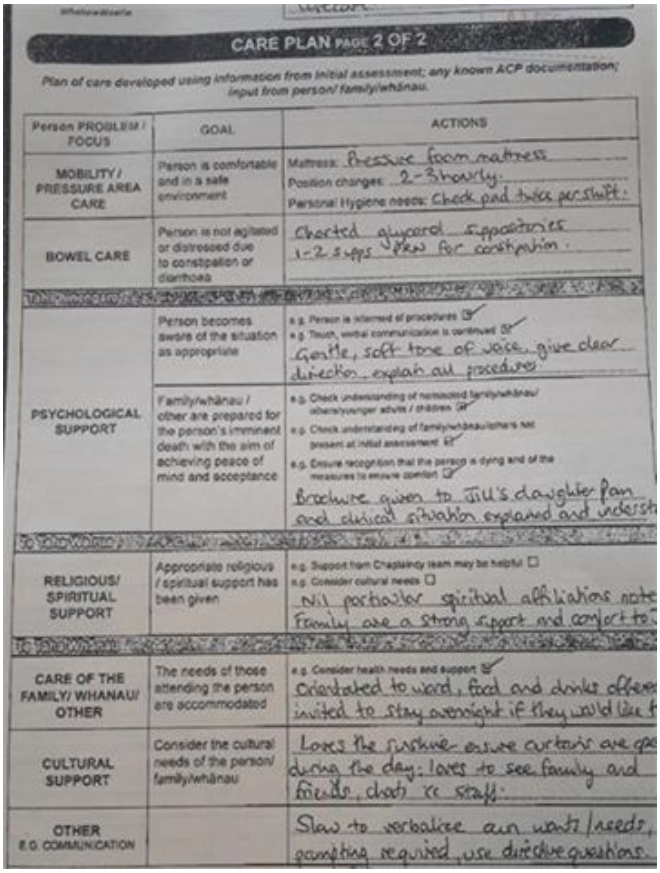
→ There was 100% support for its ongoing use in the ARC and HBDHB

"It's more manageable than the LCP was"
"gives us hints for what to look for in a palliative patient"
"it keeps focus and prompts when you are busy"
"GPs are on board because you can fax their part to them"
"it's straight forward, doesn't need instructions….and it is a refreshing stand-out colour"

→ There was universal view from Cranford Hospice nursing staff NOT to continue using the tool in the IPU setting.

"PalCare care plans make more sense for us and we do them well"
"It doesn't really make sense to move to paper notes at that stage"
"I can see how it was be very useful in the ARC setting, but not here"

→ Completed care plans were most often of a high quality and illustrated a clear understanding and application of the principles of Te Ara Whakapiri. Example below (figure 3) highlights the individualised care component unique to the Hawkes Bay toolkit.



CARE PLAN PAGE 2 OF 2

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

Person PROBLEM / FOCUS	GOAL	ACTIONS
MOBILITY / PRESSURE AREA CARE	Person is comfortable and in a safe environment	Mattress: Pressure foam mattress Position changes: 2-3 hourly. Personal Hygiene needs: Check pad twice per shift.
BOWEL CARE	Person is not agitated or distressed due to constipation or diarrhoea	Charted glycerol suppositories 1-2 stat PRN for constipation.
PSYCHOLOGICAL SUPPORT	Person becomes aware of the situation as appropriate	e.g. Person is informed of procedures ☑ e.g. Touch, verbal communication is continued ☑ Gentle, soft tone of voice, give clear direction, explain all procedures
	Family/whānau / other are prepared for the person's imminent death with the aim of achieving peace of mind and acceptance	e.g. Check understanding of normalized family/whānau/ others/younger adults / children ☑ e.g. Check understanding of family/whānau/others not present at initial assessment ☑ e.g. Ensure recognition that the person is dying and of the measures to ensure comfort ☑ Brochure given to Jill's daughter Pam and clinical situation explained and underst
RELIGIOUS/ SPIRITUAL SUPPORT	Appropriate religious / spiritual support has been given	e.g. Support from Chaplaincy team may be helpful ☐ e.g. Consider cultural needs ☐ Nil particular spiritual affiliations note Family are a strong support and comfort to
CARE OF THE FAMILY/ WHANAU/ OTHER	The needs of those attending the person are accommodated	e.g. Consider health needs and support ☑ Orientated to ward, food and drinks offere invited to stay overnight if they would like t
CULTURAL SUPPORT	Consider the cultural needs of the person/ family/whānau	Loves the rugby- ensure outcome are go during the day: loves to see family and friends, chats to staff.
OTHER E.G. COMMUNICATION		Slow to verbalise own wants/needs, prompting required, use directive questions.

Figure 3. Example completed page from care planning section showing individualised care

Evaluation Question 2: How ready is the LDOL Care Plan and Toolkit for final roll-out

→ Since the completion of the pilot period ARC sites have continued to use the tool and report a general satisfaction that it meets their needs and fills the 'gap' left by the removal of the LCP.

→ The key criticisms of the LCP have been addressed with the Hawke's Bay version, including supporting individualisation and other principles outlined in Te Ara Whakapiri (figure 2)

→ There are changes required in response to feedback which will require resourcing to make the alterations and produce a final version.

→ After each focus group and site visit, the evaluation team debriefed and concurred that there appeared to be a sense of ownership and engagement from staff using the HBDHB document and the evaluation process provided a positive inter-organisational communication opportunity.

→ Feedback from HBDHB staff was generally supportive of its use in that setting, while also feeding back some challenges and suggestions (improvements included in appendix 3)

Lead physician: *"most of the paperwork was easy, but…"*
House surgeon and Registrar: *"straightforward, easy to follow, but…."*
'*worked well, leaves no ambiguity i.e. who to ring, what to do post passing away……"*
"*found it really good to use……was easy to use and went in a logical manner.*

→ There were several suggestions for improvements for the tool, however few were 'significant' and all of which are outlined Appendix 3 from staff at all sites.

CONCLUSIONS

The HB Localised LDOL Care plan and toolkit was developed and trialled successfully per the predetermined plan with only minor delays resulting from uncontrollable factors. The evaluation process showed evidence of a commitment from participants in the trial to engaging in the use of the tool and in the critical analyses of its application. The feedback from participants can be used to directly improve the usability and impact of the tool on care planning for people at the end of life.

The review of the Liverpool Care Pathway found that "generic protocols are not regarded as the right approach to caring for dying people; care should be individualised and reflect the needs and preferences of the dying person and those who are important to them". The Hawke's Bay Localised version includes a care planning section which other versions do not. This evaluation highlighted the value of this added component.

Participants of the pilot expressed universal support for the full roll out of the document across the region in a variety of settings, excluding those that primarily use electronic health records as this was found to be an inefficient way of documenting care.

Due to the engagement of staff that worked with the document and the apparent positive relationship building aspect of this pilot, it is predicted that the modification and roll out of the localised version would be received well and further enhance integration in palliative care across settings

This piece of work supports two significant documents:

a. Ministry of Health Palliative Care Action Plan: – Priority 3 action (2017): "*Implement Healthy Ageing Strategy action: Support the implementation of the Te Ara Whakapiri Principles and guidance for the last days of life"*.
b. HBDHB Live well, stay well and die well, Palliative care in HB[i]: actions required: *"Last Days of Life (Te Ara Whakapiri) pathway is developed and implemented across the region"* with an outcome

of "*100% of ARC facilities and hospital wards have implemented the Last Days of Life (Te Ara Whakapiri) supported by Specialist Palliative Care services".*

RECOMMENDATIONS

The evaluation concluded with HB Last Days of Life Integrated Working Group being reconvened to consider findings and contribute to the development of the following recommendations:

1. During the evaluation (April 2017), a National Toolkit was produced by the Ministry of Health Working Group. The Integrated Working Group considered the new national tool and based on this evaluation, **recommend making the proposed changes the localised version and** making a commitment to rolling out this version. This is due to the inclusion of a planning tool section that involves taking the findings of an initial assessment to develop a plan of care that is individualised to the patient and the sense of ownership that the contribution to its development has resulted in.
2. ARC settings should continue to **resource the permanent use** of a LDOL care plan and toolkit due to the universal support from staff who have or are using it and the evidence of high quality care planning that the tool supports.
3. Cranford Hospice IPU should continue to review the quality of care planning using PalCare alongside the standards outlined in Te Ara Whakapiri **without the use of the paper tool**. Staff should be supported to remain familiar with the toolkit to support and champion its use in other settings. The concept of using the toolkit in the community setting should remain on agenda for consideration.
4. Only one patient died during the very short trial period in the HBDHB ward, for this reason, the data related to the completion of the document was focused on the feedback from staff. The HB Hospital should continue to resource the rollout of the LDOL toolkit across appropriate Hospital wards **if the feedback in this evaluation** is considered sufficient.
5. **On-going peer review and data analysis** should be planned to make use of the valuable information that can be obtained and shared as experienced in this evaluation. This may be useful in informing education and resourcing needs.
6. Commitment by participants to engage in the trial and implement. **Participants need to be commended** for their obvious commitment to the pilot and engagement in the feedback. This resulted in excellent and relevant feedback that will be easily applied to make improvements to the document and supporting education content.
7. The toolkit to be reviewed in 2 years by relevant stakeholders.

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i. Palliative Care Council. (2015*). Te Ara Whakapiri – Principles and guidance or the last days of life*. Palliative Care Council: New Zealand

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iii. Tools and resources to guide the care of people in their last days of life, Integrated HB DHB Working Group, 2016.

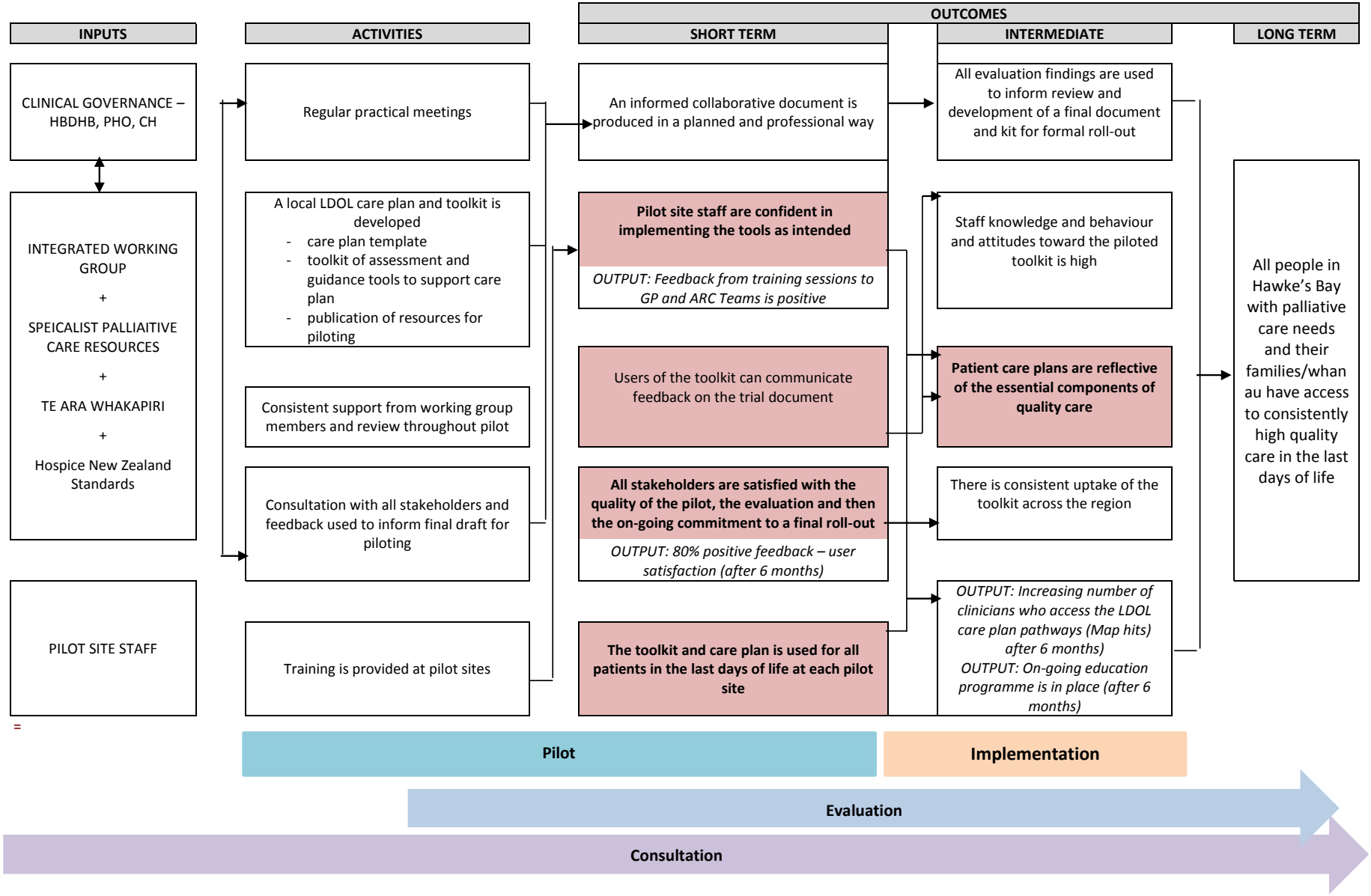
iv. SHORE & Whariki Research Centre. (2013). *Evaluation Workbook.* Massey University. School of Public Health

v. Ministry of Health Te Ara Whakapiri: http://www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life

vi. HBDHB. (2017) Live well, Stay well, Die well - Palliative Care in Hawke's Bay 2016-2026

HAWKE'S BAY LAST DAYS OF LIFE CARE PLANNING TOOLKIT PROJECT PLAN 2017 – LOGIC MODEL **APPENDIX 1**

7.2



Cranford Hospice - April 2017

EVALUATION TOOLS **APPENDIX 2**

Evaluation of the Pilot: Last Days of Life Care Plan and Toolkit – AUDIT TOOL			
Audit tool (based on pg. 44-48 Te Ara Whakapiri) was developed specifically for peer audit of patient records – Summarised for this report.			
Audit criteria	**No evidence**	**Evidence found**	**Unsure**
Has it been recognised that this person is / is at risk of entering the last days of life?			
Has a lead health practitioner been identified?			
Has the family been informed of how to contact this person?			
Physical needs are assessed and documented in care plan			
Family is consulted in developing the individualised care plan			
Review of, and anticipatory prescribing for core LDOL symptoms			
The person is aware of their changing condition?			
Consideration of food and fluids			
Consideration of ICD			
Persons preferences for EOL are assessed			
Communication barriers are identified and addressed if applicable			
Family is aware of changing condition			
Cultural needs are discussed and addressed			
Info about the facilities is provided to family			
Spiritual needs of person and family are identified and addressed			
There is ongoing assessment of the person's care			
Changing spiritual needs are discussed and addressed			
Death is verified and communicated to all services involved			
Family is informed of death.			
Info given to family about what to do next			
Family bereavement needs are assessed.			
Info given to family about support available			
Environment offers private space to meet needs of family			
The audit initially required a score to be assigned to each question. The evaluation team decided that this data was difficult to complete and did not add to the description of care plan application. It was not possible to access evidence of prescribing due to the use of electronic prescribing			

FOCUS GROUP DISCUSSION GUIDE

- Each pilot site will be offered the opportunity to have a focus group facilitated by the Cranford Hospice ARC Liaison Nurse Team on location at a time and date that is mutually agreed.
- The payment of staff to attend, and which staff members attend, will be at the discretion of the ARC Facility Manager. There is no budget in this evaluation to provide that funding.
- An invitation explaining the intention of the group will be made available for individual participant recruitment as identified.
- Tone is intended to be fun and promote open self-disclosure of feedback and experience related specifically to the Last Days of Life Care Pathway.
- The session will be structured as follows, but flexible enough to allow facilitator to use judgement and moderate as necessary:

Facilitators: Jo Loney and Sue Mary Davis Assistant (notes): Sarah Nichol

The following questions will be asked one at a time:

Opening question: What has your experience of the care plan and the toolkit been?
Introductory question: What are some of the benefits of the care plan and toolkit?
Introductory question: Can you give examples where the tool has worked well?
Transition question: Can you give examples of challenges you have experienced using the care plan and toolkit?
Key question: What would you like to see changed with the care plan and toolkit?
Key question: Is there anything else you would like to say about the care plan and toolkit?
Ending question: Are you supportive of the care plan and toolkit?
Thank you and negotiate to agree on the best way to share with the group the evaluation report and recommendations. Jo, Sue Mary and Sarah to debrief after the session and to identify factors that stood out – notes made.

Krueger, Richard A. and Mary Anne Casey (2000). Focus Groups: A Practical Guide for Applied Research. 3rd Edition. Thousand Oaks, CA: Sage Publications.

This measurement was evaluated against the national guidance document Te Ara Whakapiri.

→ The principles of care for people in their last days of life (pg. 17, Te Ara Whakapiri)

→ The minimum components of service delivery required for quality care (pg. 44-48, Te Ara Whakapiri

Findings from Aged Residential Care Facilities (ARC)

A peer review of patient files was completed by Cranford Hospice Quality Coordinator and both ARC Liaison Nurses using a pre-determined audit tool based upon the components of care outlined in Te Ara Whakapiri (pg. 44-48). Each pilot site provided access to patient LDOL care plan notes and between 2 and 4 notes were randomly selected for review. A total of 18 notes from ARC settings were reviewed and some key themes were identified. Detailed findings are recorded:

→ Reviewers were unable to assess evidence of anticipatory prescribing in relation to LDOL and the toolkit as it had not been anticipated that the pilot sites use electronic prescribing. Verbal feedback suggested that this was not an area of concern and that generally prescribers are pre-emptively charting medication for symptoms common in the last days of life (sometimes with prompting from the assessing nurse). The initiation of the care plan was at times a prompt for this discussion.

→ Many of the care plan examples had sections on cultural and spiritual needs left blank, and did not include evidence of any related conversation or assessment.

→ The final page relating to after death actions was inconsistently used, which was predicted, due to each facility having their own checklists. Staff believed that the LDOL tool was of added use (alongside existing forms), but some work is required to ensure it is most effective.

→ The progress notes remained thorough and staff did not revert to "Variance Reporting" which is the intention of the tool as it reduces the amount of documentation required.

→ Reviewers did not investigate the number of residents that died without the use of the toolkit.

→ Some clarity is required about whether a nurse can start the care plan without the approval of the GP.

→ There was a clear commitment from nursing staff to use the care plan to its fullest capacity – see example figure 3

Findings from Hawkes Bay Hospital

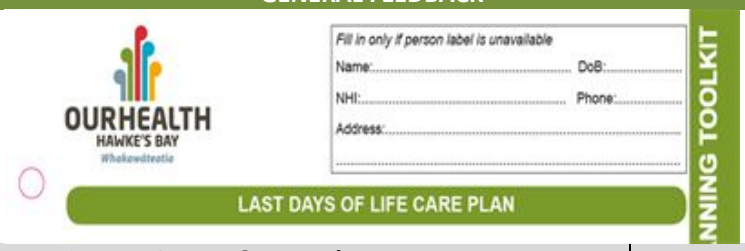
Only one patient died during the very short trial period in the HBDHB ward. For this reason, the data related to the completion of the document was focused on the feedback from staff:

- Medical Staff both indicated that "could have been helpful to have an area to put in a diagnostic summary to date at commencement of the care plan. I felt a little uncomfortable that if anybody needed to see the patient for new symptoms or whatever that would have had to refer back to the main file to get an idea of what the clinical problems were" "it would have been helpful to have a box on the front with diagnosis or the course that led the patient to the LDOL care plan"
- "A challenge is the length (for some who don't like to document things.)" …. "Initially thought it was quite a large document and found it a bit daunting"
- "Liked the resources attached to it and thought the card of how to talk to people and the prompts were really useful especially for younger nurses and new graduates……."
- "Spent some time going through the resource stuff and there were lots there to be used".
- "Liked being able to see all the things to monitor i.e., secretions and the variants on the same page"….. "Helped to see the trend of what was happening."
- "Also, felt some sort of summary in the front about the patient. On the ward, we put the old notes away. If we needed to know anything about them, we would have to go through the old notes which are often put in a different place. Not a big history just bullet points about how they got to the point they are at. Can't be too much otherwise the doctors won't want to fill it out"

Findings from Cranford Hospice IPU

- During the trial period in the IPU (10 October to 31 December 2016) there were 22 deaths. In 12 of those cases the LDOL care plan document and toolkit was implemented. While there were 3 obviously sudden deaths, this does illustrate that staff did not perceive the care plan as adding value to the care they provided, consistent with verbal feedback.
- Where the LDOL tool was used, the level of completion of the document was variable and in almost all cases the patient's electronic notes continued either as an overlap or in one or other location. A reminder that electronic notes should be discontinued during the trial, however the practice continued. The associated risks with having notes in different locations outweighed the benefits of using the paper tool and the Cranford Hospice Clinical Governance Team elected to urgently remove the tool from use as soon as this was identified as part of the evaluation.

COLLATED DATA SPECIFIC TO CARE PLAN

GENERAL FEEDBACK	
	
ARC Focus Groups & Journals	**Notes Review**
• "More manageable than LCP" • "Straight forward – a good thing" • "Gave us hints for what to look for in a palliative patient" • The colour is great – it is a refreshing colour. • Can this decision be made by and RN? At times the care plan was initiated by nurses at times with the doctor coming later and other times the LDOL section is faxed to the doctor to complete. • It doesn't overlap with other forms. It is "not repetitive – great prompts and even if we have the information somewhere else, it is a good way to check the most important things" • Easy to use – don't need instruction • "great, very positive about it" • "it keeps focus and prompts you when you are busy" • "GP's are more on-board with this because you can fax it to them" • "Does the Doctor NEED to be informed?" • "The name LDOL makes so much more sense than the LCP as it actually says what it is" • Reasons for the tool not being used where could have included: • Communication with GP • Difficult family • Disagreement with GP that the person is LDOL • APPEARS that there continues to be people giving the whole document to the family. • "It works well because the assessments page has all the information about the person.	• Patient labels were often not used and instead nurse handwritten details in its place. Is this because their labels are too big or something? Must be time-consuming. • "A few missed opportunities" to initiating the care plan – "waiting for the OK"
CRANFORD HOSPICE IPU Focus Groups & Journal	**Notes Review**
• Moving to paper notes feels like "a backward step" for many staff. Other negative consequences of using paper notes mentioned included: • Difficulty for FST to access/track down paper notes e.g. communicating with NASC	• Multiple deaths did not apply the LDOL pathway e.g. 10/22 (3 were sudden deaths).

Cranford Hospice - April 2017

OVERALL FINDINGS – CARE PLAN AND TOOLKIT **APPENDIX 3**

- Handwritten notes are harder to read, especially for those staff with English as a second language
- It is "time consuming"
- Bereavement follow up is not as easy to access the notes on how the death was etc.
- Most staff reported preferring the care planning system on PalCare and believe adequate information is held on the electronic notes.
- "a picture builds on PalCare over the course of time and moving to paper notes interferes with that"
- "it is not as easy to track medication changes e.g. doses etc."
- Acknowledged that there has been an improvement in the quality of information on PalCare since audit 12-24 months ago, with the use of a care plan issue template. *Routine audits still show some inconsistency with that however and still room to improve.*
- General feeling that the LDOL care plan is "less personable than PalCare allows"
- Universal support for this being useful in a non-specialist setting.
- No person providing feedback supported the continued use of the tool in the IPU
- Some support for a one page checklist however.
- "Where does this go on PalCare?" "it is cumbersome and clumsy"

- When LDOL pathway was used, PalCare notes also continued in detail – in both places and referring to each other.
- Not all care plans were completed. Medical staff completed other sections.
- Progress notes remained thorough and multidisciplinary. Pharmacist only wrote in PalCare.

WARD STAFF FEEDBACK TO HPCT CNS	Notes Review
• 'worked well, leaves no ambiguity i.e. who to ring, what to do post passing away. A challenge is the length (for some who don't like to document things.)' • 'Worked well. Benefits are specifically asking about the symptoms we need to look at. A challenge was not sure about starting it- otherwise it's easy to use.' • (The nurse who completed the initial assessment): "found it really good to use. Initially thought it was quite a large document and found it a bit daunting. • Took a couple of attempts to fill it out as struggled to find the time. Felt there was nothing to change as it was more an unfamiliarity with the document and that with more use it would get better. • Was easy to use and went in a logical manner. • Liked the resources attached to it and thought the card of how to talk to people and the prompts were useful especially for younger nurses and new graduates. • Spent some time going through the resource stuff and there were lots there to be used. • We would have to go through the old notes which are often put in a different place. Not a big history just bullet points about how they got to the point they are at. Can't be too much otherwise the doctors won't want to fill it out.	• Generally, well completed

FRONT PAGE – DECISION TREE

ARC Focus Groups	Notes Review
• No mention of this page in any of the focus groups or journal entries	• Unclear if should be completed or just used as a guidance flowchart. • At times ticked – others not.

OVERALL FINDINGS – CARE PLAN AND TOOLKIT — APPENDIX 3

CRANFORD HOSPICE IPU FOCUS GROUPS	Notes Review
• Some discussion regarding prognostication e.g. Patients admitted for terminal cares and then later discharged	

HBDHB WARD STAFF FEEDBACK TO HPCT CNS	Notes Review
• From the medics (lead physician): 'most of the paperwork was easy but could have been helpful to have an area to put in a diagnostic summary to date at commencement of the care plan. I felt a little uncomfortable that if anybody needed to see the patient for new symptoms or whatever that would have had to refer to the main file to get an idea of what the clinical problems were. Otherwise seemed good.' • House surgeon and Registrar: 'straightforward, easy to follow. Main feedback was that it would have been helpful to have a box on the front with diagnosis or the course that led the patient to the LDOL care plan.' • Also, felt some sort of summary in the front about the patient. On the ward, we put the old notes away. If we needed to know anything about them.	

NOMINATING LEAD PROVIDERS PAGE

LEAD HEALTH PRACTITIONER/S

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

If GP - See Page 3 for Contact Details

Nurse Practitioner .....

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

Primary Nurse .....

THIS PLAN SHOULD BE REASSESSED EVERY THREE DAYS

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

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

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

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

2 of 13

CRANFORD HOSPICE FOCUS GROUPS	Notes Review
• CH IPU staff reported that the Lead Health Practitioner concept did not apply in the IPU and by nominating a primary nurse, this was a barrier to other nurses changing the care plan if needed	• Often empty

SAMPLE SIGNATURE PAGE

PLANNING CARE

OURHEALTH HAWKE'S BAY

Fill in only if person label is unavailable

Name ..... DoB .....

NHI ..... Phone .....

Address .....

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

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

Name (print)	Full Signature	Initials	Professional Title	Date

ARC FOCUS GROUPS	Notes Review
• Several people mentioned the need for this page to be page 1 or 2 instead of page 6. • CH IPU staff reported that the Lead Health Practitioner concept did not apply in the IPU and by nominating a primary nurse, this was a barrier to other nurses changing the care plan if needed	• Appeared to be completed well • Often empty

MEDICAL OFFICER SECTION

OVERALL FINDINGS – CARE PLAN AND TOOLKIT **APPENDIX 3**

7.2

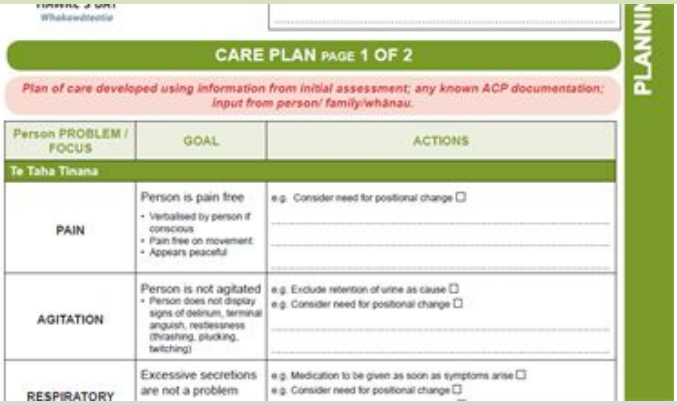
MUST BE COMPLETED BY MEDICAL PRACTITIONER

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

Individual/Specific Requests

ARC FOCUS GROUPS	Notes Review
• "GP section is not always being used" GP sometimes goes back to the usual medical progress notes. • GP reported being very pleased that the medical area is condensed compared to the LCP. • There are too many initial and date sections – it is not necessary. • Need contact number for pacing radiographer. • Need N/A option for ICD and organ donation section	• At times N/A handwritten. • At times 'no' has been ticked – unclear if this is due to interpretation of the question or not. E.g. no regarding hydration – appeared the doctor was say not necessary, when question is "was this considered/discussed" • Where no was ticked – there is not a prompt to tell the doctor to write explanation in the progress notes.
CRANFORD HOSPICE FOCUS GROUPS	**Notes Review**
• Should say "Yes, No or NA" • "Is pacemaker present" e.g. this does not need to be deactivated. • "any other implantable device"	• Doctor handwritten N/A in some instances

CAREPLAN SECTION



CARE PLAN PAGE 1 OF 2

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

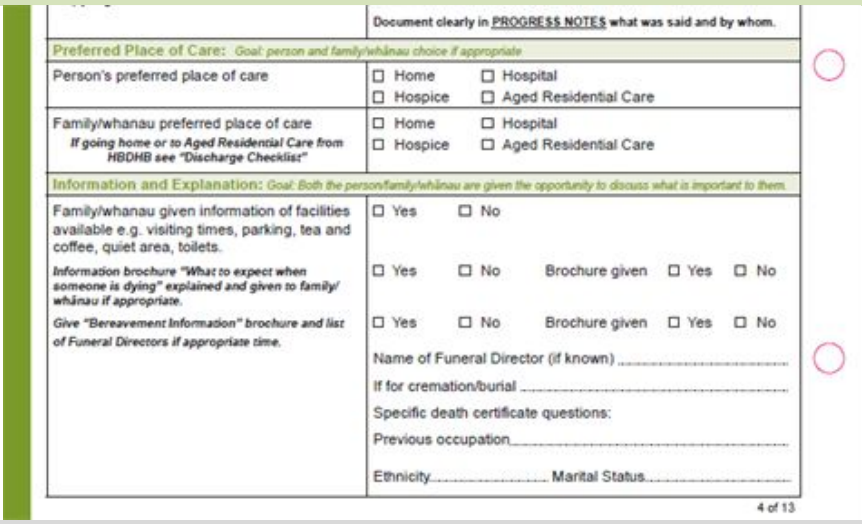
PLANNI

Person PROBLEM / FOCUS	GOAL	ACTIONS
Te Taha Tinana		
PAIN	Person is pain free • Verbalised by person if conscious • Pain free on movement • Appears peaceful	e.g. Consider need for positional change ☐
AGITATION	Person is not agitated • Person does not display signs of delirium, terminal anguish, restlessness (thrashing, plucking, twitching)	e.g. Exclude retention of urine as cause ☐ e.g. Consider need for positional change ☐
RESPIRATORY	Excessive secretions are not a problem	e.g. Medication to be given as soon as symptoms arise ☐ e.g. Consider need for positional change ☐

ARC FOCUS GROUPS	Notes Review
• Several people commented that the size of the ACTIONS boxes are too small • Suggestion that the "Actions" column should be named "interventions" • Suggestion that the examples in the action column don't say "e.g."	• Some care plans had symptoms or assessment details rather than actions in the column. • Some repeated the examples rather than just ticking them. • No place to indicate if family involved in the development of the care plan. • NO SECTION FOR FOOD AND FLUID • Difficult to add specific things like e.g. continue with insulin
Cranford Hospice IPU	**Notes Review**
• Not enough ability to document skin integrity e.g. wound care • "no ability to express care delivered other than progress notes"	• As above in ARC, with less detail at times

OVERALL FINDINGS – CARE PLAN AND TOOLKIT **APPENDIX 3**

FUNERAL DIRECTOR SECTION



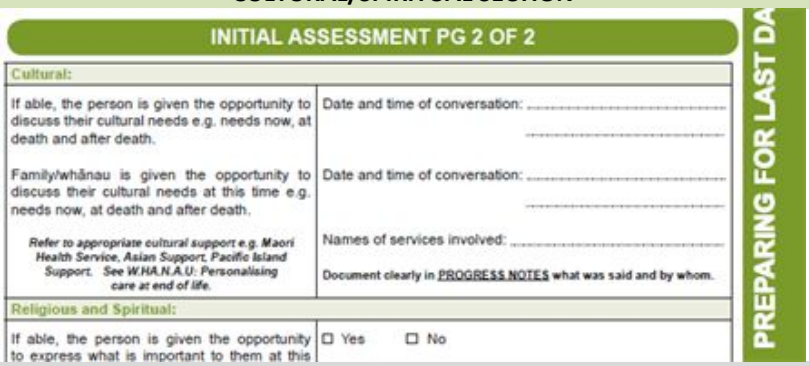
	Document clearly in PROGRES$ NOTES what was said and by whom.
Preferred Place of Care: *Goal: person and family/whānau choice if appropriate*	
Person's preferred place of care	☐ Home ☐ Hospital ☐ Hospice ☐ Aged Residential Care
Family/whanau preferred place of care *If going home or to Aged Residential Care from HBDHB see "Discharge Checklist"*	☐ Home ☐ Hospital ☐ Hospice ☐ Aged Residential Care
Information and Explanation: *Goal: Both the person/family/whānau are given the opportunity to discuss what is important to them.*	
Family/whanau given information of facilities available e.g. visiting times, parking, tea and coffee, quiet area, toilets.	☐ Yes ☐ No
Information brochure "What to expect when someone is dying" explained and given to family/ whānau if appropriate.	☐ Yes ☐ No Brochure given ☐ Yes ☐ No
Give "Bereavement Information" brochure and list of Funeral Directors if appropriate time.	☐ Yes ☐ No Brochure given ☐ Yes ☐ No
	Name of Funeral Director (if known) .....
	If for cremation/burial .....
	Specific death certificate questions:
	Previous occupation.....
	Ethnicity..... Marital Status.....

4 of 13

ARC FOCUS GROUPS	Notes Review
• One family "when I went to ask, all family members looking at me like what I am asking as their dad still alive, however the next day family told me that it given a chance for the family to discuss if and make a decision"	• Often not completed – left empty.

Cranford Hospice IPU	Notes Review
• "Lots of people don't want to talk about these things at a very stressful time and so it gets left blank".	

CULTURAL/SPIRITUAL SECTION



INITIAL ASSESSMENT PG 2 OF 2

PREPARING FOR LAST DA

Cultural:	
If able, the person is given the opportunity to discuss their cultural needs e.g. needs now, at death and after death.	Date and time of conversation: ....
Family/whānau is given the opportunity to discuss their cultural needs at this time e.g. needs now, at death and after death.	Date and time of conversation: ....
Refer to appropriate cultural support e.g. Maori Health Service, Asian Support, Pacific Island Support. See W.HA.N.A.U: Personalising care at end of life.	Names of services involved: ..... Document clearly in PROGRES$ NOTES what was said and by whom.
Religious and Spiritual:	
If able, the person is given the opportunity to express what is important to them at this	☐ Yes ☐ No

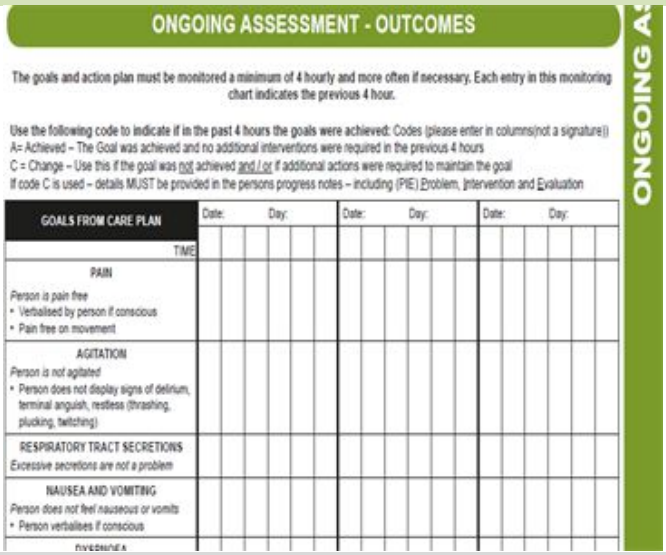
ARC FOCUS GROUPS	Notes Review
• Some staff mentioned difficulty in knowing what to ask of the family or patient. • Some said they felt that they have this information obtained over a long period and therefore is hard to decide what is most relevant.	• Incomplete in many notes.

Cranford Hospice IPU	Notes Review
• The HOPE tool is much better	• Empty in most cases. • In one case the doctor completed the whole tool, but asterixed (#) this section for the nurse to complete

OVERALL FINDINGS – CARE PLAN AND TOOLKIT **APPENDIX 3**

7.2

ON-GOING ASSESSMENT SECTION



ONGOING ASSESSMENT - OUTCOMES

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

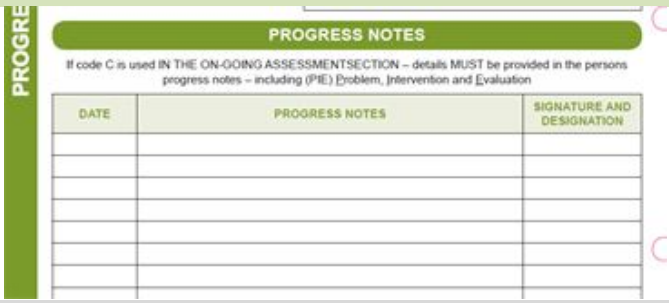
Use the following code to indicate if in the past 4 hours the goals were achieved: Codes (please enter in columns(not a signature))
A= Achieved – The Goal was achieved and no additional interventions were required in the previous 4 hours
C = Change – Use this if the goal was not achieved and / or if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

GOALS FROM CARE PLAN	Date: Day:	Date: Day:	Date: Day:
TIME			
PAIN *Person is pain free* • Verbalised by person if conscious • Pain free on movement			
AGITATION *Person is not agitated* • Person does not display signs of delirium, terminal anguish, restless (thrashing, plucking, twitching)			
RESPIRATORY TRACT SECRETIONS *Excessive secretions are not a problem*			
NAUSEA AND VOMITING *Person does not feel nauseous or vomits* • Person verbalises if conscious			

ONGOING A

ARC FOCUS GROUPS	Notes Review
• Suggestion that there should be one page for each day instead of putting 3 days on one page. • Some mentioned confusion about the number columns in each day. Some say that they • HCA's are not able to assess these things. • HCA's are not often involved heavily. • "Why aren't there times like there was with the LCP"	• At times, not all columns were used
CRANFORD HOSPICE IPU FOCUS GROUPS	**Notes Review**
• Not always easy to document on the right day. What about times?	
HBDHB WARD STAFF FEEDBACK TO HPCT CNS	**Notes Review**
• Liked being able to see all the things to monitor i.e., secretions and the variants on the same page. • Helped to see the trend of what was happening.	

PROGRESS NOTES



PROGRESS NOTES

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

DATE	PROGRESS NOTES	SIGNATURE AND DESIGNATION

PROGRE

ARC Focus Groups & Journals	Notes Review
• Most did, but some didn't seem aware that these notes were intended to be multidisciplinary. • Doctors at times reverted to usual medical progress notes despite the use of the sticker stating stop – now LDOL care plan. • Request that stickers be green also. • Need extra copies of progress notes with no page numbers	• Most did not use the code 'c' with issue and then the details of intervention as suggested. • Progress notes were very detailed. Almost all completed progress notes as they would normal notes e.g. not restricted to variances only. E.g. "no pain, no sob"
Cranford Hospice IPU	**Cranford Hospice IPU**
• Page numbers issue noted • Pages not always dated, which is an issue if they get out of order • Discomfort with variance based notes as this doesn't feel consistent with "if it is documented, it didn't happen"	• Notes recorded in both places • Patient labels not always put on all pages • Detailed notes showing achieved and changes in total – e.g. not variance based notes as intended

OVERALL FINDINGS – CARE PLAN AND TOOLKIT APPENDIX 3

FINAL OFFICES PAGE

ARC Focus Groups	Notes Review
• Some confusion over the term verification vs certification of death. • Need to add pharmacy to the list. • Everyone denied that they felt that this form overlapped with other forms in the organisation. Some organisations have a separate form, others not. • Discussed identification of bereavement support needs etc. and what follow up is possible.	• Verification of death is being completed, despite official meaning of the term. • Community providers section not very relevant

Cranford Hospice IPU	Notes Review
• Cremation / burial information should be on this page • Cremation forms require information about any surgery in the last 12 months, including the name of the surgeon • Needs part about coroner's case • Some felt that an "after death checklist was absent"?	

INSTRUCTIONS

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

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

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

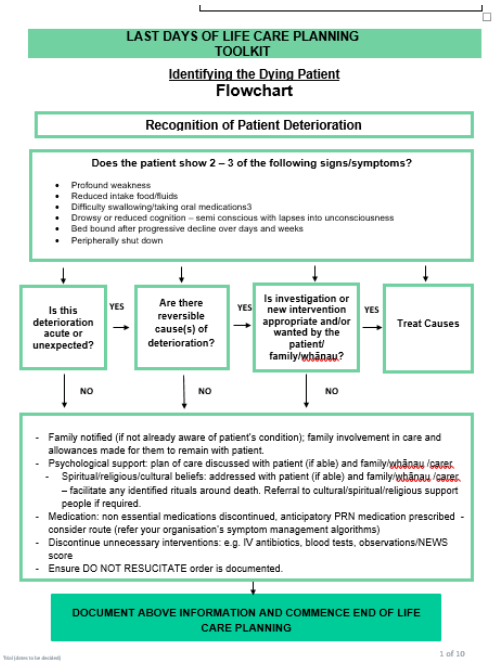
Criteria for the use of the care plan

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

Instructions for use

Document is organised in three parts and must link with the person’s clinical records. It is imperative to clearly communicate all decisions leading to a change in care, and document these conversations. This plan does not replace the need for accurate documentation in the persons’ clinical records (progress notes).

Preparing for last days of life:	Baseline assessment to identify priorities of care
Planning for care:	Person centred priorities of care
Ongoing assessment:	Regular assessments *(recommend 4 hourly or more often if required)* of the persons condition to ensure that changes are addressed in a timely manner.



References:
Ministry of Health (2015) Te Area Whakapiri Principles and Guidelines for the Last Days of Life. Wellington. Ministry of Health
International Collaborative for Best Car for the Dying Person www.mcpcil.org.uk
Ministry of Health. (2017). http://www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life

PLANNING CARE

OURHEALTH HAWKE'S BAY

First Name: _____ **Gender:** _____

Surname: _____

AFFIX PATIENT LABEL HERE

Date of Birth:_____ **NHI#:** _____

Ward/Clinic: **Consultant:**

ALL PERSONNAL COMPLETING THE LAST DAYS OF LIFE – CARE PLAN – PLEASE SIGN BELOW

You should also have and understood the 'Health care Professional' leaflet

Name (print)	Full Signature	Initials	Professional Title	Date

Lead health practitioner/s (this is the person's GP, hospital specialist or Nurse Practitioner)

Doctor: …… Pager contacts: (HBDHB) ……..

If GP – See Page 3 for Contact Details

Nurse Practitioner: …… Work number: ……After hours number: ……

Medical Assessment section completed ☐ Date:: …… Time: ……

This plan should be reassessed every three days

Reassessment date: _____Reassessment time: _____Signed_____

Reassessment date: _____Reassessment time: _____Signed_____

Reassessment date: _____Reassessment time: _____Signed_____

Discontinued date:…… Time:……

Reasons why this care plan was discontinued by MDT…….....

…….

Patient name:
NHI:
DOB:

CONTACTS PAGE

KEY SERVICE PROVIDERS:

Name of General Practitioner Notified of change in person's condition □ Yes □ No In what circumstances do they want to be contacted? If unavailable, who should be contacted?	**1st contact:** Name:…… Telephone :……Mobile…… At any time □ Not at night time □ **2nd contact:** Name:…… Telephone……Mobile ……
Community Providers are notified of 'Last Days of Life" if applicable	Cranford Hospice □ Yes □ No □ N/A District Nurses □ Yes □ No □ N/A NASC Agency □ Yes □ No □ N/A Home Support Agency □ Yes □ No □ N/A Other □ Yes □ No □ N/A …… ……

FAMILY / WHĀNAU:

If the person's condition changes, who should be contacted first? If the person's condition changes, when should they be contacted?	**1st Contact:** Name:…… Relationship…… Telephone Number:…… Mobile Number…… At any time □ Not at night time □ Staying overnight □
If the first contact is unavailable, who should be contacted? When to contact Next of Kin if different from above	**2nd Contact:** Name:…… Relationship…….. Telephone Number:…….. Mobile Number…… At any time □ Not at night time □ Staying overnight □ Name:…… Relationship…… Telephone Number:……

Advance Care Plan: *Goal: Both the person/family/whānau are given the opportunity to discuss what is important to them*

Does the person have an existing Advance Care Plan?	□ No □ Yes Located…… **Transfer any key actions to the care plan**
Does the person have an existing Directive?	□ No □ Yes Located……
Does the person have nominated Enduring Power of Attorney (EPOA) for Health? Has the EPOA been activated? Copy sighted? **Document clearly in PROGRESS NOTES what was said and by whom.**	□ Yes □ No Name……Relationship…… Contact Number…… □ Yes □ No □ No □ Yes □ No □ No

OURHEALTH HAWKE'S BAY

First Name: _____
Surname: _____
Gender: _____
AFFIX PATIENT LABEL HERE
Date of Birth:_____ NHI#: _____
Ward/Clinic: Consultant:

INITIAL ASSESSMENT – FAXABLE SHEET

Physical (Te Taha Tinana):

TO BE COMPLETED BY A SENIOR NURSE OR MEDICAL OFFICER

Diagnosis

Relevant medical history or □ refer to full patient records

Baseline information: Is the person:

□ Conscious □ Semiconscious □ Unconscious
□ Fully alert □ Confused □ Delirious

In pain	□ Yes	□ No	Dyspnoeic	□ Yes	□ No
Agitated	□ Yes	□ No	Experiencing respiratory tract secretions	□ Yes	□ No
Nauseated	□ Yes	□ No	Skin integrity	□ Yes	□ No
Vomiting	□ Yes	□ No	Risk of falling	□ Yes	□ No
Continent (bladder)	□ Yes	□ No	Experiencing order symptoms (e.g. oedema, itch, jerks)	□ Yes	□ No
Catheterised	□ Yes	□ No			
Continent (bowels)	□ Yes	□ No			
Constipated	□ Yes	□ No			

Does the patient show 2 – 3 of the following signs/symptoms?
Tick those that apply

- □ Profound weakness
- □ Reduced intake food/fluids
- □ Difficulty swallowing/taking oral medications
- □ Drowsy or reduced cognition – semi conscious with lapses into unconsciousness
- □ Bed bound after progressive decline over days or weeks
- □ Peripherally shut down (cold hands and feet)
- □ Near death awareness (stories, visitations, travel)

□ **I believe this person is entering the last days of life**

Name:…… Signature:…… Date:……

SECTION TO BE COMPLETED BY MEDICAL OR NURSE PRACTITIONER

- □ Active acute medical treatment is no longer in the person's best interest
- □ Non-essential medications discontinued and current medications reviewed
- □ PRN subcutaneous anticipatory medications charted (***See symptom Management algorithms)***
- □ The need for artificial hydration/nutrition has been discussed
- □ Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) is recorded
- □ Inappropriate interventions discontinued e.g. blood tests, routine observations, blood glucose monitoring, oxygen therapy.

Implantable Cardioverter Defibrillator (ICD) (Cardiac Services – contact: 878 8109 ext. 6603)
□ N/A □ Deactivated Date:……_____

Organ donation considered and information given to person/family ***see Tissue Donation brochure***
□ Yes □ N/A

Is the coroner likely to be involved?
□ Yes □ No

Specific requests or exceptions to the above checklist:

Nurse to transfer any key actions to the care plan

Doctor Name…… Date…… Time……

Signature……

Patient name:
NHI:
DOB:

INITIAL ASSESSMENT Pg. 2 of 3

Awareness and Mental Health (Te Taha Hinengaro)

Recognition of Dying: *Goal: Both the person/family/whānau have awareness and understanding of the diagnosis*

The person is aware they are dying? ***See guidelines on "Identifying the dying patient"***	□ Yes □ No □ Unconscious
Is the family/whānau aware their family member is dying? ***See guidelines on "Breaking Bad News" and "W.H.A.N.A.U" tool***	□ Yes □ No □ NA **Document clearly in PROGRESS NOTES what was said and by whom.**

Preferred Place of Care: *Goal: person and family/whānau choice if appropriate*

Person's preferred place of care	□ Home □ Hospital □ Hospice □ Aged Residential Care □ No preference
Family/whanau preferred place of care ***If going home or to Aged Residential Care from HBDHB see "Discharge Checklist"***	□ Home □ Hospital □ Hospice □ Aged Residential Care □ No preference

Extended family health (Te Taha Whānau) Goal: *Both the person/family/whānau are given the opportunity to discuss what is important to them.*

Family/whanau given information of facilities available e.g. visiting times, parking, tea and coffee, quiet area, toilets.	□ Yes □ No
Information brochure "What to expect when someone is dying" explained and given to family/whānau if appropriate.	Brochure given □ Yes □ No
Give "Bereavement Information" brochure and list of Funeral Directors if appropriate time.	Brochure given □ Yes □ No

Religious and Spiritual: (Te Taha Wairua)

Which ethnic group or groups does the person identify with…… You can gain important information at this time, for example, someone's iwi or other cultural affiliations. ***Refer to appropriate cultural support e.g. Maori Health Service, Asian Support, Pacific Island Support. See W.HA.N.A.U: Personalising care at end of life.***	Date and time of conversation…… Name of services involved…… **Transfer any key actions to the care plan** **Document clearly in PROGRESS NOTES what was said and by whom.**
If able, the person is given the opportunity to express what is important to them at this time e.g. wishes, feelings, faith, beliefs, values (needs now, at death and after death)	□ Yes □ No □ No needs expressed Date and time of conversation…… **Transfer any key information to the care plan**
The family/whānau is given the opportunity to express what is important to them at this time eg. wishes, feelings, faith, beliefs, values (needs now, at death and after death)	□ Yes □ No □ No needs expressed Date and time of conversation…… **Transfer any key actions to the care plan**
Religious tradition identified Person's minister/priest/spiritual advisor/tohunga (Maori spiritual advisor) Support of facility spiritual advisor / Chaplin Support of facility cultural support or Maori Health Service ***Refer to Chaplain Service or contact patient's preferred support person if required. See Spiritual care assessment tool based on FICA approach.***	□ No □ Yes please specify:…… Name:…… Phone:…… □ Yes □ No □ Yes □ No **Transfer any key actions to the care plan**

Nurse Name…….. Date…….. Time……..

Signature……..

Patient name: NHI: DOB:

INITIAL ASSESSMENT – CARE AFTER DEATH

It may be appropriate to complete some of this section before the person's death	
Accomodation and involvement: Has private space been made available for the family/whanau? Provisions are made to ensure family/whanau are able to participate in after-death care if they wish to be involved	 □ Yes □ No □ N/A □ Yes □ No □ N/A
Funeral plans: Is the person to be buried or cremated? Named of funeral director **If no funeral director – use Transfer of Body form and follow guidelines** Are valuables to be left on/with the person/tupapaku?	 □ Buried □ Cremated Service_____ □ Yes □ No Details_____
Bereavement Support: Does the family/whanau appear to be significantly distressed before, during or after the death? Was there evidence of conflict that remained unresolved within the family/whanau? **Consider using the Te Ara Whakapiri Bereavement Risk Assessment Tool**	

Care after death

Person has died	Date/Times/signature……
People in attendance at time of death	……
Person has been verified dead	Date/Time/signature……
Person certified (Medical)	Date/Time/Signature……
Discussed as appropriate with family/whānau procedures following death, e.g. funeral arrangement, viewing of the body/tūpāpaku	□ Yes □ No
Bereavement support has been discussed ***See Organisation Policy on Care at death and after death***	□ Yes □ No

Care after death – Checklist (also see organisation documentation as required)

Notify Next of Kin	□ Yes	□ No	
Notify Attending Doctor	□ Yes	□ No	
Clinical records complete	□ Yes	□ No	
Ensure body correctly identifiable	□ Yes	□ No	
Sign off Release of Body form (if applicable)	□ Yes	□ No	□ NA
WINZ notified/form printed (if applicable)	□ Yes	□ No	□ NA
Ministry of Health (MoH) notification/form printed (Death only)	□ Yes	□ No	□ NA
Options HB notified (if applicable)	□ Yes	□ No	□ NA

Community Providers are notified of Death (if applicable)	Cranford Hospice	□ Yes	□ No	□ N/A
	District Nurses	□ Yes	□ No	□ N/A
	NASC Agency	□ Yes	□ No	□ N/A
	Home Support Agency	□ Yes	□ No	□ N/A
	Other	□ Yes	□ No	□ N/A
	……			

Nurse Name…….. Date…….. Time……..

Signature……..

OURHEALTH HAWKE'S BAY

Patient name:
NHI:
DoB:

CARE PLAN pg 1 of 2

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

PATIENT PROBLEM / FOCUS	GOAL	ACTIONS What should be done to achieve the goal for this particular person?
PAIN	Patient is pain free • Verbalised by patient if conscious • Pain free on movement • Appears peaceful	Consider need for positional change ☐ _____ _____ _____
AGITATION	Patient is not agitated • Patient does not display signs of delirium, terminal anguish, restlessness (thrashing, plucking, twitching)	Exclude retention of urine as cause ☐ Consider need for positional change ☐ _____ _____ _____
RESPIRATORY TRACT SECRETIONS	Excessive secretions are not a problem	Medication to be given as soon as symptoms arise ☐ Consider need for positional change ☐ Symptom discussed with family/other ☐ _____ _____
NAUSEA AND VOMITING	Patient does not feel nauseous or vomits • Patient verbalises if conscious	_____ _____ _____
DYSPNOEA	Breathlessness is not distressing for patient • Patient verbalises if conscious	Consider need for positional change ☐ Consider existing oxygen therapy ☐
OTHER SYMPTOM (E.G. ITCH, HYPER/ HYOPGLYCEMIA)	_____	_____ _____
MOUTH CARE	Mouth is moist and clean • See mouth care guidelines	Ensure mouth is kept moist ☐ Family/whānau/other involved in care given ☐ _____ _____
BOWEL CARE	Patient is not agitated or distressed due to constipation or diarrhoea	_____ _____ _____
MICTURITION DIFFICULTIES	Patient is comfortable	Observe for distress due to urinary retention ☐ Urinary catheter or pads, if general weakness creates incontinence ☐ _____ _____ _____
FOOD/FLUIDS	Oral intake is maintained for as long as person wishes	Minimum of daily reassessment of intake methods ☐

Patient name: NHI: DoB:

CARE PLAN pg 2 of 2

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

PATIENT PROBLEM / FOCUS	GOAL	ACTIONS What should be done to achieve the goal for this particular person?
MEDICATION	All medication is given safely and accurately	If syringe driver in progress check rate and site ☐ _____ _____
MOBILITY / PRESSURE AREA CARE	Patient is comfortable and in a safe environment. Family/whanau are given opportunity to assist with personal cares	Mattress _____ Position changes: _____ Personal Hygiene needs:_____ _____
PSYCHOLOGICAL / INSIGHT SUPPORT	Patient becomes aware of the situation as appropriate	Patient is informed of procedures ☐ Touch, verbal communication is continued ☐ _____ _____ _____
	Family/whānau / other are prepared for the patient's imminent death with the aim of achieving peace of mind and acceptance	Check understanding of nominated family/whānau/others/younger adults / children ☐ Check understanding of family/whānau/others not present at initial assessment ☐ Ensure recognition that the patient is dying and of the measures to ensure comfort ☐ _____ _____ _____
RELIGIOUS / SPIRITUAL SUPPORT	Appropriate religious / spiritual support has been given	Support from Chaplaincy team may be helpful ☐ Consider cultural needs ☐ _____ _____
CARE OF THE FAMILY /WHANAU /OTHER	The needs of those attending the patient are accommodated	Consider health needs and support ☐ _____ _____
CULTURAL SUPPORT	Consider the cultural needs of the patient/ family/whānau	_____ _____ _____
OTHER **E.G. COMMUNICATION**		

Health Professional Name:

Signature: **Date:**

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

Patient name:
NHI:
DoB:

ONGOING ASSESSMENT - OUTCOMES

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

Use the following code to indicate if in the past 4 hours the goals were achieved:
Codes (please enter in columns)

A= Achieved
The Goal was achieved and no additional interventions were required in the previous 4 hours

C = Change
Use this if the goal was not achieved and / or if additional actions were required to maintain the goal
If code C is used – details MUST be provided on the interventions sheet

GOALS FROM CARE PLAN	Date	/ /						/ /					
	Time												
Pain *Patient is pain free* • verbalised by patient if conscious • pain free on movement													
Agitation *Patient is not agitated* • patient does not display signs of delirium, terminal anguish, restless (thrashing, plucking, twitching)													
Respiratory tract secretions *Excessive secretions are not a problem*													
Nausea and vomiting *Patient does not feel nauseous or vomits* • patient verbalises if conscious													
Dyspnoea *Breathlessness is not distressing for the patient* *• verbalised by patient if conscious*													
Other symptoms (e.g. oedema, itch)													
Mouth care *Mouth is moist and clean* • see mouth care guidelines													
Micturition difficulties *Patient is comfortable*													
Medication *All medication is given safely and accurately*													
Nurse initials each set of entries													
	AM		**PM**		**N**		**AM**		**PM**		**N**		
Mobility / pressure area care *Patient is comfortable and in a safe environment*													
Bowel care *Patient is not agitated or distressed due to constipation or diarrhoea*													
Psychological / insight support *Patient becomes aware of the situation as appropriate*													
Family/whanau/other are prepared for the patient's imminent death with the aim of achieving peace of mind and acceptance													
Religious / spiritual support *Appropriate religious / spiritual support has been given*													
Care of the family /whanau/other *The needs of those attending the patient are accommodated*													
Cultural support *Consider the cultural needs of the patient/ family/whānau*													
Other e.g. communication													
Nurse initials each set of entries													

ONGOING ASSESSMENT

Patient name:
NHI:
DoB:

PROGRESS NOTES

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

DATE	PROGRESS NOTES	SIGNATURE AND DESIGNATION

Patient name:
NHI:
DoB:

INTERVENTIONS REQUIRED SHEET

What occurred?		Interventions taken		Was intervention effective?		If no, what further interventions was taken?	Initials
				Yes	No		
Date:	Time:	Date:	Time:				
Date:	Time:	Date:	Time:				
Date:	Time:	Date:	Time:				
Date:	Time:	Date:	Time:				
Date:	Time:	Date:	Time:				
Date:	Time:	Date:	Time:				
Date:	Time:	Date:	Time:				

7.4

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

Additional tools

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

Tool:	Where to access
1. Identifying the dying patient – flowchart	Information Pack In hospital: Via Nettie Map of medicine – Node: ?
2. Symptom Management Algorithms Hawkes Bay Algorithms	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine – Node: ?
3. Hospital Discharge Checklist	In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine – Node: ?
4. W.H.Ā.N.A.U: personalising care	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine – Node: ?
5. Spiritual care assessment tool (FICA)	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine – Node: ?
6. Breaking bad news flow chart (SPIKES)	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine – Node: ?
7. List of cultural support (Be aware of organisations own resources)	??
Brochures available:	**Where to access**
What to expect when someone is dying -information for family/ whānau	For supplies of brochure contact : ?? Cranford Hospice Telephone 06 8787047
Tissue Donation – information for patients and family/ whānau	For supplies of brochure contact: Donor Co-Ordinator Organ Donation of New Zealand Ph 09 6300935
What to do after death, grief and bereavement support – practical information for family/ whānau	For supplies of brochure contact: Funeral Directors Association of NZ (Inc) P O Box 10888 Wellington 6143 Email: info@fdanz.org.nz Website: www.funeralsnewzealand co.nz

Breaking Bad News Flowchart

Preparation

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

↓

What does the patient know?

It would help me to know what you understand about your illness, how did it all start, what is happening now? "I am afraid it looks more serious than we had hoped"
(this is about gaining the person's level of understanding and engagement, ACP and EPOA)

↓

Is more information wanted?

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

↓

Give an alert!.... and…….pause!

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

↓

Allow patient to refuse information at this time

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

↓

Give Explanation (if requested)

A narrative of events may be helpful

↓

Elicit and listen to any concerns

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

↓

Summarise and plan

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

↓

Offer availability and support

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

↓

Communicate with Multidisciplinary Team and Document

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

Adaption of SPIKES*

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

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

OURHEALTH HAWKE'S BAY

First Name: _____ **Gender:** _____

Surname: _____

AFFIX PATIENT LABEL HERE

Date of Birth:_____ **NHI#:** _____

Ward/Clinic: **Consultant:**

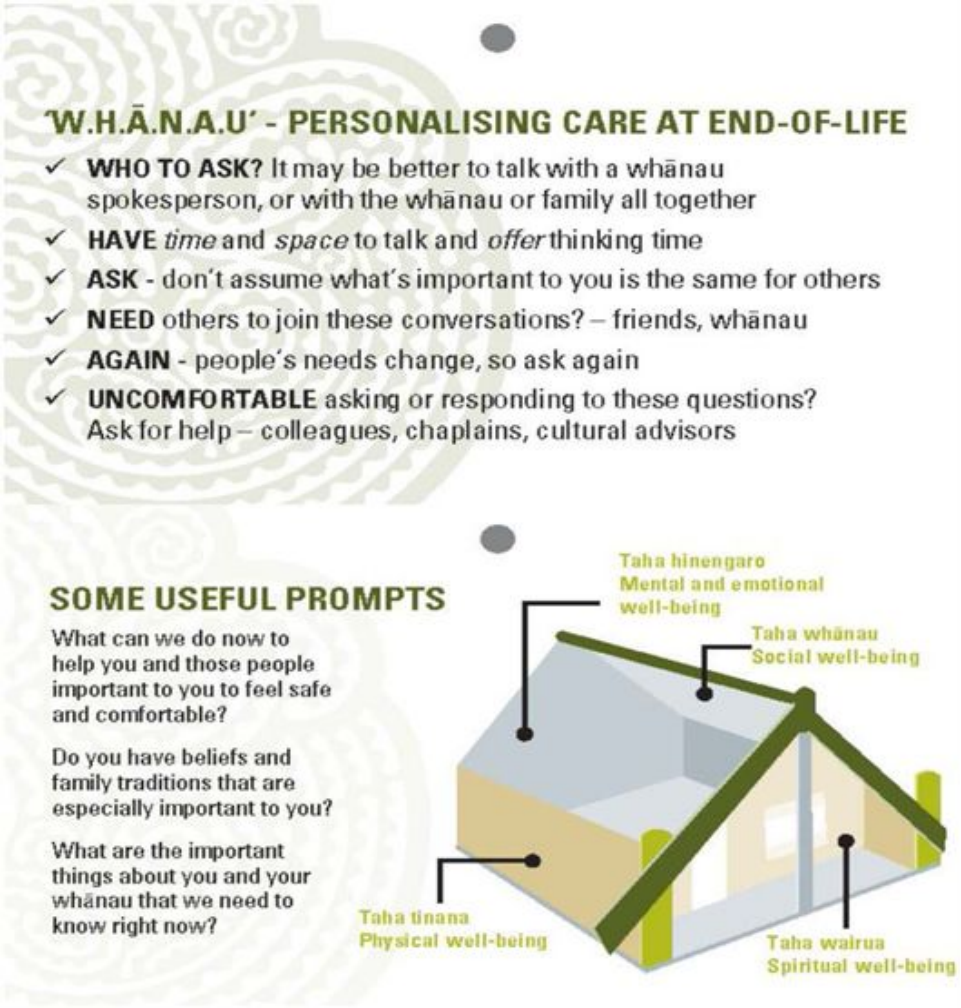
DISCHARGE CHECKLIST FOR A PERSON IN THEIR LAST DAYS OF LIFE

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

W.H.A.N.A.U: Personalising Care At End-Of-Life

Source: Batten et al (2014)

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



Spiritual Care Assessment Tool Based on FICA Approach

Source: Puchalski and Larson (1998)

Background

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

Suggested questions

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

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

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

F Naturalist

I Feels at one with nature. Each morning she sits on her patio looking out over the trees in the woods and feels 'centered and with purpose"

C Close friends who share her values

A After discussion about belief, she will try to meditate, focusing on nature, on a daily basis to increase her peacefulness

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

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

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

RECOMMENDATION

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

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

EXECUTIVE SUMMARY

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

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

The action plans identify the one remaining action relating to job sizing for the ICU SMOs. Please note that there is a planned meeting with the union (ASMS) and the SMOs on 22 August, after a significant amount of negotiation, proposals and counter proposals being put forward. At this meeting the DHB will put its final offer and proposed contract to the SMOs.

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

Action	Responsibility	Implementation deadline	Progress Update
A documented job sizing process needs to be established and agreed between the DHB and ASMS with clearly defined roles and responsibilities with an agreed timescale, with a maximum of 12 months for the work to be completed	John Gommans, Colin Hutchison + Craig Sidoruk	Dec-16	ICU SMO job sizing drawing to a conclusion. Final discussions with Union planned for 22 August where an offer will be made to close this matter.
Undertake a full review of the current ICU SMO rostering practices.	Colin Hutchison	Sep-16	As above
Develop systems to ensure nurse staffing ratio's are appropriate for both ICU and HDU patients	Ian Elson/Chris McKenna	Nov-16	Complete
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	Complete
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	Complete
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	Complete. SMOs are now managed within their Directorate providing greater visibility of hours worked linked to the roster system.
Each Directorate will be required to develop an annual service plan to reduce the risk of 'crises' occurring in the future	Sharon Mason	Jul-16	Completed
Establish effective effective mechanisms for escalation of risks to relevant governance bodies in a more consistent and transparent manner.	Kate Coley	Immediate	Complete.
Monthly meetings set up with HS Directorate teams to review directorate risks & identify any actions, escalation that needs to occur	Kate Coley	Immediate	Complete
Risks identified that are significant to be discussed with HSLG and escalated to EMT/Clinical Council/FRAC as necessary	Sharon Mason	Immediate	Complete
Implementation of a new event system so that we will be able to triangulate information and allow us to understand where a risk is developing before it becomes critical	Kate Coley	Jan-17	Complete - Decision made. Move into Project for implementation by December 2017

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

3. Management					
3.1. HB Hospital need to consider value of a quality ICU service to quality care delivery at HB and maintenance of specialist surgical services	Clarification required on number of funded ICU and HDU beds, then develop plan to maintain staffing to budget. Operational guidelines developed for when ICU reaches capacity. Budget bid for increased RN to resource 4 HDU and 7 ICU beds not prioritised for approval.	Organisation Clinical Services Plan to determine the philosophy of care for HB hospital and HB ICU to determine level of service provision for Hawke's Bay. Current RN budget for 8 RNs per shift plus 1 ACNM 12 hr day shift. 8 RNs night shift 12hr. Patient care provision should be matched to available nursing resource. Paper being written to raise nursing resource constraints and patient safety risk to go to HS leadership.	HSLT	Complete	Paper endorsed by HSLT to recruit to budgeted nursing FTE. Important issue for Clinical Services Plan. ICU and Medical Directorate engaged with the Surgical Expansion Program.
3.2. HB Hospital should clearly identify funded bed capacity and devise clear operational guidelines for when ICU reaches funded capacity. This requires administrative responsibility and should not be left to the medical and nursing staff to resolve alone.		ICU - CCDM & VRM to clarify. Escalation Plan documented.Continuous review of staffing requirements v demand patterns. For further analysis and paper to HSLT	Medical Directorate	Complete	As for 3.1
3.3. Review number of physical beds required to meet population need and the type of service the organization wishes ICU to provide.		No guidance provided with external review	HSLT	Feb-18	Complete. Awaiting development of clinical services plan.
3.4. HBDHB should identify costs (financial and outcome) associated with increased transfer out of sick patients, should share this data with staff and utilize this in future planning discussions	Determine whether maintaining treatment for patients in Hawke's Bay is more cost-effective than transporting to tertiary care	Blueprint Escalation plan developed for times of surge in numbers and/or acuity of patients to be tabled to HS for agreement to support for implementation. Costs have been identified with flight review project. Changes require organisation support with regards to planning for 'at capacity' events	Medical Directorate	**Complete**	Transfer costs and impact on care understood by service. ICU Escalation plan reviewed and included in organisation plan.
3.5. Serious consideration should be made to reconfigure medical cover to ICU within a structure of safe working hours and reasonable roster	Recruitment of additional Intensive Care Physician position in 2015/16	Recruitment has allowed development of a safe roster but additional work including SMO job sizing under way.	Medical Directorate	**Complete**	7 SMO and 8 Registrar roster now in place. Business case for 8th SMO approved. Partially filled and remainder currently being recruited to.
3.7. Significant positive change has occurred and continuing. Administration take care to facilitate positive change and beware of applying excessive financial strain during a time of transition and transformation	Undertake a full review of the current ICU SMO rostering and authentication practices (as outlined in internal audit report) with view to enabling and requiring staff to electronically record actual hours worked. Implement recommendations from TAS internal audit - leave management and rostering Feb 2015. Agree threshold for actual hrs worked, training, on call based on health and safety legislation, employment agreements, safety parameters. Responsibility of individual and manager/HoD/MD to monitor hours.	Rostering paper presented to FRAC. Job sizing under way. Await outcome of job sizing project	Medical Directorate	Jun-17	The vulnerability around ICU medical staffing has significantly reduced with SMO and registrar increases. Once final outcome of ICU job sizing exercise completed this recommendation will be closed.

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

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora – Mental Health**
	For the attention of: **Māori Relationship Board, Clinical and Consumer Councils**
Document Owner:	Sharon Mason – Executive Director Provider Services
Document Author(s):	Justin Lee – Acting Service Director; Simon Shaw – Medical Director; Peta Rowden – Acting Nurse Director
Reviewed by:	Paul Malan – Strategic Service Manager; Health Services Leadership Team and Executive Management Team
Month:	August 2017
Consideration:	For Discussion

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Council:

Note actions being taken to address continuing issues in :

- Rate of Compulsory Treatment Orders for Maori
- Number of children and youth without a discharge plan
- Wait times for non-urgent Mental Health or Addiction Services

OVERVIEW

Te Ara Whakawairoa (TAW) is a report drawn from the Māori Health Plan and is reported on quarterly with champions to ensure improvements are made and sustained.

The Māori Relationship Board identify areas of concern which require action and exception reporting through governance committees and then onto the HBDHB Board.

This report focuses on key actions being taken to improve Mental Health Services for Māori.

UPCOMING REPORTS

The following are the indicators of concern in 2017 / 2018.

Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
Mental Health	Rate of section 29 Compulsory Treatment Orders	81.5%	Sharon Mason	Allison Stevenson	August 2017
	Percentage of clients discharged from Child, Adolescent and Family Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) Services with a transition (discharge) plan	95%	Sharon Mason	Allison Stevenson	August 2017
	PP8 mental health wait times for non-urgent mental health or addiction services seen within three weeks (mental health provider arm), 0 to 19 years	80%	Sharon Mason	Allison Stevenson	August 2017

WHY ARE THESE INDICATORS IMPORTANT?

Use of Section 29, Compulsory Treatment Orders (CTO) is symptomatic of system-wide and socioeconomic issues. Monitoring rates is important to provide data for teams to prepare for clients with CTO and for them to respond appropriately. Māori have 3 – 4 times higher rates of use of Section 29 compared to non-Māori showing that just less than half the consumers on CTO are Māori.

The percentage of clients discharged from Child, Adolescent and Family Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) Services with a transition (discharge) plan is an indicator of integration with primary care. The current data shows improvement needed in the partnership between primary and secondary services.

The proportion of people aged 0 to 19 years requiring non-urgent Mental Health or Addiction Services seen within three weeks, shows that people are not currently receiving services within acceptable timeframes of referral to face-to-face appointment. Where consumers are waiting a long time for appointments this points to services not having been timely and effective in their care.

Inequality in Outcomes in Mental Health Status for Māori
Along with a number of other indicators, this data shows continuing and persistent inequity in quality of care for Maori. This is evidenced by :

- Māori have a high rate of access to Mental Health Services than non-Māori.
- Māori have 3 – 4 times higher rates of use of Section 29 compared to non-Māori on average.

- Estimated twelve month prevalence of schizophrenia for Māori (0.97%) is significantly higher than for non-Māori (0.32%[i]).
- Hospitalisation rate and readmission rate is higher for Māori (17%).

First Indicator : Rate of Section 29 Compulsory Treatment Orders

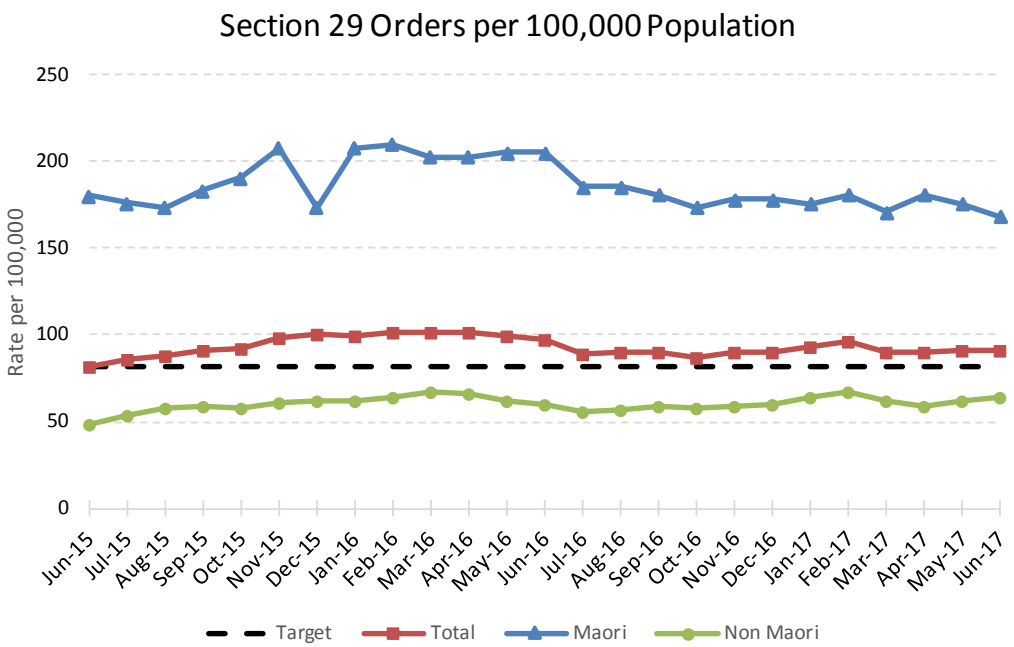
The Office of the Director of Mental Health reports annually on rates of Section 29 use by DHBs. The report comments that Māori have 3 - 4 times higher rates of use of Section 29 compared to non-Māori on average.

Responsiveness requires clear understanding of who is impacted and of the socioeconomic issues that increase vulnerability. Better understanding helps to increase collaboration with external agencies, including cultural and social agencies, so as to provide a more holistic, integrated and comprehensive response.

No target was assigned to DHBs for this indicator through the "DHB Māori Health Plan Guidance". However, the guidance document does mention that DHBs are to "reduce the rate of Māori on the Mental Health Act". The guidance document goes on to state[ii]:

> *New Zealand has very high rates of compulsion under the Mental Health Act, compared with similar jurisdictions. Māori are nearly three times as likely as non-Māori to be treated under a community treatment order which represents a significant disparity. There are regional and local differences, not necessarily related to population mix, which DHBs need to understand and work to reduce. The mental health indicator also supports implementing the priority actions for Māori in Rising to the Challenge, and the Mental Health and Addiction Service Development Plan 2012-2017 including other actions in the plan that relate to addressing disparities or self-management.*

HBDHB Section 29 Orders – June 2016 to June 2017



		Target	Total	Maori	Non-Maori
2016/17	Q1	≤ 81.5	89.7	183.9	57.0
	Q2	≤ 81.5	89.3	176.7	59.0
	Q3	≤ 81.5	93.2	175.9	64.6
	Q4	≤ 81.5	90.7	175.1	61.5

COMMENTS:

In Q4 2016/17 the rate ratio of Maori to non-Maori for compulsory treatment orders was 2.8:1 a reduction from 3.2:1 in Q1. This is trending in the right direction however the 95% Confidence Interval for the rate ratio for Hawke's Bay for the calendar year 2015 were approx. 2.8:1 to 5.7:1

Our current target is to achieve reduction to a sustained rate ratio of 2:1 Maori to non-Maori as this would represent a significant change from the current rate ratios.

Broadly, with regard to the prognosis in treatment of schizophrenia, there are two key factors which impact significantly, including: (a) longer duration of untreated psychosis and (b) higher functional impairment[iii]. Assertive services, especially at initial onset of psychosis, which support functional gain are crucial to generating positive outcomes.

Actions being taken to achieve plan include:

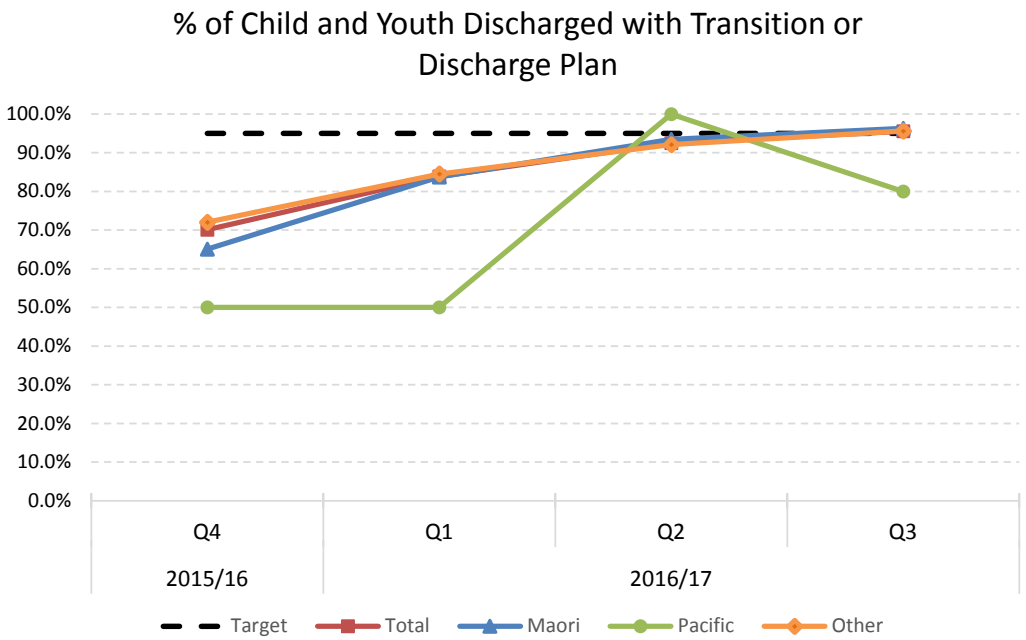
- Home Based Treatment team to provide services closer to home, to prevent mental health conditions worsening and reduce the need for people to be admitted to Nga Rau Rakau when acutely unwell, hence reducing the need for compulsory treatment.
- Provision of Acute Day Service for the community, based in Nga Rau Rakau will be operational in 2017/18, again reducing the need for admission.
- The Clinical Risk Management System is being used to provide expert review of risk management for high risk patients, reducing the need for longer term compulsory treatment.
- Te ara Manapou, the newly founded pregnancy and parenting service for women and whanau with addictions problems who are not engaged with services, will help give children a better start in life and may have impact oncompulsory treatment in the long term
- Extended whanau are increasingly being used in reviews of compulsory treatment, by both community key-worker and psychiatrist. This will enable the whole network around the person to provide alternatives to continuing compulsory treatment orders.
- Targeted treatment pathways have been developed with wider availability of evidence-based therapies, such as Dialectical Behavioural Therapy to treat emotionally unstable personality disorder with associated suicide risk. Trauma-based Cognitive Therapy is being used to treat Post Traumatic Stress Disorder and reduce the severity and duration of some conditions.
- Greater use of longer interval injectable antipsychotic medication will well reduce the need for compulsory treatment associated with refusal to continue necessary treatment and subsequent relapse.

Second Indicator

Percentage of Clients Discharged from CAFS and Youth Alcohol and Other Drug (AOD) Services with a Transition (Discharge) Plan

This indicator is that after three face-to-face meetings with the child and family, a transition or discharge plan must be generated and sent to family and/or referrer.

CAFS is now meeting the KPI on transition planning. Improvement over time has largely been driven by regularly reviewing reporting, and correcting occasions when a discharge plan has not been completed. Our Pacific data shows low referral volumes, meaning not completing of a single transition plan tends affect data significantly.



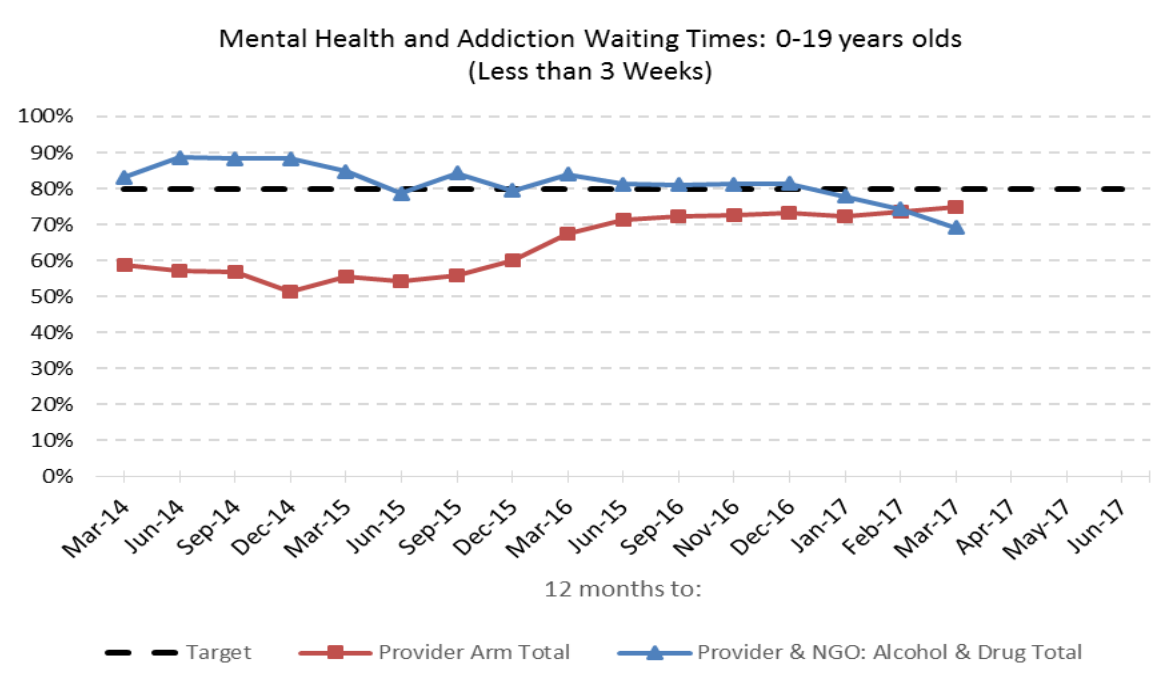
Third Indicator

Mental Health Wait Times for Non-Urgent Mental Health or Addiction Services Seen within Three Weeks (provider arm) 0 – 19 years

This indicator is defined by the time between receiving the referral to the time the child / family are seen face to face by a health practitioner. It should be noted that if there is an acute need, the young person is seen the same day.

Discussion between a number of Child and Adolescent Mental Health providers highlights two significant issues:

- First, some settings have noted a shifting of clinical practice, in that referrals are seen quickly (meeting the KPI) but the subsequent contact is scheduled at a significantly later period. This has led to calls to monitor not just the initial appointment, but also the timeliness of subsequent appointments. Positively, in the Hawkes Bay, subsequent contacts are monitored closely and we are not seeing significant waits between initial contact and subsequent ongoing work.
- Second, the goal of the KPI is largely to provide a measure of service responsiveness. If a family do not attend a planned appointment, then this counts against the KPI. Similarly, family preferences are also considered, which can impact on the KPI (i.e., over school holidays, request is often for later appointments due to travel or other commitments). This encourages our services to be provided in a way that meets whanau needs including in a time and place convenient to them.



Note: the table below reports data to March 2017.

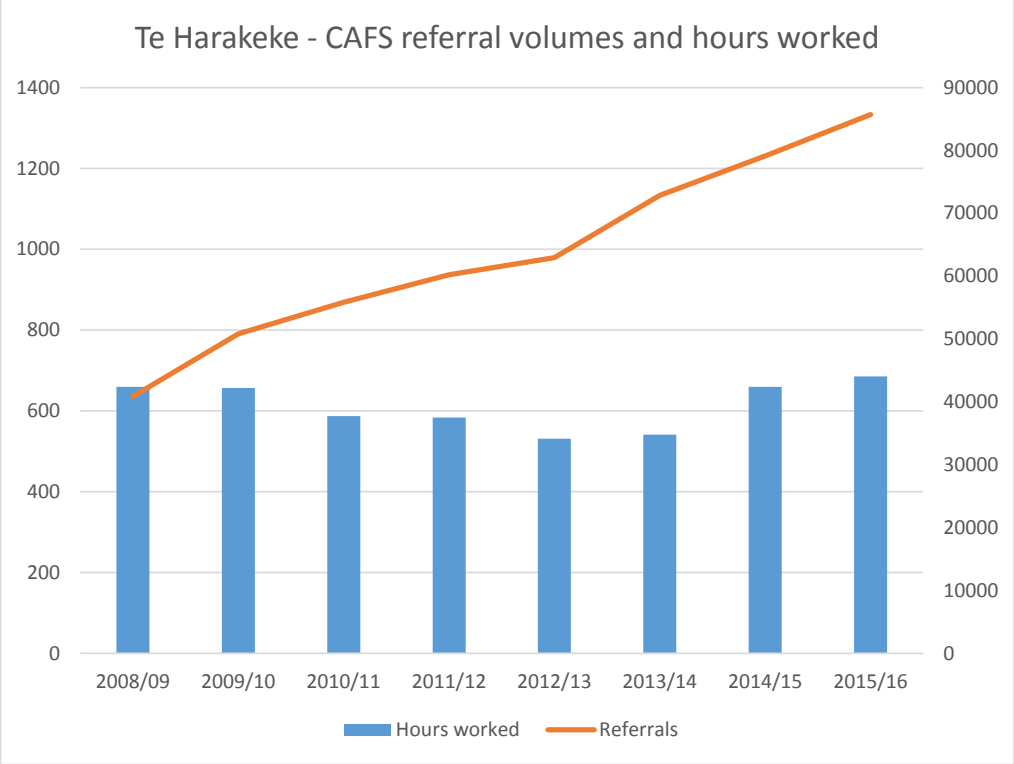
	Mental Health Provider Arm									
	<3 weeks					**<8 weeks**				
12 months to	Target	Provider Arm Total	Māori	Pacific	Other	Target	Provider Arm Total	Māori	Pacific	Other
Mar-17	80.0%	74.8%	78.0%	72.2%	72.6%	95.0%	90.9%	92.8%	88.9%	89.7%

As per the graph above, our youth addictions team (1.8 FTE) has an increase in wait times, and is now now failing to meet the KPI at 10.8% below the target. Analysis indicates drivers for this include: (a) Access issues in nearly ½ cases (clinical review indicates strong follow-up); and (b) issues around data reporting (i.e., family contacts not appearing to trigger meeting the KPI), which CAFS Clinical Manager will resolve urgently with the health information reporting team. The data errors indicate that performance is being underestimated.

Access issues impact on the wait times KPI. Efforts to address this have included:

- Telephone contact with the family is occurring shortly after referral to introduce the service and to ensure the proposed appointment time works for the family.
- Kaetakawaenga support is available to the team. At referral, families who may benefit from support are identified by the Kaetakawaenga, and their role in engagement facilitated.
- CAFS are seeking to engage with young people in settings familiar to the young person (i.e. at schools, at other agencies where the young person or family already have relationships).

Timeliness and responsiveness are crucially affected by the match of capacity to demand. Of note, CAFS referral volumes have significantly increased since 2008, while hours worked by clinicians has remained stable over time (see graph below). Vacancies impact on wait times KPI, and we expect this to be seen in April – June 2017 (during which several vacancies were present).



It is clear that we need to deliver responsive and clinically sound services for children and young people with moderate to severe mental health difficulties.. Delivering such services not only supports meaningful change in the lives of the most vulnerable whanau, but also represent an opportunity for early intervention, with associated social and economic benefits. We need to ensure that our services have the correct capacity to match the needs of ou communities..

CHAMPIONS REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THIS INDICATOR

Compulsory Treatment Orders

An audit of Mental Health and Addiction Services performance on CTO has given us some baseline understanding of the actions required to reduce the numbers of people under CTO. As a result of this we have implemented a new model of care for acute and community services. This includes a shift in focus to a recovery approach that builds resilience for people with low-prevalence conditions and / or high needs and is more responsive to the wider socioeconomic factors that drive the need for intensive mental health treatment. These have enhanced access by integrating hospital and community services, strengthening collaboration with kaupapa services, and developing better primary care responses.

From Annual Plan 2016/ 2017

Short-term outcome		Activity	Monitoring and Reporting
Māori Health Priority	**Reduce the rate of Compulsory Treatment Orders**	Home-based treatment team increases family involvement with planning and crisis intervention by Q4.	**Rate of CTO** in Māori and non-Māori **100% of intensive service staff** trained by Q3 **Number of referrals** to specific services **SI5**: WHĀNAU ORA Key Indicator
		Ongoing daily step up step down with Ngā Rau Rākau, CMH, HBT, EMHS, Wai-O-Rua and TTOH to improve discharge and admission communication.	
		Implement intensive day programme from Q1.	
		Staff education around sensory modulation and trauma informed care to help reduce restrictive models of care.	
		Increase availability of treatment options across community mental health services.	
		Building networks within the community – increased use and referrals to NGOs within the community for follow up; meetings with NGOs and whānau/families to agree on and document plans & outcomes by Q2.	

Transition and Discharge Planning

Every CAFS clinician who has primary responsibility for a case now completes the core transition document. The completed transition plans are communicated to the primary referrer. Regular auditing of exceptions assists in identification of the small number of cases in which transition plans were not completed, and this is corrected.

From Annual Plan 2016/ 2017

Short-term outcome	Activity	Monitoring and Reporting
Improve the follow-up care for those discharged from Child and Adolescent Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) services	Formalise implementation of Transition Planning Checklist as standard practice in Q1. Amend discharge documentation to include standard prompt to primary referrer in Q2. Introduce "error flag" in patient administration system to prompt completion in Q3.	**PP7:** 95% of clients discharged with have a transition (discharge) plan + exception reporting
	Ongoing monthly audit and performance monitoring of compliance with transition plan policy.	

Reducing Waiting Times

A significant amount of procedural and administrative work has been completed this has included establishing prompts with appropriate policies and procedures to ensure proactive management of referrals. This is enhanced with good monitoring of results and attention to the needs of people having difficulty accessing the service.

From Annual Plan 2016/ 2017

Short-term outcome	Activity	Monitoring and Reporting
Improve access to CAFS and Youth AOD Services	Trial an initial phone contact by Choice Clinician and implement as standard practice if successful by Q1.	**PP8:** 80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks this year + narrative report
	Liaise with KPI Forum stakeholders and other DHBs regarding "face-to-face" rule for first contact with children and families by Q2.	
	DNA's and joint appointments – review policy and impact of current practice by Q3. Redesign if necessary.	
	Scoping of potential for alternatives to admission for youth to be developed by Q2, e.g. Home-Based Treatment, and the mechanisms by which this would be sustainable.	

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

From the HBDHB Annual Plan 2017 / 2018[iv], the table below shows the activity that is planned to improve CTO performance.

Mental Health	Improve the quality of mental health services, including reducing the rate of Māori under community treatment orders.	**One team**	1. Monitor Compulsory Treatment Orders (CTOs) by ethnicity and continue with actions which have contributed to a decrease in CTOs for Māori; partnership with police; education of nurses and key workers to support whānau to understand legal issues and the process of CTO courts. 2. Explore written material which is used to explain these processes to whānau in other centres, with a view to using locally, if appropriate.	Q1-4 Q2	PP36: Reduce the rate of Māori on the mental health Act: section 29 community treatment orders relative to other ethnicities.

To support transition planning there are actions that will be progressed in 2017/18
CAFS will

- Continue to audit and improve performance against transition plan KPI
- Introduce 'error flag' or discharge checklist into ECA to prompt completion

.

Actions to improve maintaining waiting for 2017/18 include
CAFS:

- Increase collaboration with NGOs to enhance capability and to reduce demand for secondary services.
- Deliver group therapies in primary care by CAFS clinician, to increase access to evidence-based intervention.

RECOMMENDATIONS FROM TARGET CHAMPION

Further reduction in CTO will be achieved by acting on analysis to ensure the most appropriate use of compulsory treatment. I support the intentions to increase family involvement, integrate services and service providers, and develop staff capability and to build networks.

The intentions in the Annual Plan 2017/18 regarding Compulsory Treatment Orders will deliver ongoing improvement. I will in addition require that the service ensure robust operational performance monitoring of these aspects of service quality to capture the gains.

Transition planning targets are now being met and I will ensure that CAFS undertake regular audit of monitoring to make sure this is maintained.

I will ensure that waiting times in child and adolescent mental health and addictions continue to reduce despite significant increase in demand. As well as continuing to work on improving data quality, and ensuring that services are delivered that are valued by our people I wil ensure ensure that we have the capacity to match demand.

The identified areas for improvement and timeframes are outlined in the following table

Description	Responsible	Timeframe
Home Based Treatment: establish framework for regular review of frequent presenters/clients with CTO history	ACM Home Based TreatmentTeam Manager Community Mental	June 2018
Acute Day Service fully staffed and operational	ACNM Nga Rau Rakau	December 2017

Te Ara Manapou PPS – Service fully staffed and operational	Service Directorship Clinical Team Leader Manager Community Mental Health	July 2018 March 2018
Clinical Risk Management System – review of and focus on CTO	CRMS Committee Service Directorship	September 2017
Develop Process and Response map for acute presesentation under Police MH Partnership strategy	Project Working Group/Quality Improvement Coordinator Service Directorship	March 2018
Actions to improve maintaining waiting for 2017/18 include CAFS: Deliver group therapies in primary care by CAFS clinician Increase collaboration with NGOs to enhance capability and to reduce demand for secondary services.	CAFS Manager Service Directorship	December 2017
Actions to improve Transition Planning completeion include CAFS: Continue to audit and improve performance against transition plan KPI Introduce 'error flag' or discharge checklist into ECA to prompt completion .	CAFS Manager CAFS Manager	Quarterly September 2017

REFERENCES

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[ii] http://nsfl.health.govt.nz/dhb-planning-package/201617-planning-package-and-review-plans/mhp-guidance

[iii] Diaz-Caneja, C., Pina-Camacho, L., Rodriguez-Quiroga, A., Fraguas, D., Parellada, M., * Arango, C. (2015). Predictors of outcome in early-onset psychosis: A systemic review. Schizophrenia (2015) March (1): Article number 14005.

[iv] Hawke's Bay District Health Board, Draft Annual Plan 2016/17. HBDHB.

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Māori Plan Q4 (Apr- Jun 2017) Dashboard Report**
	For the attention of: **Clinical and Consumer Council**
Document Owners:	Tim Evans, General Manager Planning, Informatics and Finance Tracee Te Huia, Executive Director, Strategy & Health Improvement
Document Author(s):	Patrick LeGeyt, Acting GM Maori Health; Justin Nguma, Senior Health & Social Policy Advisor Māori Health and Peter Mackenzie, Business Intelligence Analyst
Reviewed by:	Executive Management Team
Month:	August 2017
Consideration:	For Monitoring

RECOMMENDATION

That Clinical and Consumer Council:

Note the contents of this report.

CONTENTS OF THE REPORT

This is a report on the Māori health indicators agreed as part of the development of 2016 /17 Annual Māori Health Plan.

A quick reference summary dashboard is included and shows our position as at the end of this quarter for all indicators. The dashboard uses traffic light methodology (as described in the key on page 6) to represent this.

As this report is for the period ending June 2017, some results may vary to those presented in other reports.

KEY FOR DETAILED REPORT AND DASHBOARD

Baseline	Latest available data for planning purpose
Target 15-16	Target 2015/16
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 4 PERFORMANCE HIGHLIGHTS

Achievements

1. Māori Workforce grew from 12.5% in Q1 to 14.3% in Q4and met the annual target of ≥13.8% for 2016/17 by 15 positions *(Page 61)*

The Māori Staffing Recruitment Plan initiatives this year moved the focus from just Nursing to all occupational groups and has resulted in an increase of Māori staff across all Services. Over the last 12 months 20.1% of the new staff employed at the DHB identified as Māori.

Areas of progress

1. Immunization rates for 8 months old Māori dropped slightly from 94.4% in Q1 to 94% in Q4 but still trending positively towards the expected target of ≥ 95%.

   The disparity gap between Māoriand non-Māori in Q4 is1.6% compared to 2.1% in Q1.This trend can partly be attributed to the growing publicity against immunization. The national coverage has also dropped by 0.4% to 91.9%. *(Page 8)*

   Efforts have been focused on raising awareness among whānau through Health HB Whānau Wellness sessions and we are planning to provide education to Family Start workers in the coming quarter. We are also exploring the use community champions in promoting immunization among the whānau.

2. Ambulatory Sensitive Hospitalization (ASH) for 0-4 year old Māori dropped significantly from 91.7% in Q1to79.5% in Q4 but trending positively towards the target of ≤82.8%. The disparity gap between Māori and non-Māori slightly increased from 11.4% in Q1 to 12.6%in Q4. *(Page 46)*

   The equity gap between Māori and non-Māori is being addressed through collaborative programmes with key stakeholders. These include: i) the “Under 5 years caries free equity project”; and ii) respiratory initiative focused on exploring respiratory pathway post presentation to secondary care services.

   ASH rates for 45- 64 year olds dropped significantly from 196% in Q1 to 178.5% in Q4 and trending positively towards the target of ≤138%. The disparity between Māori and non-Māori has increased from 87% in Q1 to 110.9 in Q4.

   Cardiac admissions continue to be a major concern and there are several initiatives currently in place to address this challenge.

3. Cervical screening for 25-69 year old Māori women in Q4 was 73% up by 0.3% from 72.7% in Q1and trending positively towards the expected target of ≥ 80%. On the other hand the disparity gap between Māori and non-Māori has narrowed to 2.2% in Q4 compared to 5.5% in Q1. *(Page 52)*

   HBDHB remains the 1st in cervical screening coverage for Māori women out of the 20 DHB’s. This success is a result of good collaboration between primary care, population health and Māori providers. The addition of Pacific Community Support worker has also increased our coverage among the Pacific women and we are now looking at the logistics of extending our services to the growing Asian population.

   Breast screening for 50-69 year old Māori women has dropped slightly from 67.1% in Q1 to 66.2% in Q4 but still trending positively towards the target of ≥ 70%. The disparity gap between Māori and non-Māori has grown slightly from 7.4% in Q1 to 8.7% in Q4.

4. The Māori staff cultural competency training has grown by 4% over the year from 77.5% in Q1 to 81.5% in Q4. Medical and Support Staff consistently remain well behind the other areas and at 36.9% are well below the expected target of ≥100%. *(Page 63)*

   Concerns about the low participation of the medical staff in the training have been shared with the CMO. The Strategy & Health Improvement Directorate is working with the CMO to address the attendance bottleneck for the medical staff.th

5. Access to referral services for Alcohol and Other Drugs for 0-19 year old Māori within 3 weeks decreased slightly from 81.61% in Q1 to 78% in Q4 but trending positively towards the expected target of ≥80%. *(Page 69)*

   On the other hand, referral services for 0-19 year olds within 8 weeks increased slightly from 91.7% in Q1 to 92.8% in Q4 and trending positively towards the target of ≥ 95%. There is no disparity gap between Māori and non-Māori in Q4.

   This progress is partially attributed to the efforts of the Kaitakawaenga active focus on linking with whānau and continued collaborative work with other providers.

6. PHO enrolment has increased by 1.3% from 96.6% in Q1 to 97.9% in Q4 and trending positively towards the ≥100%. The disparity gap between Māori and non-Māori has gone down from 0.3% in Q1 to 0.2% in Q4. *(Page 40)*

   Within the last quarter the PHO has worked to increase the number of practices that are now open for enrolment.

Challenges

1. Acute hospitalization for Rheumatic Fever has risen from 4.82% in Q1to 7.23 in Q4 (one new case for the quarter) and trending away from the expected target of ≤1.5. The disparity gap between Māori and non-Māori has grown from 2.96 in Q1 to 6.54 in Q4. *(Page 15)*

   There has been an increasing interest in knowing whether the presentation of the new cases with increased complexity (e.g. presenting with chorea) and among the young adults represents a genuine national trend as overall rheumatic fever rates decline. The information will help us understand this phenomenon better, for effective interventions.

2. Māori under Mental Health Act compulsory treatment orders (CTO) has slightly decreased from 183.9 in Q1 to 175.1 in Q4. This shows a reduction in rate ratio of Māori to non-Māori under compulsory treatment orders from 3.2:1 in Q1 to 2.8:1 in Q4. While still far away from the MOH target of 81.5 the data is trending in the right direction and our aim is to bring it down to a sustained rate ratio of 2:1 Māori to non-Māori as this would represent a significant change from the current rate ratios. *(Page 32)*

   High numbers of patients under CTO is a product of many factors including the problem of schizophrenia. Broadly, with regard to the prognosis in treatment of schizophrenia, there are two key factors which impact significantly, including: (a) longer duration of untreated psychosis and (b) higher functional impairment. Early treatment of initial onset of psychosis is likely to mitigate the impact of functional impairment resulting in less number of patients under CTO. Other measures include: home based treatment; provision of acute day services; targeted treatment pathways; and greater use of longer interval injectable antipsychotic medication.

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 4 APRIL – MAY 2017 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%	95.4%	94.0%	95.6%	≥ 95%	-3		↑
65+ Influenza (12m)	68.0%	21.0%	54.0%	59.0%	≥ 75%	-578		↑

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	7.23	9.64	3.1	≤ 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%	66.0%	No new data, waiting for the publication of the QIF		≥ 75%	-		↑
At 3 months	46.0%	39.0%			≥ 60%	-		↑
At 6 months	46.0%	50.0%			≥ 65%	-		↑

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 (12m)	65.3%	72.7%	Reported Annually in Q3		≥ 95%			↑
% Caries Free at 5yrs (12m)	36.0%	44.0%			≥ 67.0%			↑

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%	No new data, waiting for the publication of the QIF					↑

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	175.9	175.1	61.5	≤ 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%	97.5%	97.9%	98.1%	≥ 100%	-890		↑

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%	84.9%	79.5%	66.9%	≤ 82.8%	-		↓
45-64 years (6m)	172.0%	211.3%	178.5%	67.6%	≤ 138%	-		↓

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%	73.1%	73.0%	75.2%	≥ 80.0%	-644		↑
Breast screening (50-69 yrs) (3m)	68.4%	66.7%	66.2%	74.9%	≥ 70.0%	-135		↑

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%	4.7%	5.2%	≥ 13.8%			
Management & Administration	16.5%	19.1%	19.9%	≥ 13.8%			
Nursing	10.6%	11.6%	12.1%	≥ 13.8%			
Allied Health	12.6%	13.2%	4.3%	≥ 13.8%			
Support Staff	28.2%	29.3%	31.6%	≥ 13.8%			
Māori staff - HBDHB (3m)	12.3%	13.5%	14.3%	≥ 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%	37.5%	36.9%	≥ 100.0%			
Management & Administration	79.1%	88.5%	89.4%	≥ 100%			
Nursing	70.0%	85.6%	86.0%	≥ 100%			
Allied Health	77.3%	89.9%	90.8%	≥ 100%			
Support Staff	35.6%	64.9%	64.4%	≥ 100%			
HBDHB (3m)	65.6%	80.9%	81.5%	≥ 100%	-		↑

*Obesity still to be confirmed

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)	63%	74.1%	78.0%	72.6%	≥ 80%	-		↑
% of 0-19 year olds seen within 8 weeks of referral (3m)	86.5%	92.0%	92.8%	89.7%	≥ 95.0%	-		↑

Indicator Legend
Target attained
Within 10% of target
10-20% away from target
Greater than 20% away from target

11

CLINICAL ADVISORY & GOVERNANCE GROUP REPORT

OURHEALTH HAWKE'S BAY
Whakawateatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

12

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

13. Minutes of Previous Meeting (Public Excluded)

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

15. Health Awards

16. Investment Prioritisation

17. Member Topics of Interest – issues / updates

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

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

HAWKE'S BAY CLINICAL COUNCIL

ANNUAL GENERAL MEETING 2017

MINUTES OF THE HAWKE'S BAY CLINICAL COUNCIL ANNUAL GENERAL MEETING HELD IN THE "THE LIBRARY", MISSION ESTATE, CHURCH ROAD, NAPIER ON WEDNESDAY, 10 AUGUST 2016 AT 3.25 PM

PUBLIC

Present:
Dr Mark Peterson (Co-Chair)
Chris McKenna (Co-Chair)
Dr Tae Richardson
Dr David Rodgers
Dr Robin Whyman
Dr Malcolm Arnold
Dr Andy Phillips
Dr Kiri Bird
Debs Higgins
William Allan
David Warrington
Jules Arthur
Anne McLeod

In Attendance:
Dr Kevin Snee, Chief Executive Officer, Hawke's Bay District Health Board
Ken Foote, Company Secretary
Dr Nick Jones, Public Health Specialist *(on behalf of Dr Caroline McElnay)*
Barbara Ryan, Quality Improvement & Innovation Team Leader *(on behalf of Kate Coley, Director Quality Improvement & Patient Safety)*
Tracy Fricker, Council Administrator and EA to DQIPS
Graeme Norton, Chair HB Health Consumer Council
Kerri Nuku, Māori Relationship Board Member
Dr Russell Wills, Medical Director QIPS

Apologies: Dr John Gommans and Dr Caroline McElnay

SECTION 7: ANNUAL MEETING

25. WELCOME AND OPENING

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

26. APOLOGIES

Apologies were noted as above.

27. MINUTES OF PREVIOUS ANNUAL MEETING

The minutes from the previous Annual General Meeting held on 12 August 2015 were confirmed as a correct record of the meeting.

Moved and carried.

28. MATTERS ARISING FROM ANNUAL GENERAL MEETING

The matters arising from the Annual General Meeting in 2015 were noted as actioned.

29. ELECTION OF CHAIR / CO-CHAIRS

The Chair advised that he and Chris McKenna were happy to stand as Co-Chairs for the next 12 months.

Ken Foote (Company Secretary) called for nominations of the positions of Chair and Co-Chair.

David Rodgers nominated Mark Peterson and Chris McKenna. This was seconded by Debs Higgins.

The Company Secretary confirmed that with no further nominations Dr Mark Peterson and Chris McKenna were duly elected as Co-Chairs.

30. REVIEW OF LAST 12 MONTHS (2015-16) YEAR IN SUMMARY

Information included in the meeting papers. No discussion held.

SECTION 8: WORKSHOP

31. REVIEW HB CLINICAL COUNCIL TERMS OF REFERENCE

The updated Terms of Reference are included in the meeting papers for information. The Terms of Reference were reviewed last year.

32. QIPS ANNUAL PLAN

The QIPS Annual Plan was included in the meeting papers. No discussion regarding this document. Please provide feedback on the draft plan to kate.coley@hbdhb.govt.nz.

33. CLINICAL GOVERNANCE COMMITTEE STRUCTURE

See Appendix 1 for notes from the discussion held regarding Clinical Committees.

34. REVIEW OF COUNCIL'S ANNUAL WORK PLAN 2015-16 (PAST YEAR) AND DEVELOPMENT OF ANNUAL WORK PLAN 2016/17

See Appendix 1 for notes from the discussion held regarding the priority areas/actions for focus in 2017.

Before closing the meeting the Chair acknowledged Dr Malcolm Arnold's contribution to the Clinical Council during his tenure.

The meeting closed at 5.10 pm

Confirmed: _____
Chair

Date: 14/9/16

Appendix 1

CLINICAL COUNCIL ANNUAL MEETING HELD 10 AUGUST 2016

WORKSHOP NOTES

STRUCTURE

Ken Foote facilitated the Workshop which commenced at 4.40 pm, requiring some prioritisation for the use of the 20-30 minutes available.

Ken outlined a general structure which would require some review of the issues/objectives set for 2015/16 (to help identify what needed to be carried forward), and then looking ahead to the priority challenges for 2016/17.

Specifically the components of this process include:

- Review/confirm existing TOR for Council
  - Discuss/confirm existing scope, structure and processes
- Review/confirm existing Functions, Roles and Strategies set out in the Annual Plan 2015/16
- Review achievements of 2015/16 Annual Plan objectives – agree on issues to be carried forward.
- Review notes from last year's Annual Meeting Workshop to agree/confirm achievement / non achievement of issues, strategies, actions, trends identified, and what needs to be waived and/or carried forward
- Review the "QIPS 2016/17 Annual Plan" to identify specific areas of focus for Clinical Council.
- Review/approve the "Governing for Quality Plan" as a reminder of Council's role to provide clinical improvement and patient safety advice and assurance to the HBDHB and HHB Boards, to help them meet their respective due diligence governance responsibilities in this area.
- To discuss agree how Clinical Council and individual members would be integrated/included within the proposed new clinical governance committee / advisory group structures.
- To open up the meeting for members to raise issues or suggest ideas where Council could proactively add value to the Hawke's Bay Health system, and our consumers?

CLINICAL COMMITTEES

Given the limited time available, it was agreed to focus initially on the proposed new committee structure.

It was suggested that each member should have a role on at least one Advisory Group and (where appropriate) one of the Committees.

General discussion on the proposed structure resulted in agreement to make the following changes:

- Correct the name of CAG, to "Clinical Advisory & Governance Committee"
- Move "Maternity Governance Group' to sit under "Clinical Effectiveness and Audit".
- Rename "Research Education & Training" to Professional Development & Research" or other such title to reflect the Advisory Groups sitting under it.
- Add "Education & Development Group" to sit under "Professional Development & Research" (once new name confirmed).

- Acknowledge two components of Records Management with 'Clinical Records' reporting to Director of Quality Improvement & Patient Safety.

Initial expressions of interest for membership of Advisory Groups were:

- **Professional Development & Research**
  - Research — John Gommans
  - Credentialing
    - SMO — Robin Whyman
    - Nursing — Chris McKenna
    - Allied Health — Andy Phillips
  - Nursing & Midwifery Council — David Warrington
  - Allied Health Forum — Anne McLeod, Andy Phillips, Billy Allan
  - Pre Vocational Training / RMOs — Russell Wills
  - Education & Professional Development — Anne McLeod

- **Clinical Effectiveness : Audit**
  - Clinical Audit — ?
  - Clinical Pathways — Mark Peterson, Andy Phillips, David Rogers
  - Laboratory — Kiri Bird
  - Radiology — Mark Peterson
  - Pharmacy & Therapeutics — Billy Allan
  - Maternity Governance Group — Jules Arthur

- **Patient Safety & Risk Management**
  - Infection Control — Chris McKenna
  - Falls — Chris McKenna, Andy Phillips, Robyn O'Dwyer
  - Clinical Events — John Gommans, Andy Phillips, Robyn O'Dwyer
  - Restraint — ?
  - Clinical Risk — ?
  - Patient at Risk — ?
  - Family Violence — Russell Wills, Jules Arthur, Debs Higgins, Andy Phillips

- **Patient Experience**
  - Complaints / Compliments etc — Russell Wills

- **Information Management**
  - Data Quality & Integrity — Caroline McElnay, David Rogers

With the limited time remaining, members were asked to suggest other priority areas/actions for focus in 2017 – these included:

- **Meeting Agendas**
  - Need to be more manageable
  - Focus on those papers/presentations with significant clinical issues – be more selective
  - Accept more papers as "information only" requiring no presentation or general discussion, but providing for members to raise concerns at the meeting and/or provide feedback direct to the document owner/author.
- **Advisory & Assurance Function**
  - Review "risk management" processes and reporting to ensure Clinical Council has full visibility of all significant clinical quality and patient safety issues, so that they can assure themselves that appropriate mitigation actions/plans are being implemented and therefore provide the Boards of HBDHB and HHB with appropriate and relevant "early warnings". Advice and/or assurance on such matters.
- **Engagement with Consumer Council**
  - Agreed that more needs to be done on the "partnership" envisaged
- **Workforce Development**
  - Still a high priority to prepare the workforce for "new" environment and culture
- **Health Literacy**
  - Would like to see real progress
- **Prioritisation Process**
  - Keen to see enhancements come out of the current review
- **Proactive / Innovative**
  - Agreed that members need to be more proactive and innovative in bringing issues to Council, rather than just 'reacting' to papers presented to it.

NEXT STEPS

General agreement that the Co-Chairs, Kate Coley and Ken Foote would work together to update/prepare a draft Annual Plan for 2016/17 for discussion with Council in September 2016, based on comments above.

Further discussions will be required as memberships and TORs are developed for the new committee structure.

MATTERS ARISING - nil

Hawke's Bay Clinical Council
The past year in summary 2016/2017

Strategic Input

- Integrated Urgent Care Alliance
- Urgent Care Project Updates
- Hawke's Bay Health Alliance – Implications of delegations to Clinical Council
- Health Literacy
- Community Pharmacy Services Position Paper
- Regional Tobacco Strategy for HB 2015-2020
- Best Start Healthy Eating
- Youth Health Strategy
- Transform and Sustain Programme Refresh
- 13-17 Year Old Primary Care Zero Rated Subsidy Framework
- Health Equity
- System Level Measures

Service Development and Design Input

- Collaborative Pathways
- Elective Services Performance
- Laboratory Services
- Radiology Services
- Transforming Primary and Community Health Care in HB
- Gastroenterology and Endoscopy Services
- Renal Services
- End of Life - Advanced Care Planning
- HB Palliative Care Strategy
- Long Term Conditions Report
- Mobility Action Plan preliminaries for MoH RFP
- Orthopaedic Review – Closure Phase 1 (Redesign and delivery of Muscular Skeletal Service
- Orthopaedic Review – Phase 2 draft
- Rheumatic Fever Target 2016-17
- Alcohol Harm Reduction Position Statement
- Establishing Health and Social Care Localities in HB
- Person & Whanau Centred Care
- Designated Prescriber – Registered Nurses
- Manage My Health (MMH) Provider Portal: Pilot Phase
- Health Awards Judging
- Relationship Centred Practice
- Imaging Guidelines in the Secondary Care Environment
- Maintaining the Radiology Service to Primary & Secondary Care
- Integrating GP Services in Wairoa
- Travel Plan "Go Well"
- Clinical Committees Review
- Health Literacy
- Implementation of the HB Clinical Governance Committee Structure
- Support for Pacing Service
- Clinical Services Plan
- People Strategy
- Surgical Expansion Project – Clinical & Consumer Engagement
- Community Pharmacy Services Agreement

Quality

- Quality Accounts
- Quality Improvement Programme
- Using Consumer Stories to Improve Quality of Care
- HB Clinical Research Committee
- Consumer Stories for system improvement
- Complementary Therapies Policy
- Learnings from ICU Review 2013 and action plan
- Gastroenteritis Outbreak in Havelock North –August 2016
- Serious Adverse Events Report
- Quality Dashboard
- Laboratory Specimens Labelling Improvement Initiative
- Consumer Experience Feedback Results
- Legislative Compliance
- Health Systems Performance
- Health Round Table Data
- Clinical Coding

Monitoring

- Maternity Clinical Governance Group quarterly reports
- Maternity Service Annual Clinical Report
- Integrated Urgent Care
- Falls minimisation
- Annual Maori Health Plan
- Pasifika Health Action Plan
- Monitoring Consumer Reports
- Monitoring Event Reports
- Consumer Council
- Customer Focused Bookings
- Nursing Workforce
- Travel Plan
- Te Ara Whakawaiora / Culturally Competent Workforce
- Te Ara Whakawaiora / Healthy Weight Strategy
- Te Ara Whakawaiora / Smoking (National Indicator)
- Te Ara Whakawaiora / Cardiology (national indicator)
- Te Ara Whakawaiora / Access
- Te Ara Whakawaiora /Oral Health
- Te Ara Whakawaiora / Did not Attend
- Te Ara Whakawaiora / Breastfeeding
- Te Ara Whakawaiora /Mental Health and AOD
- Annual Maori Health quarterly dashboards
- HB Clinical Council TOR
- HB Clinical Council Annual Plan
- Improving the Quality of Unscheduled Care & Acute Patient Flow (ED 6 Hours)
- High Level Budget Review

Committees and Relationship Development

- Laboratory Services Committee
  - Laboratory Guidelines
- HB Clinical Research Committee
- HB Radiology Services Committee - radiology service improvement
  - Radiology Guidelines
- HB Research Committee
- HB Nursing and Midwifery Leadership Council
- Clinical Quality Advisory Committee updates (PHO)
- Maternity Clinical Governance Group
- Collaborative Clinical Pathways
- Infection Prevention Control Committee
- Falls Minimisation Committee

CLINICAL COUNCIL ATTENDANCE RECORD

2016-2017

Members	Aug	Sept	Oct	Nov	Dec	Feb	Mar	Apr	May	Jun	Jul	Mtg(s)	Of total Meetings
Chris McKenna	1	1	1	1	1	1	1	1	A	1	1	10	of 11
Dr Mark Peterson	1	1	A	1	A	1	1	A	1	1	1	8	of 11
Dr John Gommans	A	A	1	1	1	1	1	1	1	1	1	9	of 11
Jules Arthur	1	1	A	1	1	A	A	A	1	1	1	7	of 11
Dr Kiri Bird	1	1	1	1	1	1	1	1	A	1	A	9	of 11
Dr Caroline McElnay	A	A	1	1	A							2	of 5
Billy Allan	1	1	1	1	1	1	1	A	1			8	of 11
Robyn O'Dwyer	A	A	A									0	of 3
David Warrington	1	1	1	1	1	1	1	1	1	1	1	11	of 11
Dr Tae Richardson	1	1	1	A	A	A	1	A	A	A	1	5	of 11
Dr Malcolm Arnold	1											1	of 1
Dr Andy Phillips	1	A	1	1	1	1	1	1	1	1	1	10	of 11
Dr David Rodgers	1	A	1	1	1	1	1	1	1	1	A	9	of 11
Debs Higgins	1	1	1	1	1	1	1	1	1	1	1	11	of 11
Robin Whyman	1	A	1	1	1	1	1	1	1	1	A	9	of 11
Anne McLeod	1	1	1	A	1	A	A	A	1	1	A	6	of 11
Russell Wills		1	1	1	1	1	1	1	1	1	A	9	of 10
Lee-Ora Lusis							1	1	A	1	1	4	of 5
Nicolas Jones								1	1	1	1	4	of 4
Maurice King											1	1	of 1
	13	10	13	13	12	11	13	11	12	14	11		

22.2

Hawke's Bay Clinical Council

Tenure as at August 2017

Tenure		Term	Expiry
Kiri Bird	General Practitioner	1st	Sep 17
Robin Whyman	Senior Medical / Dental Officer	1st	Sep 18
David Rodgers	General Practitioner	1st	Sep 18
Anne McLeod	Senior Allied Health Professional	1st	Sep 18
Debs Higgins	Senior Nurse	1st	Sep 18
Lee-Ora Lusis	Senior Nurse	1st	Sep 19
Russell Wills	Senior Medical / Dental Officer	1st	Sep 19
David Warrington	Senior Nurse	2nd	Sep 19
John Gommans	Chief Medical Officer - Hospital		N/A
Mark Peterson	Chief Medical Officer - Primary Care		N/A
Chris McKenna	Chief Nursing Officer		N/A
Tae Richardson	Clinical Lead Clinical Advisory Governance Committee		N/A
Nicholas Jones	Acting Director Population Health		N/A
Jules Arthur	Director of Midwifery		N/A
Andy Phillips	Chief Allied Health Professions Officer		N/A
Maurice King	Community Pharmacist		31 Dec 17

22.3

Terms of Reference - Tenure

- Normally appointed for 3 years
- Ideal for one third retire by rotation each year (ie 2-3)
- Members may be reappointed but for no more than 3 terms.

Note

Members appointed by role/position do not have a finite term.

TERMS OF REFERENCE

Hawke's Bay Clinical Council

September 2015

Purpose	The Hawke's Bay Clinical Council is the principal clinical governance, leadership and advisory group for the Hawke's Bay health system.
Functions	The Hawke's Bay Clinical Council (Council) • Provides clinical advice and assurance to the Hawke's Bay health system management and governance structures. • Works in partnership with the Hawke's Bay Health Consumer Council to ensure Hawke's Bay health services are organised around the needs of people. • Provides oversight of clinical quality and patient safety. • Provides clinical leadership to the Hawke's Bay health system workforce.
Level of Authority	The Council has the authority to make decisions and/or provide advice and recommendations, to the Boards of HBDHB and Health Hawke's Bay Limited (as appropriate). To assist it in this function the Council may: • Request reports and presentations from particular groups • Establish sub-groups to investigate and report back on particular matters • Commission audits or investigations on particular issues • Co-opt people from time to time as required for a specific purpose. The Council's role is one of governance, not operational or line management. **Delegated Authority** The Council has delegated authority from the CEOs and Boards to: • Make decisions within the mandate and scope set out in the Hawke's Bay Health Alliance – Alliance Agreement • Make decisions and issue directives on quality clinical practice and patient safety issues that: ▪ Relate directly to the function and aims of the Council as set out in the Terms of Reference; and ▪ Relate directly to the provision of, or access to, HBDHB publicly funded health services; and ▪ Are clinically and financially sustainable; and ▪ Are affordable within HBDHB's current budgets. All such decisions and/or directives will be binding on all clinicians who provide and/or refer to public health services funded (in whole or part) by the HBDHB.
Membership	Members appointed by tenure shall normally be appointed for three years whilst ensuring that approximately one third of such members 'retire by

	rotation' each year. Such members may be reappointed but for no more than three terms. Members appointed by role/position do not have a finite term. *By role/position:* • CMO Primary Health Care • CMO Hospital • Chief Nursing Officer • Midwifery Director • Director of Allied Health • Chief Pharmacist • Director Population Health • Clinical Lead PHO Clinical Advisory and Governance Committee *By Appointment (tenure):* • General Practitioner x 2 • Senior Medical / Dental Officer x 2 • Senior Nurse x 3 • Senior Allied Health Professional When making appointments, consideration must be given to maintaining a wide range of perspectives and interests within the total membership, ensuring in particular that Māori health and rural health interests and expertise are reflected.
Chair	The Council will annually elect a chair and deputy, or co-chairs.
Quorum	A quorum will be half the members if the number of members is even, and a majority if the number of members is odd.
Meetings	Meetings will be held monthly at least ten times per year, or more frequently at the request of the chair/co-chairs. Meetings will generally be open to the public, but may move into "public excluded" where appropriate and shall be conducted in accordance with HBDHB Board Standing Orders as if the Council was a Board Committee. A standing reciprocal invitation has been extended to the Hawke's Bay Health Consumer Council for a representative to be in attendance at all meetings. Matters may be dealt with between meetings through discussion with the chair/co-chairs and other relevant members of the Council.
Reporting	The Council will report through HBDHB and Health Hawke's Bay Limited Chief Executives to the respective Boards. A monthly report of Council activities/decisions will be placed on the DHB website when approved.
Minutes	Minutes will be circulated to all members of the council within one week of the meeting taking place.

HAWKE'S BAY District Health Board Whakawāteatia	**Quality Annual Plan – Review 2016–2017**
	For the attention of: **Clinical Council, Consumer Council & Finance Risk and Audit Committee**
Document Owner & Author:	Kate Coley – Executive Director of People & Quality
Reviewed by:	Executive Management Team
Month:	August, 2017
Consideration:	For Information

RECOMMENDATION

That Clinical Council, Consumer Council & the Finance Risk and Audit Committee:

1. Note the contents of the report

PURPOSE

The purpose of this paper is to provide the Clinical & Consumer Councils and FRAC with a full review of the Quality Improvement & Patient Safety Annual Plan 2016/17.

EXECUTIVE SUMMARY

The DHB has both a stated commitment to quality and safety and a well-established patient safety and quality management system in place. The annual plan for 2016/17 was aligned to a number of foundational documents as follows:

- Hawke's Bay "Working in Partnership for Quality Framework"
- National programmes & safety markers (Health Quality & Safety Commission)
- Regional priorities (RSP through the Central regions Safety & Quality Alliance)
- Transform & Sustain
- HQSC "Governing for Quality" February 2016 publication

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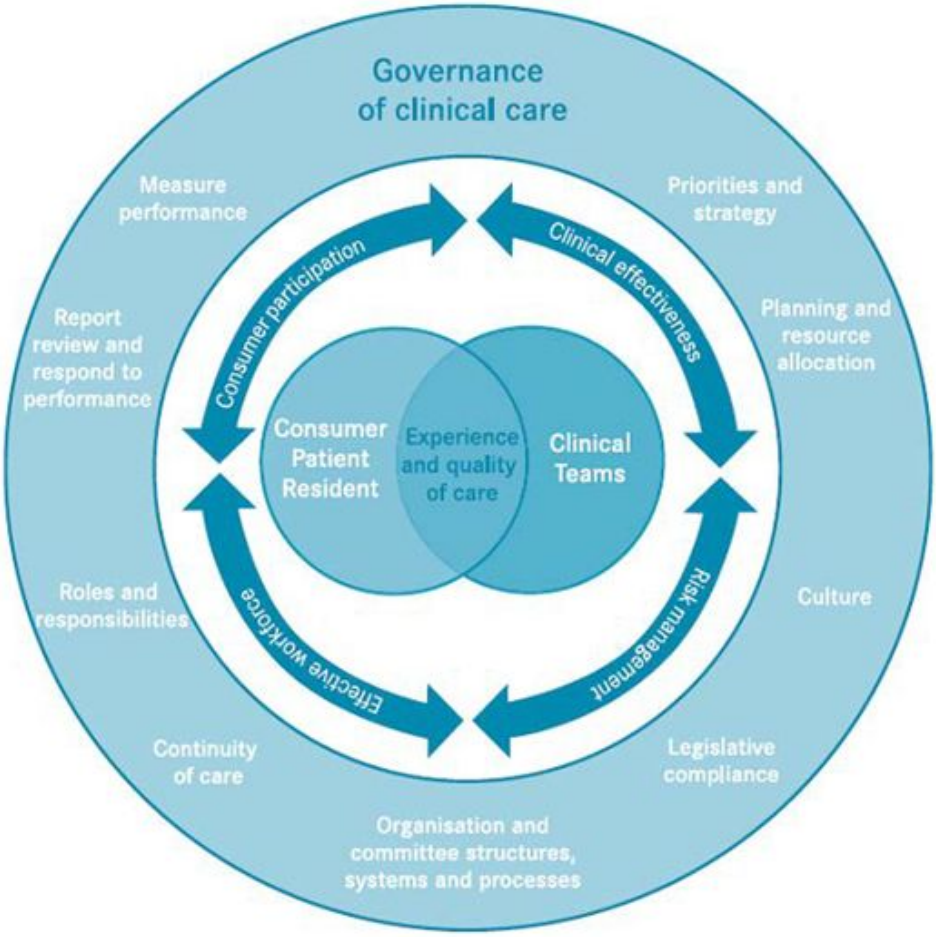
In addition to this the DHB aligned the annual plan to the recognised definition of clinical governance and framework.

Clinical Governance is defined as

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

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

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



[1]

The key challenge as an organisation and the wider sector is to continue to maintain and embed the quality framework so as to ensure that patient safety and quality of clinical care is part of everyone's business and is embedded in our culture.

Appendix 1 details the progress against agreed objectives for 2016 – 17 in relation to embedding a clinical governance framework.

SUMMARY OF ACHIEVEMENTS

The following highlights the key achievements and activities that have been implemented in the past 12 months:

- Significant improvement in directorates and services engagement with consumers in co-design projects. The Consumer Engagement manager has provided support and advice for projects, improvement initiatives and developed capability around ensuring that the consumer's voice is heard.

[1] Victorian Clinical Governance Policy Framework, 2009

- Improvement advisors becoming embedded with Directorate leadership teams and providing a high level of support and expertise in key programmes of work including Faster Cancer Treatment, FLOW, Surgical Expansion.

- Achievement of all HQSC Safety markers and maintaining number one position in Hand Hygiene for the last three quarters of 2016/17.

- Investment made to increase the skills and capability of teams in relation to improvement methodology, patient safety, privacy matters and consumer engagement.

- Establishment and endorsement of a new clinical governance committee structure and advisory groups providing assurance to Clinical Council and Board on matters relating to patient safety and clinical quality.

- Positive feedback from MoH and HQSC on our fourth Quality Accounts publication.

- Development of Relationship Centred Practice development programme supporting clinicians to improve their face to face engagement with consumers across the central region.

- Development of the Consumer Engagement Strategy with the implementation falling into the refreshed Transform & Sustain programme of work.

- Full RFP process undertaken to identify a provider for the new cross sector integrated risk management system.

- Better relationships built at a local level with the PHO, Primary Care and other contracted providers through interactions with experts from the People & Quality directorate.

KEY PRIORITIES FOR 2017-18

The following identifies the key priorities for the 2017-18 annual plan, which will be far more focussed on significant projects and pieces of work rather than the normal business as usual activities.

- Projects and activities relating to the implementation of the health literacy principles

- Full implementation of the clinical governance committee structure and the establishment of an effective communication and reporting framework, ensuring clinical assurance and the sharing of learnings across the sector.

- Development and implementation of the Quality dashboard which will be reported quarterly to Clinical Council and FRAC/Board.

- Implementation of the new Integrated Risk Management System across the DHB and the development of a rollout across the rest of the sector over the next 3-5 years.

- Implementation of a new local patient experience survey and mechanisms for closing the loop with our patients identifying the improvements that we have implemented based on that feedback.

- Utilisation of internal audit to review the self-assessment undertaken in August 2016 aligned to the HQSC “Governing for Quality” publication to ensure that this was objective assessment and provide recommendations for any further improvement.

- Continue to grow the capability of clinical teams across the sector ensuring a sustainable improvement and accountability model going forwards.

APPENDIX 1 - QIPS - Annual Plan 2016 – 2017 Annual Review of Progress

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Progress Update
Wellness	Ensure that our systems of communication are responsive to the people of Hawke's Bay	Development of a sector wide Health Literacy Framework/Principles	Principles endorsed by all relevant governance bodies	**Complete** Health literacy principles agreed. Presentation to Board in July outlining work completed and what is planned for the next six months
		Implementation of Health Literacy Framework	Action plan developed and monitored on a quarterly basis	**Ongoing**. Presentation to July Board outlining activities already completed, current activities across the sector for the next six months. Further reports to be provided on a six monthly basis.
		Support development and continual review of our health website in conjunction with Communications team	Website continually updated	**Complete - Ongoing**. Close working relationship with Communications team ensuring that messages are effectively developed. Quality Accounts a key opportunity for DHB to engage effectively with the community around all of the projects and initiatives underway.
		Continue to support quality improvement initiatives.	Projects benefits realised	**Complete - Ongoing**. Consumer Engagement Manager and Improvement Advisors involved in multiple projects. This ensures that projects include improvement science methodologies and tools, and the right consumers are involved so to enable co-design with the clinical teams. Projects are across the sector and include Oncology review, surgical site expansion project, bowel screening programme, FLOW, Faster Cancer treatment, customer focussed booking, family violence, Right patient, Right Practice, Right results (Primary Care), Long Term Conditions framework, SAE Review (Primary Care), Maternal mental health care pathway, hand therapy services.

APPENDIX 1 - QIPS - Annual Plan 2016 – 2017 Annual Review of Progress

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Progress Update
Wellness	Improving the Communication between health professionals and the consumer	Implementation of HL Training programmes to support clinicians to understand how to best engage with consumers	Training programmes developed and utilised	**Ongoing.** Development of Relationship Centred Practice for all clinical teams to improve health literacy understanding and skills to better engage with consumers. This programme was also rolled out to Central regions as part of their agreed programme of work. Engaging effectively with Maori a key component in regards to skill development across the organisation. PHO/GP online training in Health literacy available and in place. Health Literacy introduction currently under development as part of the rollout of the health literacy project.
		Continue to build awareness with clinical teams around patient centred care e.g. Patient Safety Week (November)		**Ongoing**. Patient Safety Week undertaken in November of each year. Focus in 2015 and 16 was around consumer engagement and "what matters to you". Work in relation to building our culture will fully support the embedding of our patient centred approach along with the Health Literacy principles, Consumer engagement strategy, and better utilisation of the patient experience survey (national and local).
		Development of a quarterly sector wide quality dashboard focussed on patient safety, clinical effectiveness and patient experience	KPI's developed	**Outstanding**. The clinical governance committee structure has been endorsed by Clinical Council and is currently being implemented with development of new TOR for the agreed 5 clinical committees, a subsequent refresh of the advisory group's terms of reference and membership review for all meetings. This governance structure will evolve to work across the sector and include consumers ensuring that patient safety and clinical quality are better connected and transparent.

APPENDIX 1 - QIPS - Annual Plan 2016 – 2017 Annual Review of Progress

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Progress Update
				Once the advisory groups have been formed they will identify KPIs for the quality dashboard which will be presented to both Clinical Council and FRAC/Board on a quarterly basis.
Monitoring & Measuring	Presentation of quality health information	Communication of the dashboard to relevant governance bodies and to the sector	Quarterly report communicated & shared	**Outstanding** Once the advisory groups have been formed they will identify KPIs for the dashboard which will be presented to both Clinical Council and FRAC/Board on a quarterly basis.
		Publication of the annual Quality Accounts report	Report completed and positive feedback received from community and HQSC	**Complete - Ongoing** 2016 Quality Accounts released. Feedback again from MOH and HQSC was positive in regards to the content, style and quality of the accounts. HQSC and MOH are stepping back from monitoring DHB Quality accounts, however the annual requirement remains for accounts to be published. Planning for 2017 Accounts has commenced with a full release September/October 2017.
		Review of information provided to patients on admission and on discharge, with a view to making improvements.	Plan developed and implemented with improved patient responses to national patient experience survey	**Outstanding** This will be identified as a project for the patient Safety team alongside the health literacy advisor in Q2 of the 2017/18 financial year.

APPENDIX 1 - QIPS - Annual Plan 2016 – 2017 Annual Review of Progress

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Progress Update
		Reduce the harm from falls through an integrated approach through the falls minimisation Committee	Improved engagement across the sector leading to a reduction in falls & harm from falls	**Complete - Ongoing** Falls Committee is representative of all stakeholders including hospital, PHO, ACC, Sport HB, SMO, ARRC, and St Johns, actively working together to coordinate HB regional campaigns e.g. Focus on Falls – April Awareness Month. Hospital Working Group – working with facilities to improve bedside lighting, call bell access and nonslip flooring.
	Improve HB Health Sector performance against HQSC quality safety markers (HQSM)	Ensure Falls risk assessment and care plans are completed for all admissions	HQSM achieved/exceeded consistently (90% target)	**Achieved - Ongoing** Improvement advisors completed initial audit of all adult areas and developed actions plans to increase compliance to HQSM. Targets are now consistently met and reported. Percentage of patients aged 75 and over (Maori and Pacific Islanders 55 and over) that are given a falls risk assessment. HBDHB 96.7%. (National threshold 90%) Percentages of patients assessed as being at risk have an individualised care plan which addresses their falls risk. HBDHB 98% (National threshold 90%)
Monitoring & Measuring	Presentation of quality health information	Review of all falls to ensure learnings are identified and opportunities for improvement are implemented.	Recommendations/ learnings shared and implemented	**Completed – Ongoing** Clinical Event Advisory group reviews all falls which result in harm and thorough investigations are completed. Learning outcomes and recommendations are endorsed by the advisory group and these learnings are shared and disseminated across the sector.

APPENDIX 1 - QIPS - Annual Plan 2016 – 2017 Annual Review of Progress

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Progress Update
		Reduce the risk of health associated infection by maintaining the achievement at or above the 80% compliance rate for hand hygiene.	80% compliance rate achieved/exceeded consistently	**Achieved – Ongoing** HB continues to trend above 85%. In the last three quarters of 2016/17 the DHB was number 1 across the country.
		Reduce the risk of harm from pressure injury with the establishment of a cross sector pressure injury review committee.	Establishment of cross sector Pressure Injury Committee	**Complete – ongoing** This is a new initiatives from HQSC and ACC and has been evolving at a national level. The DHB has a Clinical Nurse Specialist (Wound) who has been working with patient Safety Advisor and the relevant stakeholders to establish a committee structure similar to the successful Falls Committee. This committee will report through the newly established clinical governance committee structure. Needs analysis of all RN's over 800 staff canvassed (Hospital, ARRC, Hospice but excluding physical disability residential facilities initially) to develop targeted training – will include MDT in future. Programmes and initiatives to be developed in 2017/18. Envisaged that a KPI/target will be developed by HQSC which will be reported against quarterly.
		Support the development of a pressure injury strategy and implement any learnings from pressure injury events identified.	Development of programme of work	**Complete** Provided input and feedback into the development of the national policy and suggested programmes of work.

APPENDIX 1 - QIPS - Annual Plan 2016 – 2017 Annual Review of Progress

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Progress Update
		Development of a quarterly sector wide quality dashboard focussed on patient safety, clinical effectiveness and patient experience	KPIs developed	**Outstanding** Once the advisory groups have been formed they will identify KPIs for the quality dashboard which will be presented to both Clinical Council and FRAC/Board on a quarterly basis.
Monitoring & Measuring	Ensuring that quality improvement and safety reporting and monitoring is provided and communicated effectively	Communication of the dashboard to relevant governance bodies and to the sector	Report provide quarterly to relevant governance bodies and wider	**Outstanding** Once the advisory groups have been formed they will identify KPIs for the quality dashboard which will be presented to both Clinical Council and FRAC/Board on a quarterly basis.
		Continue to utilise benchmarking data provided by Health Roundtable (HRT) to identify further areas for improvement.	Quarterly Executive Summary shared with HS and Improvement initiatives identified and implemented	**Complete – Ongoing** Executive summaries have been provided and presented to HS leaders which have supported a number of pieces of work including cardiology pathways and bed days programme. Continue to subscribe to HRT as this provides benchmarking data from other NZ DHB's and other Australian health providers.
		Ensure reporting of Serious Adverse Events and ACC Treatment Injury information is completed with learnings identified and recommendations implemented.	SAE Report provided annually	**Complete – ongoing** Considerable work has been undertaken by Patient Safety & Clinical Compliance team to ensure adverse events are reviewed within required timeframe with clinical partners leading the reviews. Learning reports have been developed, signed off by the Clinical Event Advisory Group and disseminated across the HB health sector. New Integrated risk management system will provide the sector with the ability to better

APPENDIX 1 - QIPS - Annual Plan 2016 – 2017 Annual Review of Progress

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Progress Update
				monitor trends, near misses and provide informative reports leading to improvement activities. SAE report endorsed by Board in September and released with no negative media interest. ACC Treatment injury release in April 2017 again received no negative media interest.
		Review all current clinical provider contracts to ensure they meet the HB sectors quality and patient safety requirements.	Principles of quality applied to clinical provider contracts.	**Outstanding** This work will be carried over into the 2017/18 financial year.
Working With HB Community & Patient Experience	Improving clinical oversight in all provider contracts	Consider the development of a mechanism to collect information to monitor quality and safety within our contracted providers	Ensure appropriate reporting processes	**Outstanding**. RFP completed for new Integrated Risk management reporting system which will enable a full rollout of the tool across the sector over the coming years. This will ultimately give greater visibility and transparency across the sector of any issues relating to patient safety and quality with our providers. Excellent working partnership with the PHO through ED of P&Q, Patient Safety & Clinical Compliance Manager and Improvement advisor. This has provided the teams with the ability to support Primary Care when issues have arisen. Advice and support is also provided to other contracted providers including ARRC and Cranford Hospice.
		Development of an overarching Person & Whanau Centred Care strategy, encompassing Patient Experience, Consumer Engagement &	High level paper developed and feedback sought before finalisation.	**Ongoing**. All the elements identified have been encompassed into the Building our Culture work-stream under the Transform & Sustain refresh. The health literacy framework has been endorsed and a presentation to Board

APPENDIX 1 - QIPS - Annual Plan 2016 – 2017 Annual Review of Progress

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Progress Update
		Health literacy pieces of work.		outlining the work already completed, and the plan for the next 6 months will be presented in July. Consumer engagement strategy endorsed by EMT and Consumer Council and will be presented to Board in August. The Big Listen will be undertaken in September and this will inform the development of the People Strategy to support a change in culture over the next 5-10 years.
	Improving the process of gathering patient experience data and stories, sharing them widely across the sector.	Continue to participate in the National Patient Experience Survey	Communication & Awareness building strategy implemented	**Complete – Ongoing** Continue to participate in national experience survey, however limitations exist due to a low response rate. DHB has agreed that we need to look at a local experience survey/mechanisms to ensure that we better hear the voice of our patients more systematically and regularly. ,
		Development and implementation of a local patient experience survey aligned to the values of the sector.	Provide HQSC with information and undertake quarterly analysis of results	**Outstanding**. The development and implementation of a local experience survey is now part of the Transform & Sustain refresh programme. It is envisaged that by the end of 2017 we will be clear around the mechanism(s) for gathering the feedback more effectively with a full rollout by end of Q3 2017/18. Key to this project is our ability to hear the voice of our Pasifika and Maori patients through multiple mechanisms. Finally, we need to ensure the linkage to the services and with the Improvement advisors to implement improvements identified and to close the loop with our patients through the principle of "You Said, We Did" regular communications.

APPENDIX 1 - QIPS - Annual Plan 2016 – 2017 Annual Review of Progress

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Progress Update
		Targeted approach to seeking out feedback from Maori & Pasifika patients	Develop and Test questions Identify mechanism to gather data	**Outstanding** As above
		Continue to share patient stories with Board and more widely across the sector.	Mechanisms identified and implemented	**Complete – ongoing** Stories continue to be shared at Board. Toolkit will support services in capturing and sharing their own stories for quality improvement purposes. Further refresh of how we ensure we take the sharing of consumer stories to the next level, building a library of video's, interviews, and clinical/patient teams presenting the stories together.
		Share quarterly results of both national and local survey results with relevant governance groups identifying themes and areas for improvement	Information provided as part of ¼ dashboard Results shared and teams to identify improvement activities	**Complete – ongoing** Quarterly presentations provided to all governance boards identifying the feedback trends and where there are opportunities for improvement. Once the quality dashboard is developed and the new local patient experience survey and integrated risk management reporting system is in place then reporting will mature and be more effective for clinical teams.
		Identify a variety of mechanisms to engage effectively with our Community around health matters to gather their feedback and ideas	Identify provider to support effective community engagement and implement programme	**Outstanding** Initial conversations with potential providers have been undertaken. This action will transfer to Q4 2017/18 and be reviewed once the local patient experience survey has been fully implemented.

APPENDIX 1 - QIPS - Annual Plan 2016 – 2017 Annual Review of Progress

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Progress Update
	Improving the process of monitoring consumer feedback and relevant recommendations and improvements	Development of a Consumer Engagement framework and guideline for all staff.	Consider all research, draft and gather feedback before finalisation and communication to all teams Discuss with PMO	**Outstanding** Draft consumer engagement strategy endorsed by Consumer Council and EMT with very minor amendments. Will be presented to Board in August. The implementation of the strategy forms a project under the new Transform & Sustain refresh programme of work.
	Developing community engagement and communication channels	Ensure that all Project TOR require specific discussion in regards to the level of consumer engagement	Development of series of education programmes	**Complete – Ongoing** All project terms of references now incorporate the application of key principles of early engagement at project start up. Consumer Engagement Manager heavily involved in providing advice to teams, departments and services to enable the voice of the consumer to be heard in all pieces of co-design work. For example Oral Health, surgical expansion programme, AT&R Review, Oncology, vascular services, and refresh of PAG. Ad hoc support and development is provided to teams and as part of the implementation of the Consumer Engagement Strategy a generic programme will be delivered. This programme is currently being co-designed with Communities, Women and Children directorate.
	Supporting the consumer voice to become part of nay planning or redesign process	Continue to build capability in co-design methodology and utilising patient experience feedback to improve service design and delivery	Programmes delivered with high participation	**Complete – Ongoing** Number of workshops held with governance groups, and directorate leadership teams alongside specific advisory support by Consumer Engagement Manager. As part of the implementation of the strategy a manager toolkit will be developed alongside a training package for all teams. Currently co-designing this with the Communities, Women and Children's Directorate as they develop programmes and projects.

APPENDIX 1 - QIPS - Annual Plan 2016 – 2017 Annual Review of Progress

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Progress Update
		Implementation of quality forums within HB bringing together those responsible for quality across GP Practices, ARRC and NGOs to enable sharing of learnings and development of a programme of work to support these providers	Quality forums established	**Outstanding** Some focus groups and forums have been undertaken in the last 12 months with ARC facilities, wider sector (HB Lean Improvement Group) and some GP Practices. In 2017/18 we will need to ensure that these forums are better embedded and the DHB supports Primary & Community providers where it is able.
		Ensure effective representation of HB on Central Regions Quality Safety Alliance to support achievement of objectives within RSP	Participation and engagement high from all areas	**Complete – Ongoing** Executive Director of People & Quality (EDPQ) member of the national and central regions Quality managers group and actively attends quarterly meetings. A number of the RSP activities have been completed including regional phased implementation of Relationship Centred Practice training, contributions to HQSC 'Open Book' learnings, and collaboration on adverse event management policy development
Leadership & Workforce	Maintain and build relationships across the sector, regionally and at a national level	Build relationships with HQSC and Ko Awatea	Participate in relevant groups and influence decision making Establish training partnership Implement Improvement Network	**Complete – Ongoing** EDPQ has strong existing relationships at HQSC and Ko Awatea which has enabled the development of a business case from Ko Awatea to deliver the Improvement Advisors programme and Improvement Fundamentals in the central region. Due to financial constraints at many of the DHBs this has yet to be implemented, however it is envisaged that an improvement fundamentals could be sponsored by HQSC for the central region in 2017/18. This will enable over 200 staff to be up skilled in improvement methodology across the region.

APPENDIX 1 - QIPS - Annual Plan 2016 – 2017 Annual Review of Progress

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Progress Update
				Number of DHB abstracts accepted for sharing at APAC Conference in September 2017, however this will no longer occur due to the APAC cancellation. Member of ED team identified to attend Improvement Advisor Master class training at Ko Awatea. This will provide further expertise to the FLOW project.
		Implementation of new clinical governance committee's structure to ensure effective reporting to clinical council.	Committees established, with TOR, cross sector representation and reports provided through to Clinical Council	**Outstanding**. The clinical governance committee structure has been endorsed by Clinical Council and is currently being implemented with development of new TOR for the agreed 5 clinical committees, a subsequent refresh of the advisory group's terms of reference and membership review for all meetings. This governance structure will evolve to work across the sector and include consumers ensuring that patient safety and clinical quality are better connected and transparent. Once the advisory groups have been formed they will identify KPIs for the quality dashboard which will be presented to both Clinical Council and FRAC/Board on a quarterly basis.
		Establishment of an annual audit programme to ensure all clinical areas undertake regular audits against key HQSM and sector wide priorities	Audit Committee established, and programme of work endorsed by Clinical Council. Reports provided on a quarterly basis	**Complete – ongoing** Audit Advisory group identified in the new clinical governance committee structure with the Terms of Reference currently under development. An annual audit plan will be developed and endorsed by the advisory group will findings and recommendations reported through to Clinical Council.

APPENDIX 1 - QIPS - Annual Plan 2016 – 2017 Annual Review of Progress

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Progress Update
				Currently all clinical areas across the DHB (Hastings, Napier, Wairoa and CHB) all undertake monthly clinical audits aligned to the relevant certification standards and HQSM requirements. The results of these monthly audits are shared with the health services leadership team and areas for improvement identified and implemented.
	Facilitating the quality agenda through clinical and management leadership and governance structures, promoting board responsibility for quality improvement and patient safety	Develop and implement mechanisms to ensure learnings from patient events and incidents are shared and recommendations are fully implemented.	Mechanisms agreed, learning shared and recommendation implementation monitored by Clinical Event Advisory Groups	**Complete – ongoing** The Clinical Event Advisory group is well established in the clinical governance committee structure. The recent new national serious events management policy has provided the opportunity to review the membership of this group and a new process for investigating serious adverse events is currently being co-designed with clinical partners. A new Patient Safety learning document has been developed and during the course of the year a number of learnings have been shared across the sector reducing the risk of a similar incident occurring with another patient. Recently presented a number of patient events/reviews and the proposed new SAE investigation process at Grand Round.
		Implementation of new risk management framework	Framework, tools and reporting mechanisms in place and utilised	**Outstanding** RPF completed to identify a new integrated risk management system for the whole of the HB health sector.
		Review of current event reporting system.	Business Case developed and endorsed	**Complete** Business case approved and RFP undertaken and now completed.

APPENDIX 1 - QIPS - Annual Plan 2016 – 2017 Annual Review of Progress

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Progress Update
		Facilitate and lead the implementation of a new event, risk and feedback reporting system	Project plan developed and implemented	**Outstanding** RFP Completed. Project Manager in place to support the implementation of the new system supported by subject matter experts from the Quality team and IS. Project plan endorsed with implementation of new system by end of 2017 within the DHB, with the second phase being the roll out to PHO and number of GP practices in early 2018.
		Review of current quality policies and procedures to support quality improvements and safety across the Hawkes Bay health system	Policies refreshed	**Complete - Ongoing** Number of policies reviewed and streamlined to align to best practice. These include Visitor policy, Consumer Engagement Policy, Serious Adverse Events Policy, Open Disclosure policy.
		Ensure Privacy action plan is implemented and annual audit it undertaken to meet requirements of GCPO.	Privacy plan reported against on a quarterly basis	**Complete – Ongoing** Annual audit against GCPO requirements undertaken and completed. Privacy advisory group established as part of the clinical governance committee structure. This group will develop the Privacy strategy and action plan in conjunction with Patient Safety Manager, Privacy Officers and Information Services. There are a number of issues from an information security context which have been highlighted to the CIO and work is underway to resolve these issues as a priority. Online Privacy training available to all staff and part of all orientation programmes. Privacy training has been provided to a number of GP practices and private providers.
		Facilitate and support the implementation of	Progress reports provided as per MOH requirements.	**Complete – Ongoing**

APPENDIX 1 - QIPS - Annual Plan 2016 – 2017 Annual Review of Progress

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Progress Update
		Certification corrective actions with all clinical teams	Corrective actions closed by MOH.	Corrective action report completed and submitted to Health Cert. Ongoing work to be undertaken by services to ensure compliance with Standards. Mid-point surveillance due in October/November 2017.
		Legislative Compliance annual review undertaken	Audit undertaken Report provided to FRAC	**Complete** Legislative compliance audit undertaken and findings shared with FRAC. Recommendations paper to be developed for FRAC in November to consider whether there is a necessity to undertake a separate compliance check due to the variety of audits that are undertaken such as certification, ACC Partnership programme and IANZ audits which align to the legislative requirements.
		Development of a programme of work to support building the capability of all teams.	Annual Education programme developed and delivered	**Complete – Ongoing** Quality Improvement Training provided via Basic Management Programme x4 times in 2016 – in excess of 60 staff attended. Individualised training for Allied health and Presbyterian Support professionals from across the sector. National Quality Improvement training study Day facilitated on site. Ko Awatea onsite training (Improvement Methodology and Improvement for Leaders) and ongoing liaison support in place. Improvement Advisors have developed new training programme for sector (practical application of improvement science), including workbook/training manual. New Improvement templates developed to facilitate ease of use of quality tools, all available on Our Hub. Ongoing advice and support provided to all teams by Improvement advisors. The intention of undertaking this training is to build skills and capability of our frontline teams so that they are able to continuously look at improvements in their area's and that there is accountability and responsibility for those with the clinical teams, reducing the reliance on the quality team.

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Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Progress Update
				Continue to market and encourage all staff to complete online training modules: 'Enquiring Minds' (for new employees); Ko Awatea 'Improving Together'; and MoH Lean training.
		Review of position profiles and performance appraisal process to ensure quality and patient safety components are included.	Position profiles & PAS templates updated	**Outstanding** New position profile template identifies a key purpose in positions around continuous improvement aligned to our Akina value. All clinical position profiles focus on quality and patient safety as part of their competency requirements. Overarching performance appraisal system and process still to be refreshed.
Leadership & Workforce	Implementing clinical leadership and building leadership capacity at all levels	Continue to map talent across tier 3 and tier 4 management populations across the sector identifying potential.	Annual Mapping exercise undertaken and reports provided	**Complete – Ongoing** Talent mapping completed for all tier 3 and 4 managers. Report to be provided to EMT and feedback to be provided to all managers. Nationally all DHBs have agreed to align their leadership development and talent mapping to the State Services Commission framework. This work will be undertaken in 2017/18 with Hawke's Bay as the lead for central region as we are the only DHB who currently undertakes talent mapping. The framework will mean the refresh of the leadership competencies, 360 assessment, development programmes, performance appraisal system and the talent mapping methodology. Once this is completed the sector will have the ability to map all its leaders, identify emerging leaders, put in place succession planning and develop a number of leadership development offerings.

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Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Progress Update
		Extend the current talent mapping strategy to identify hidden and emerging talent	Tool developed and implemented, with hidden talent identified	**Outstanding** See above
		Implementation of a development strategy for those identified to ensure succession plans are clearly identified and managed.	Plan implemented	**Outstanding** See above
		Implementation of new Staff Engagement Survey	Staff Engagement Survey run	**Complete** Staff engagement survey on hold. The work with April Strategy in the coming months includes an online survey which will be utilised on an ongoing basis.
		Review of information and feedback with the identification of organisational wide actions.	Reports collated and summarised for presentation	**As above.** All feedback gathered through The Big Listen (Online surveys and workshops September) will be shared with the sector and the People Strategy developed to ensure that actions are taken.
Leadership & workforce	Improving workforce engagement	Implementation of actions	Action plans developed and progress against action monitored regularly.	**As above**
		Implementation of GEMBA Walks	Agree approach and purpose	**Outstanding**

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			Implementation and identification of areas for improvement	Await the outcomes of the Big Listen and consider the implementation of this as a quick win or year 1 priority of the People Strategy.
		Support staff to attend training and conference opportunities to continue to build expertise and skills	Learnings shared and skills increased	**Complete – Ongoing** Training and development opportunities provided to People & Quality team which are aligned to the objectives and deliverables of the directorate and the organisation ensuring that learnings and opportunities for improvement are disseminated. Attendance at APAC conference in September. A number of improvement advisors completed Masters during the year.
		Support staff to complete annual performance appraisals and development plan to ensure staff are supported to maintain professional competencies	Performance Appraisal targets achieved	**Complete – Ongoing** Appraisals completed
		Ensure that all staff have annual leave plans	Annual Leave indicators achieved	**Complete – Ongoing** Annual Leave plans standing meeting agenda item and all directorate members have plan in place. .
QIPS Team	QIPS Workforce Development	Ensure that the QIPS team has opportunities to share knowledge and skill across the team through regular team meeting, quarterly	Planning days implemented Successes celebrated	**Complete** New People & Quality Directorate planning days undertaken to clearly define purpose, aims and objectives for 2017/18 financial year. Successes are celebrated and shared with all team members.

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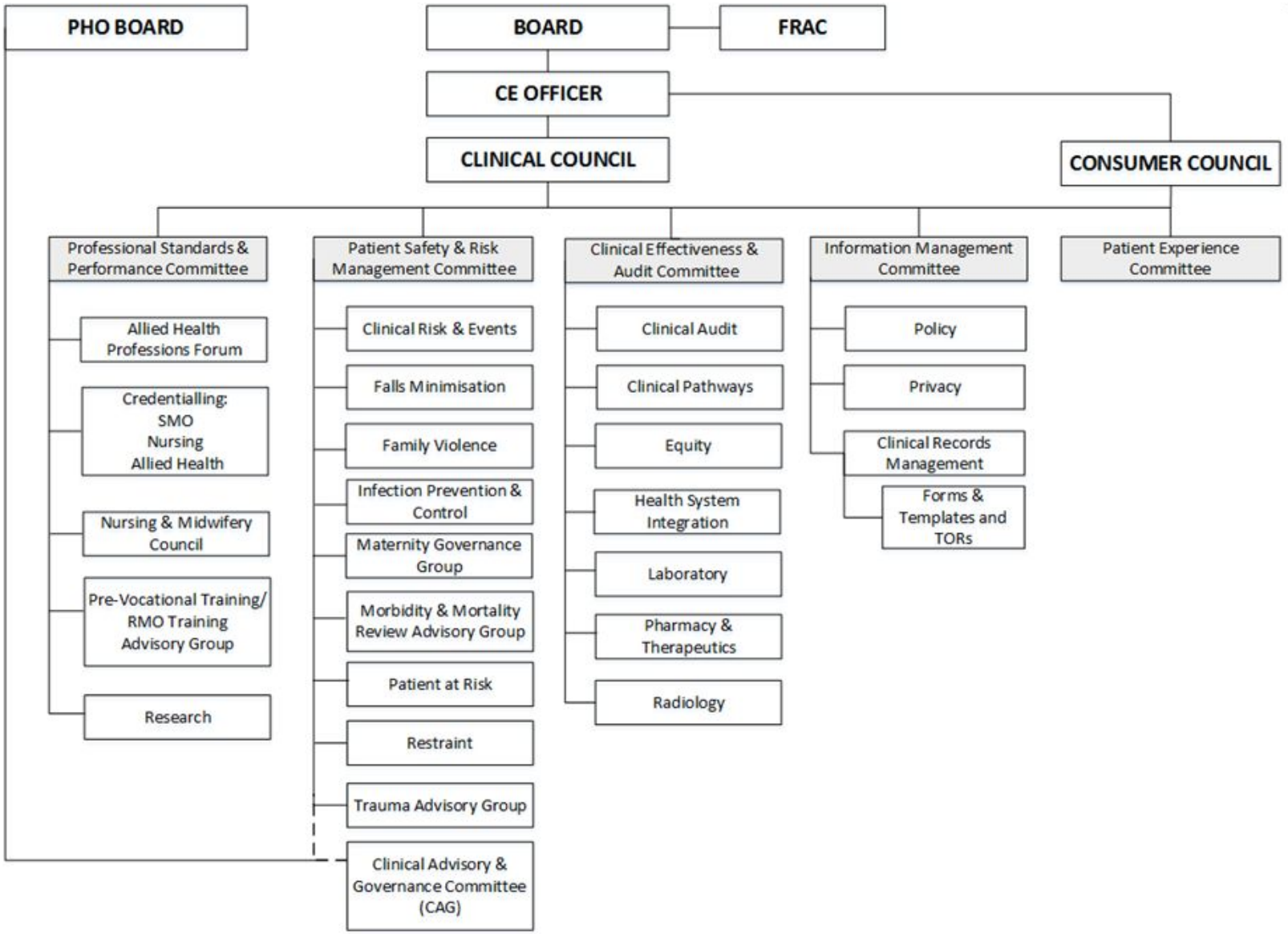
Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Progress Update
		sessions and annual planning day.		
		Budget and saving efficiencies for QIPS	Budget savings achieved	**Achieved** Budgeted savings achieved in Quality, with an underspend in the year of $100k.

CLINICAL GOVERNANCE COMMITTEE STRUCTURE UPDATE

Russell Wills, David Warrington,
David Rodgers and Andy Phillips

25.1

CLINICAL GOVERNANCE COMMITTEES STRUCTURE



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

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.	• 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	• 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.	• 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

	• Provide input through representation on EMT, Alliance Leadership Team and through attendance at HB Health Sector Leadership Forum.	experience' through the health system.	• 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.	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.
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**
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.

DEVELOPMENT OF COUNCIL'S ANNUAL WORKPLAN 2017-18

ELECTION OF CHAIR / CO-CHAIRS