Hawke's Bay Health
Consumer Council Meeting

Date: **Thursday, 15 March 2018**

Meeting: **4.00 pm to 6.00 pm**

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

Council Members:

Rachel Ritchie (Chair)
Rosemary Marriott
Heather Robertson
Terry Kingston
Tessa Robin
Leona Karauria
Sami McIntosh
Deborah Grace
Jenny Peters
Olive Tanielu
Jim Henry
Malcolm Dixon
Sarah Hansen
Dallas Adams
Kylarni Tamaiva-Eria
Dr Diane Mara

Apologies:

In Attendance:

Kate Coley, Executive Director People & Quality (EDP&Q)
Ken Foote, Company Secretary (Co Sec)
Tracy Fricker, Council Administrator / EA to EDP&Q
Debs Higgins, Clinical Council Representative
Linda Dubbeldam, Health Hawke's Bay Representative

HB Health Consumer Council
Agenda

Public

Item	Section 1 – Routine	Time (pm)
1.	Karakia Timatanga (Opening) / Reflection	4:00
2.	Apologies	
3.	Interests Register	
4.	Minutes of Previous Meeting	
5.	Matters Arising – Review Actions	
6.	Consumer Council Workplan	
7.	Chair's Report (verbal) – Rachel Ritchie	
8.	Youth Consumer Council Report (verbal) – Dallas Adams	
9.	Consumer Engagement Update (verbal) – Kate Coley	
	Section 2 – Discussion	
10.	CEO Update (verbal) - Kevin Snee	4:30
11.	Clinical Governance Structure - Value Assessment – Andy Phillips	4:45
12.	Establishing Health and Social Care Localities in HB (update) – Jill Garrett	5:00
13.	Clinical Services Plan Sector Update – Ken Foote	5:15
14.	Consumer Council Annual Plan 2017/18 - Progress Report	5:25
15.	HB Health Sector Leadership Forum Reflections	5:35
	Section 4 – General	
16.	Topics of Interest – Member Issues / Updates	5:55
	Karakia Whakamutunga (Closing)	6.00

NEXT MEETING:

Thursday, 12 April 2018 at 4.00 pm, Corporate Boardroom HBDHB

Interest Register

Hawke's Bay Health Consumer Council

15 February 2018

Name **Consumer 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**
Rachel Ritchie (Chair)	Put the Patient First	Involved when group was active	Advocating for Diabetes Patients	Unsure	Real / potential / Perceived
Rosemary Marriott	YMCA of Hawke's Bay	Member	Youth Including health issues	No	
	Totara Health	Consumer Advisor	Health and wellbeing	No	
Heather Robertson	Restraints Committee of DHB	Committee Member	Representing Consumers on this Committee	No	
Terry Kingston	Interest in all health matters, in particular - Mental Health, Youth, Rural and Transport.			No	
	Age Concern Hawke's Bay	Board Member		No	
	Positive Aging Trust	Committee Member		No	
Tessa Robin	Te Kupenga Hauora - Ahuriri	Finance and Quality Manager	Responsible for overseeing QMS for organisation and financial accountability	No	Potential - Employer holds contracts with HBDHB
Leonna Karauria	NZ Maori Internet Society	Chairperson	Advocacy on Maori Communities	No	
	Simplistic Advanced Solutions Ltd	Shareholder / Director	Information Communications Technology services.	Yes	If contracted for service, there could be a perceived conflict of interest.
	Wairoa Wireless Communications Ltd	Director/Owner	Wireless Internet Service Provider	Yes	Approached in early 2014 by HBDHB and contracted for service to provide wireless internet service to Wairoa Rural Health Learning Centre and Hallwright House. Could be a perceived conflict of interest.
Jenny Peters	Nil				
Olive Tanielu	HB District Health Board	Employee	Work with Pacific Island children and families in hospital and in the community	Yes	Perceived/potential conflict between employee HBDHB and roles of Consumer
Malcolm Dixon	Hastings District Councillor	Elected Councillor		No	
	Scott Foundation	Allocation Committee		No	
	HB Medical Research Foundation Inc	Hastings District Council Rep		No	
James Henry	Health Hawke's Bay Ltd	Facilitator	Part-time role. Improving lifestyles for people with chronic illness.	No	

Name **Consumer 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**
Sarah de la Haye	Nil				
Sami McIntosh	Eastern Institute of Technology	Student Nurse	Practical placements	No	Perceived potential if applying for work.
Deborah Grace	Isect Ltd	Director	IT Security Awareness	No	
Dr Diane Mara	Napier Family Centre	Chair	Social Service Organisation	Yes	Perceived/possible conflict as NFC has a small contract for PND from HBDHB
	IHC Hawke's Bay Association	Chair	Disability Intellectual Stakeholder	No	
	Pacifica Women's Tiare Ahuriri Branch (Inc)	Branch Chair	Development Leadership for Pacific Women	No	

MINUTES OF THE HAWKE'S BAY HEALTH CONSUMER COUNCIL
HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD
CORPORATE OFFICE ON THURSDAY, 15 FEBRUARY 2018 AT 4.00 PM

PUBLIC

Present: Rachel Ritchie (Chair)
Heather Robertson
James Henry
Sarah Hansen
Deborah Grace
Jenny Peters
Dr Diane Mara
Leona Karauria
Olive Tanielu
Malcolm Dixon
Dallas Adams
Kylarni Tamaiva-Eria
Sami McIntosh
Rosemary Marriott
Tessa Robin (late arrival)

In Attendance: Ken Foote, Company Secretary
Kate Coley, ED People and Quality
Brenda Crene

Apology: Terry Kingston

SECTION 1: ROUTINE

1. KARAKIA TIMATANGA (OPENING) / REFLECTION

Rachel Ritchie (Chair) welcomed everyone and Leona provided the Karakia to open the meeting.

2. APOLOGIES

The apologies as above were noted.
An apology was also received from Linda Dubbeldam, attendee member.

3. INTERESTS REGISTER

No conflicts of interest were noted for items on the day's agenda.
Action: Malcolm Dixon asked to have Sport HB removed from the Interest Register

4. PREVIOUS MINUTES

The minutes of the Hawke's Bay Health Consumer Council meeting held on 9 November 2017 were confirmed as a correct record of the meeting. The Public Excluded minutes of that meeting were also confirmed.

The minutes of the combined meeting with the Hawke's Bay Clinical Council held on 6 December 2017 were also noted without any changes notified.

Moved by Malcolm Dixon and seconded by Leona Karauria. **Carried.**

5. MATTERS ARISING AND ACTIONS

Item 1: Timing for IS Workshop Remains an action with timing to be advised.
Anne Speden who was in attendance (later in the meeting) for the Clinical Portal Project, advised the IS Workshop will be delayed as IS will receive output from the Big Listen and CSP workshops prior to enable a constructive workshop with Consumer Council at a future date.

Item 2: Workplan – Consumers on Projects
The Project Management Office will provide a stocktake. Consumer members felt a project list included with the papers as a standard item would desirable.

Action: Kate Coley to discuss this with Kate Rawstron and have this provided for the March meeting.

Item 3: Matariki Regional Economic Development Strategy and Social Inclusion Strategy

Further to prior information provided there had since been email communications between Rachel Ritchie and Shari Tidswell.

Members advised it was hard to understand the context of the paper.

This work was evolving. Malcom Dixon offered to put some context around it at a future meeting.

Diane felt the message needs to be "without good health our community does not advance". Without these messages, this work can only go so far.

Ken Foote advised that Social Inclusion is very much a part of the economic strategy and had been driven by the HBDHB. As this work evolves it will become clearer. It needs to be noted that this is not a DHB process. We let you know that it is happening and when the time is right advise and engage.

A query was asked around Treaty Settlements and whether discussion had been had with these parties?

Action: Reschedule the "Matariki Regional Development Strategy and Social Inclusion Strategy" for April.

6. CONSUMER COUNCIL WORK PLAN

The work plan was provided with the meeting papers.
Papers which had been deferred were noted and will be followed up by the Chair being:

- Implementing the Consumer Engagement Strategy from July 17
- Recognising Consumer Participation - Policy Amendment from July 17

Members were made aware that the HB Health Sector Leadership Forum would be held on 7 March at the Napier Sailing Club between 9.00am – 3.00pm (doors open from 8.30am). The programme would be issued once finalised.

7. CHAIR'S REPORT

The Chair conveyed the following to members:

- Patient & Whanau Centred Care following the joint workshop in December was progressing and moving forward.
- Cancer Network Steering Group were seeking a nomination(s) for Consumer Council representatives and Rachel would re-send the email – sent earlier the day of the meeting and finalise. **Action**
- Consideration of the position on Alcohol (raised with the Board) had been delayed until April. Ken Foote advised that currently the DHB do not pay for, or buy alcohol. If any person who wished to have alcohol at any work related function(s) outside of work hours, they purchase their own and this had occurred at the HB Health Awards function since inception.

8. CONSUMER ENGAGEMENT MANAGER'S ROLE

Jeanette Rendle the Consumer Engagement Manager had resigned and left the organisation at the end of January to start up her own company. The loss of Jeanette had already been felt by Consumer Council members.

The position was currently vacant and Kate Coley was in attendance as (ED of People and Quality), conveying she was keen to hear the views of Consumer Council members about the role prior to scoping and advertising for a replacement.

Feedback:

- It was observed by members that Jeanette's role became too large for one person and appeared completely top heavy.
- Felt the balance of the role of Consumer Engagement Manager was out of kilter and should be either Strategic or Operational.
- Youth Consumer Council members reported a huge gap since Jeanette had left. She attended every Youth Consumer Council meeting. Her support for YCC included printing detail, preparing and running events around consumer engagement, as well as taking minutes to enable more discussion between members.
- When dealing with complaints, it was noted that many people took their frustrations out on Jeanette.
- It was felt that her original job description had duties and additional expectations tagged on. It was noted a complaints adviser had been brought in to assist.
- It is a very wide role, as consumers become involved in more projects.
- This role is an interface and is all about connecting people.

The Chair felt the interface with the services and projects within the DHB to connect with volunteers' consumer input from members' here/outside is vital. If organisation value consumer engagement on an ongoing basis which they say they do, that would mean a role in itself!

Jeanette was very clearly stretched and her loss was immediately felt. We had a passionate person who was prepared to go above and beyond. She was handed stuff that was not in her brief as Consumer Engagement Manager. This organisations talks about consumer engagement but is not resourced to cope.

- The Consumer Engagement role / service needed to be well framed and well resourced.
- Members liked the idea of a "Consumer Engagement team"

Action: **Members were asked to email any additional feedback to Kate Coley directly on kate.coley@hbdhb.govt.nz**

9. YOUTH CONSUMER COUNCIL REPORT

Dallas Adams and Kylarni Tamaiva-Eria provided updates activities Youth Consumer Council (YCC) activities as follows:

- The current focus was on restructuring the YCC and were working Rowan Manhire-Heath which will include a review of the Terms of Reference (ToR) to prioritise suicide, mental health, alcohol and other drugs. The reasons ascertained as to why youth use liquor and other drugs had been relayed as due to the pressure of education. YCC were changing direction to work alongside EIT. A draft ToR was being developed alongside their peers and would be provided to Consumer Council when available. YCC were looking at funding options also and had approached EIT and their sponsors Taiwhenua, Options and the DHB to see where help may come from. There had also been help from schools.

Action: **Malcolm Dixon would email Dallas and Kylarni with the link to the Hastings District Council's community grant detail which closes on 31 March 2018**.

- Dallas had had a meeting with Emma Foster – to be more involved with YCC. They have youth representative within their structure and will provide a youth member as well.

Action: **Rosemary Marriot advised that Stacy Tito was on the Board of the YMCA and she would be a useful contact person for the YCC. Rosemary to email contact detail to Dallas and Kylarni.**

Dallas is now the Student President of Younited Hawkes Bay.

SECTION 2: DISCUSSION/DECISION

10. CLINICAL PORTAL PROJECT

The Chair welcomed Anne Speden and Jos Buurmans (Enterprise Architect) to the meeting.

Key points:

- This is about implementation of a consolidated view of patient information. Previously known or referred to (in the Central Region) as CRISP and then RHIP.
- The project is being funded out of the IS capital budget – with no need for further capital funding and will take less operational funding than first anticipated.
- A lot of resource has been allocated to unpick something which was really complicated.
- This system replaces the current clinical aspect of ECA (patient management system).
- This is an Orion product designed for clinical care which a number of DHBs have implemented. In April we will be able to view regional data. From June view our own and regional data. At the end of 2018 we will be able to input data into the system.
- HB are now leading the region and have gleaned some key learnings from those who have implemented and had issues.
- We are now ready to implement and have formed a key strategic relationship with the system provider Orion. Christchurch has been the innovation hub for Orion in NZ. It is now highly likely that HB will be a secondary innovation hub.
- A service design based platform will be designed in conjunction with clinicians and other groups to ascertain workflows to enable products to be designed workflow(s). This will provide efficiencies, ensuring agility of design around people and processes.
- Re Sapere: Anne spoke to them regarding the current state of health in HB – waiting for where to from here. Plan to mock up a holistic system for presentation to EMT and Board in March.
- Re Workshop in March? Sapere running workshops and have decided not to talk to consumer until work on Big Listen and CSP has been pulled together first. (Action 1: amended to reflect this). The Chair asked Anne to ensure they keep having consumer input please.
- Jos is working on strategy and in time this will be **emailed to consumer members. Action**
- The word service design is about designing a service for a clinician and a consumer.
- We are taking a "standard platform" developed for the Central Region.
- The base platform is for clinicians first and foremost. Immediate advantage is to talk with other DHBs in the region. Others to be added on will require consumer engagement.

Feedback:

- Acknowledged Anne's team and leadership it has only been in the last 6-12 months that any traction has been made and this is phenomenal. Anne was sincerely thanked for the work undertaken. .
- It was ascertained there was a need for a **Consumer Council representative** and Leona Karauria offered her services, as she had with RHIP.
- Security and privacy was raised. Advised looking at data governance and how that works with that being clinically led on how it is designed. At moment swapping base data in current state. Make sure with Policy that patient safety and patient data issues are captured and discussed along the way. Need a process to identify and triage patient safety issues and privacy.
- Medical practices have their own portal? How will this work in with GPs?
  In response: This is an integrated care platform (conception). Bringing together in a trusted environment for consumers to access as well. Also need to enable the workforce. Other

things from consumer perspective enabling access to their records. It isn't one system but functions like one system?

11. CONSUMER COUNCIL DISABILITY STRATEGY

The Company Secretary provided an update.

The key points included:

- The request from Consumer Council through the CEO for a Disability Strategy to be prepared had worked with Chris Ash appointed as the EMT lead and Leigh White as the person who will develop the strategy for HB.
- Leigh needs to orientate herself first.
- Leigh will meet with the group that put the strategy together, and Heather Robertson will be approached to link into the group to enable this to occur.
- An oversight group will work with Leigh to commence the process.

SECTION 3: MONITORING / FOR INFORMATION

12. CLINICAL SERVICES PLAN UPDATE

The Company Secretary provided an update the new Revised Plan.

The Clinical Services Plan (CSP) process had been underway for some months now, with progress reports and relevant documents being delivered and posted on Our Health Website.

As at 1 November 2017, the CSP Plan was to be in initial draft form and available by 31 March 2018. During December it became clear that the Big Listen, other projects and the general workload pressures being experienced, were not allowing the process to flow as expected, so the decision was made to slow it down to 'get it right'.

In late January 2018, a revised plan and timeline was agreed between EMT, Sapere and the CSP Project Team. A summary of this revised plan follows:

- Baseline Document and Summary Statement to be approved 28 February 2018
- Documentation for Future Options Workshops distributed mid-March 2018
- Future Options Workshops conducted early April 2018
- Integrated Workshops held early May 2018
- First draft completed 30 June 2018
- Draft CSP reviewed and updated July 2018
- Wide sector and community engagement on draft CSP – August / September 2018
- Final CSP completed early October 2018
- Final CSP adopted by HBDHB Board 31 October 2018

The Clinical Services Plan will tell us what we are going to do! This is when the People Strategy and Culture work is included as well as the Equity work.

- By calendar year end 2018, we will be developing a new **"5 to 10 Year Strategy**" for the HB health system which will bring together Transform and Sustain which will give us a great base to move forward from.

- In the interim will continue managing for improvements. Chris Ash will be looking at what the PHO and other stakeholders can do to enhance developments in primary care including modernising general practice. And also what can be improved from within the provider arms.

The Chair raised the notion around services with Patient and Whanau Centred Care (PWCC) amongst all this as it is not natural speak. We as consumers must ensure ongoing advocacy. The Chair will attend CSP meetings and continue to advocate for PWCC.

13. SUICIDE PREVENTION UPDATE

The paper was included for information and Penny Thompson was in attendance to provide a brief overview and answer queries.

It was not about targets these days but about developing a framework for services. Examples of work occurring with Flaxmere was explained. Wairoa have access to the resources to use but need to contact them about the approach to take.

More community events to make it okay to talk about suicide. Penny was not familiar/aware of HBDHB's Youth Consumer Council Group or the members in attendance. Dallas and Kylarni were introduced to Penny.

Printed message material hand outs and tools were displayed. One example being, if concerned about a child (mother) **A E I O U** is being used in other DHB regions.

Statistics and data availability was queried. In response Penny advised there was a very real lack of up to date suicide statistics, due to slow availability of results from the Coroner's office. This has been an ongoing issue for years. The Police measure suicide differently and it was not easy to report on.

A query around the Lava Pacific Concept (Auckland training provided). The concept was clarified as "train a trainer".

14. NGĀTAHI VULNERABLE CHILDREN'S WORKFORCE DEVELOPMENT PROGRESS

An update on the project was provided by Dr Russell Wills and Bernice Gabrielle, Programme Manager and Clinical Psychologist.

This is all about children who are at risk of abuse and neglect, and consultation as part of the process was not included in the report but was done during Russell's term as the Children's Commissioner. They had consulted with young people and care givers – who have informed the development of this project. Worked though the competency framework and aims – and involved them in decision making. Taking them through the competencies themselves.

70% of vulnerable children are Maori, therefore whanau interviewed were Maori. Grateful for the advice which has informed everything since. Governance of the curriculum has been evolving. Currently the work streams are looking at the best sources nationally to meet the demands and skills. Feedback now before leaders Hui.

Questions and Feedback:

- How do you measure how successful you have been?
  In response: Happy to circulate evaluation (212 pages) but has been summarised down to 9 pages, shows success.
- There is a Competency Framework for staff/people to work in this space
- There will be a formal evaluation with funding applied for via Transform and Sustain Steering Group (23 Feb). An RFP is pending agreement on this.
  We deliver 220 babies per year of very high risk
  We have 500 children in care.
  2000 children are of concern
  This equates to more than 2,500 children and 800 families and whanau.
- RFP is really clear – baseline data required and ongoing data collection at Client and Practitioner level.

- Leona – queried risk and mitigation? Agency leaders not able to contribute their time – vague around risk what breakdown of what the risks were.
  Risk register is that a governance issue?
  What are the specifics as to why project would not be achievable – reinvest with primary money.
  You have a brief – do you identify what outcomes percentages are for Maori but there are other children of mixed ethnicity who are also at risk. How can cultural competencies be built up from mixed groups?
  Diversity is hard to deal with. Want to help fix the important issues.
  Risk Mitigation was explained and Leona was satisfied – there appeared to be a misunderstanding.
- Rosemary asked are other youth agencies in HB involved.
  In response: 24 agencies agreed.
  Will there be a second wave of invitees as Local Councils, Totara Health and YMCA's appear to be missed?

15. TE ARA WHAKAWAIORA - ACCESS 0-4 / 45-65 YEARS (LOCAL INDICATOR)

The paper was included in the meeting papers for information. No issues discussed.

16. HBDHB PERFORMANCE FRAMEWORK EXCEPTIONS DASHBOARD Q2 (OCT- DEC 2017)

The paper was included in the meeting papers for information. No issues discussed.

SECTION 4: GENERAL

17. TOPICS OF INTEREST – MEMBER ISSUES / UPDATES

No topics were raised or discussed

The meeting closed at 6.05pm.

Confirmed: _____
Chair

Date: _____

FAREWELL TO JEANETTE RENDLE, CONSUMER ENGAGEMENT MANAGER

5

HB HEALTH CONSUMER COUNCIL - MATTERS ARISING (Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	11/08/17 15/2/18	**IS Workshop** IS Workshop will be delayed as IS will receive output from the Big Listen and CSP workshops prior to enable a constructive workshop with Consumer Council at a future date.	Company Secretary	TBC	Request from IS Manager - latter part of 2018
2	12/09/17 15/2/18	**Consumers on Projects** List of projects requested by Consumer Members. Asked that **Current Projects** be included as a standard item on the Consumer Council Agenda going forward.	Kate Coley Admin	May May	Stocktake being done
3	9/11/17 15/2/18	**Matariki Regional Economic Development Strategy and Social Inclusion Strategy** – needs more discussion time Reschedule for April Agenda for further discussion.	Chair Admin	 April	
4	15/2/18	**Interest Register:** Remove Malcolm Dixon as a Trustee of Sport HB.	Admin		Actioned
5	15/2/18	**Deferred papers – Chair to follow up on:** Implementing the Consumer Engagement Strategy from July 17 Recognising Consumer Participation - Policy Amendment from July 17	Chair		
6	15/2/18	**Cancer Network –** nominations email circulated and representatives advised.	Chair	Feb	Actioned
7	15/2/18	**Consumer Engagement Manager's Role** – views sought from consumer members. Additional comments to be emailed directly to Kate.Coley@hbdhb.govt.nz to enable the role to be reviewed and scoped.	Kate Coley members		Verbal update to March Meeting

Action	Date Entered	Action to be Taken	By Whom	Month	Status
8	15/2/18	**Hastings District Council's Community Grant** details to be provided by Kylarni and Dallas.	Malcolm Dixon	Feb	
9	15/2/18	**Youth Council contact details:** YCC Board member details to be provided to Kylarni and Dallas.	Rosemary Marriott	Feb	
10	15/2/18	**Clinical Portal Project:** Jos Buurmans (Enterprise Architect) in the IS Department was currently preparing a Strategy and offered to share it with Consumer Council Members. To be followed up on by Admin and circulated to members once available.	Admin	Mar	

OURHEALTH HAWKE'S BAY Whakawateatia

HB HEALTH CONSUMER COUNCIL
WORKPLAN 2017-2018

Meetings	Papers and Topics	Lead(s)
12 Apr 18	***For Discussion - Decision***	
	Mobility Action Plan Update (presentation)	Andy Phillips
	Clinical Services Plan (verbal update)	Ken Foote
	Annual Plan 2018/19 - first draft	Chris Ash
	People Strategy – draft	Kate Coley
	Oncology Model of Care	Sharon Mason/A Stevenson
	Alcohol Position Statement and Strategy	Sharon Mason
	IS Roadmap	Anne Speden
	Monitoring and for Information	
	Te Ara Whakawaiora - Breastfeeding (National Indicator)	Chris McKenna
	Te Ara Whakawaiora - Cardiovascular (National Indicator)	John Gommans
	Te Ara Whakawaiora - Healthy Weight (National Indicator)	Sharon Mason/S Tidswell
	Te Ara Whakawaiora - Did not Attend (Local Indicator)	Sharon Mason / C Receveur
	Te Ara Whakawaiora - Culturally Competent Workforce (Local Indicator)	Kate Coley / P Davies
	Building a Diverse Workforce & Engaging Effectively with Maori	Kate Coley
9 May	***For Discussion - Decision***	
(Quarterly Meeting with Clinical Council)	Clinical Services Plan (verbal update)	Ken Foote
	Best Start Healthy Eating & Activity Plan (update)	Sharon Mason / S Tidswell
	Maternal Wellbeing Model of Health (presentation)	Sharon Mason / J Arthur
	Monitoring and for Information	
	Smokefree Update (6 monthly)	Sharon Mason / J Wilson
	HBDHB Performance Framework Exception Dashboard Q3	Tim Evans / P LeGeyte
14 Jun	***For Discussion - Decision***	
	Clinical Services Plan (verbal update)	Ken Foote
	Annual Plan 2018/19 – second draft	Chris Ash
	People Strategy - final	Kate Coley
	Collaborative Pathways (presentation)	Mark Peterson / L White
	Monitoring and for Information	
	Te Ara Whakawaiora - Oral Health (National Indicator)	John Gommans / R Whyman
	Youth Health Strategy	Kate Coley
	Urgent Care Service Update (6 monthly)	Wayne Woolrich

CHAIR'S REPORT

Verbal

YOUTH CONSUMER COUNCIL REPORT

Verbal

CONSUMER ENGAGEMENT UPDATE

Verbal

10

CEO Update

Verbal

Governance Report Overview

HAWKE'S BAY District Health Board Whakawāteatia	**Clinical Governance Structure – Value Assessment**
	For the attention of: **HB Clinical Council**
Document Owner	John Gommans and Andy Phillips, Co-Chairs
Document Author(s)	John Gommans and Andy Phillips, Co-Chairs
Reviewed by	Executive Management Team
Month/Year	March, 2018
Purpose	For Approval
Previous Consideration Discussions	Clinical Council (December 2017 and February 2018)
Summary	• At the request of the HBDHB Board. Clinical Council were asked to review the structure, value and workloads of Council's proposed clinical committees and advisory groups. • EMT has discussed clinical council recommendations and the following incorporates EMT feedback • A governance structure is proposed with - Four Clinical Committees reporting to Council, which align with the four pillars of clinical governance. - An information management committee will not be set up to report to clinical council since there is already an IS Governance committee in existence with strong clinical representation - A range of advisory groups that already exist within the DHB but these will expand their scope over time to fulfil sector wide clinical governance needs and obligations • Primary & community care representation will be strengthened within the clinical committee structure • Equity is reflected in the governance structure and reporting lines. To help achieve this, achieving the triple aim will be part of the terms of reference for each committee and advisory group - the simultaneous pursuit of Improved quality, safety and experience of care for individuals; improved health and equity for all populations; and best value for public health system resource • Clinical Council agreed the requirement for equity in the health sector's governance structure(s) but that how this is best achieved while also meeting clinical governance needs requires further discussion with other governance bodies • A technical clinical advisory group on equity will be formed once a new Executive Director with this in their portfolio is recruited.

	• The issue of integration within the governance structure will be on hold pending agreement of the updated Alliance structure • Primary Care (PHO) Clinical Advisory and Governance Group will report directly to council as well as the PHO • The final recommendations of clinical council will be presented to the March 2018 HBDHB Board meeting • It will be necessary to develop a business case for the costs of supporting the clinical governance structure. This will include estimated admin support costs of $95K plus costs for enabling primary & community care clinicians participation on Advisory Groups • The intention is that the clinical governance structure will be implemented with appropriate supports by 1 July 2018.
Contribution to Goals and Strategic Implications	• Improving Value from public health system resources through the prudent use of clinicians within clinical governance structures • Improving quality, safety and experience of care through effective clinical governance • Improving Health and Equity for all populations through establishing equity with clinical governance structures
Impact on Reducing Inequities/Disparities	The intention of embedding equity within the clinical governance structure is to ensure that staff at all levels are aware of their responsibility to abolish health inequity
Consumer Engagement	Nil to date
Other Consultation /Involvement	Nil to date
Financial/Budget Impact	Additional cost for supporting the clinical governance structure and backfilling for primary care representation
Timing Issues	• March Clinical Council meeting for final recommendation • Recommendation to March 2018 Board meeting • Implement new structure by 1 July 2018
Announcements/ Communications	Communication to HB health system following March 2018 Board meeting

RECOMMENDATION:

It is recommended that HB Clinical Council

1. **Approve** the proposed clinical committees and advisory group structure
2. **Note** the intention to present clinical council's recommendations to the March 2018 HBDHB Board meeting
3. **Note** the intention for phased increase in primary & community care representation on Clinical Committees to ensure a whole of sector approach
4. **Note** the intent for clinical governance training to be provided for all members of Advisory Groups and Clinical Committees
5. **Note** the incorporation of triple aim in Terms of Reference for all elements of the governance structure and the intent to set up a technical advisory group on equity pending recruitment of an Executive Director
6. **Note** that an overarching governance committee on equity will be subject to further discussion with other governance bodies.
7. **Note** the reporting line for the Primary Care (PHO) Clinical Advisory and Governance Group

8. **Note** that the issue of integration within the governance structure is on hold pending agreement of the Alliance structure
9. **Note** that it will be necessary to develop a business case for the costs of supporting the clinical governance structure
10. **Note** that the intention is that the clinical governance structure will be implemented with appropriate supports by 1 July 2018

HAWKE'S BAY
District Health Board
Whakawāteatia

Ensuring Best Value From the Hawkes Bay Health System Clinical Governance Committee Structures

Author(s):	**John Gommans and Andy Phillips, Co-Chairs of HB Clinical Council**
Date:	**7 March 2018**

PURPOSE

At the request of the HBDHB Board, Clinical Council were asked to review the structure, value and workloads of Council's proposed clinical committees and advisory groups. The intention is that these can be implemented with appropriate supports by 1 July 2018. Clinical Council has reviewed the implications of this structure in terms of their value, the function of and need for each separate advisory group in terms of the Councils role in 'clinical governance', ensuring that their purpose did not conflict with other governance structures or processes, and resource implications including clinician and management time plus administrative support.

A panel undertook an initial review. At its December and February meetings Clinical Council identified and endorsed a number of proposed changes and these are presented for ratification by council in this paper

CLINICAL GOVERNANCE

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

Good clinical governance is essential to ensure continuous improvement in the safety and quality of care; and makes certain that there is accountability and creates a 'just' culture that is able to embrace reporting and support improvement i.e. key functions of clinical governance include monitoring of quality and safety, and provision of clinical advice.

In 2001, the Institute of Medicine described quality health care as safe, effective, patient-centred, timely, efficient, and equitable. Delivering good clinical governance requires attention to each of these domains.

CLINICAL COUNCIL

Clinical Council is the principal clinical governance, leadership and advisory group for the Hawkes Bay health system. The structure agreed by clinical council in June 2017 is show in Appendix 2. Its functions are to:

- Provide clinical advice and assurance to the HB health system management and governance structures
- Work in partnership with the HB Health Consumer Council to ensure the HB health system is organised around the needs of people
- Provide oversight of clinical quality and patient safety
- Provide clinical leadership to the HB health system workforce
- Co-ordinate and manage this clinical governance structure

CLINICAL COMMITTEES

There will be the four clinical committees aligned to the domains of safety and quality. These are:

- Professional Standards and Performance Committee – to provide assurance that all essential requirements relating to credentialing, professional standards, clinical training and research are actively promoted and maintained
- Clinical Effectiveness & Audit Committee – to provide advice and guidance to ensure that quality clinical practice is delivered by all publicly funded health service, diagnostic, pharmaceutical and therapeutic providers.
- Patient Safety & Risk Management – to provide assurance that all matters relating to patient safety and clinical risk are effectively monitored and managed
- Patient Experience – to jointly develop and recommend strategies, systems, policies, processes and actions that will contribute to the continuous improvement of patient's experience within the HB health system

The PHO Clinical Advisory and Governance Committee reports directly to the PHO Board with a reporting line to Clinical Council

CLINICAL ADVISORY GROUPS

Supporting the governance work of and reporting to the five clinical committees there will be 19 Clinical Advisory Groups (AGs). Most of these already exist to some extent within the DHB but have not been well aligned with clinical council and/or are not well integrated across the sector. Hospital services are currently well represented within the AGs which will be expanded to include cross sector representation and particularly from community and primary care. This will demonstrate that primary care contribution is valued by the sector. This will require additional resource to enable primary care clinician's engagement e.g. so that backfill can be provided. This remuneration will be at a level not less than the cost of providing backfill. There is currently variable expertise in governance within clinical committees and advisory groups, and training is required.

THE PLACE OF EQUITY IN CLINICAL GOVERNANCE

Although there are inequities related to age, gender, and income the most consistent and compelling inequities in NZ are between Māori and non-Māori. The causes of this are multifactorial including

- Differential access to the determinants of health and exposures leading to differences in disease incidence
- Differential access to health care
- Differences in quality of care received.

Under the New Zealand Public Health and Disability Act 2000, DHBs have a statutory responsibility to "reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders":

The NZ healthcare triple aim explicitly acknowledges this with the simultaneous pursuit of iimproved quality, safety and experience of care for individuals, improved health and equity for all populations and best value for public health system resource.

To deliver on this, equity is a sector wide responsibility with several other groups already working in this space, including Population and Public Health Services, Maori Relationship Board and Pacifica working groups. Clinical Council debated and agreed a recommendation for the position of equity within the clinical governance structure.

Council agreed that equity is an important element of service quality and that health equity should be everyone's business. In recognition of this, the triple aim will be explicitly part of each Terms of Reference. It is proposed that a technical equity advisory group reporting to Clinical Effectiveness and Audit Committee is set up once a new Executive Director is appointed. The function of this Advisory Group is the provision of advice to clinical researchers and clinical services to support equitable outcomes from health services and systems. The Equity Technical Advisory Group will support services to deliver equitable, value for money, sustainable services and systems which are person and whānau centered, effective, safe, timely, accessible and efficient.

Appropriate Governance of equity at a high level is required for the Hawkes Bay Health System and how this is best addressed requires engagement with other governance bodies. Clinical Council believes that a high level governance committee is required which will need to include clinical governance of equity as an important element of delivering clinical quality within its remit.

ADMINISTRATIVE SUPPORT

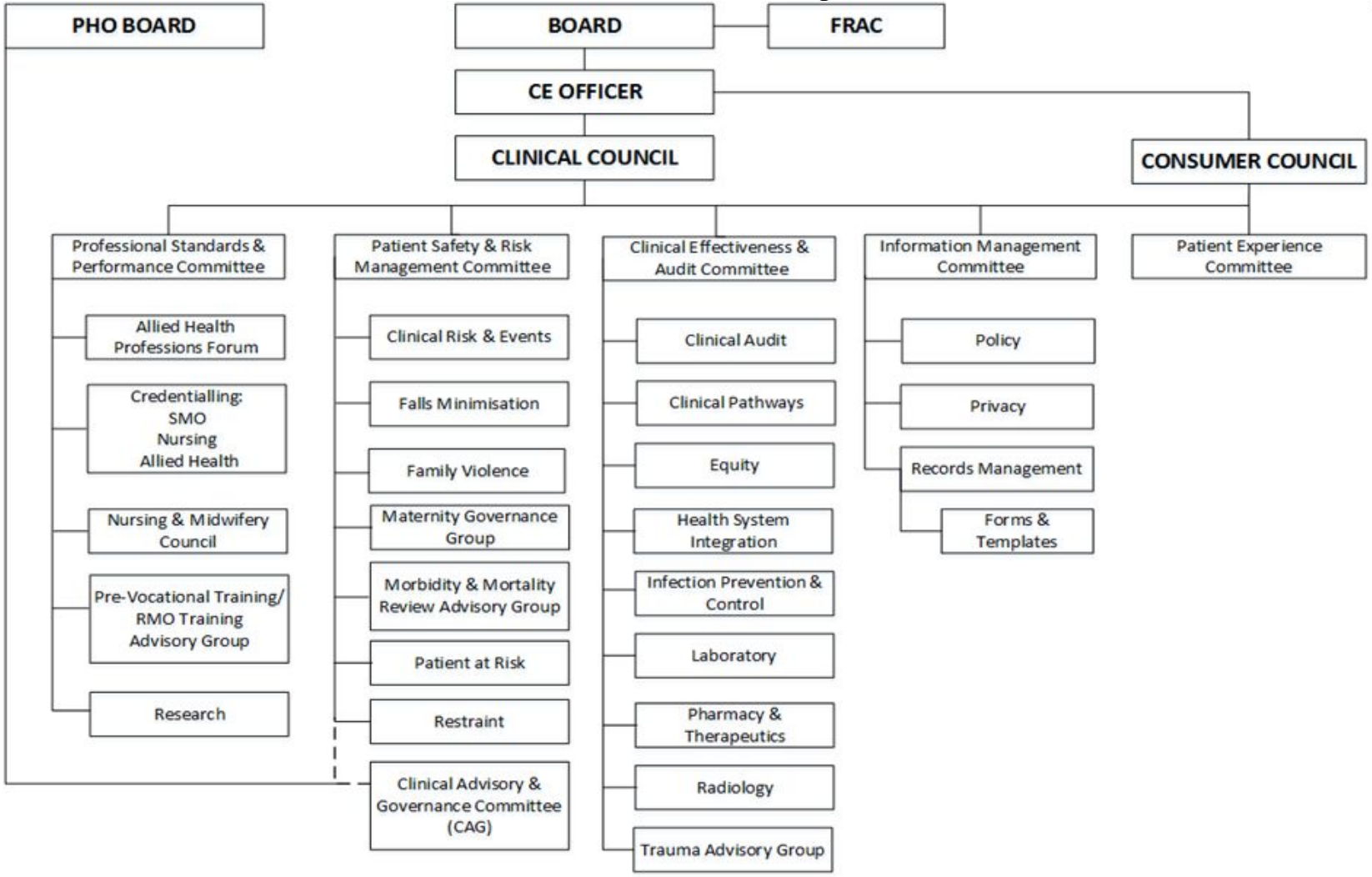
The company secretary reviewed the administrative support required for effective operation of the governance structure. This is shown in appendix 3. It is noted that a business case will need to be constructed to request funding.

RECOMMENDATION:

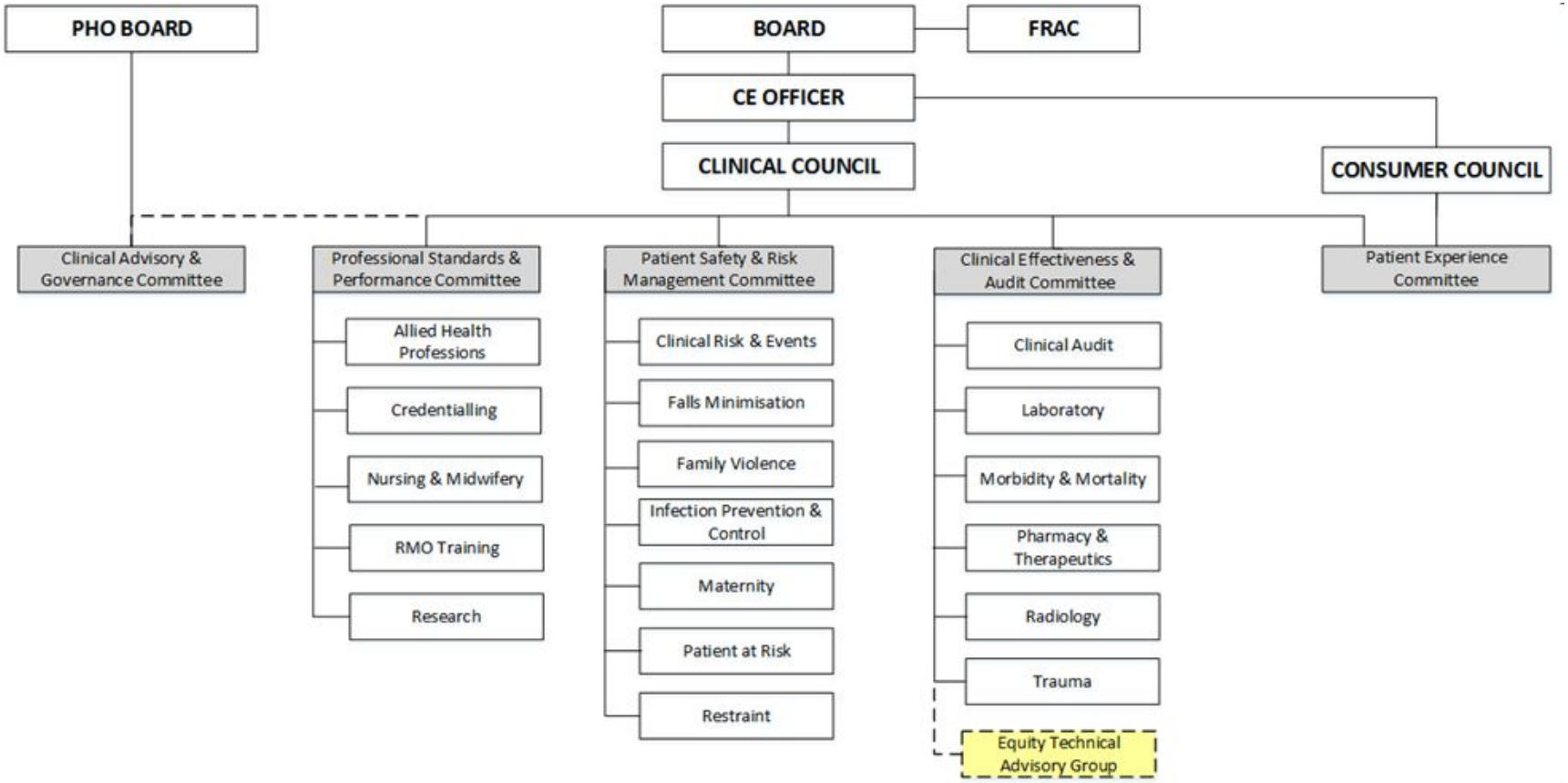
It is recommended that HB Clinical Council

1. **Approve** the proposed clinical committees and advisory group structure
2. **Note** the intention to present clinical council's recommendations to the March 2018 HBDHB Board meeting
3. **Note** the intention for phased increase in primary & community care representation on Clinical Committees to ensure a whole of sector approach
4. **Note** the intent for clinical governance training to be provided for all members of Advisory Groups and Clinical Committees
5. **Note** the incorporation of triple aim in Terms of Reference for all elements of the governance structure and the intent to set up a technical advisory group on equity pending recruitment of an Executive Director
6. **Note** that an overarching governance committee on equity will be subject to further discussion with other governance bodies.
7. **Note** the reporting line for the Primary Care (PHO) Clinical Advisory and Governance Group
8. **Note** that the issue of integration within the governance structure is on hold pending agreement of the Alliance structure
9. **Note** that it will be necessary to develop a business case for the costs of supporting the clinical governance structure
10. **Note** that the intention is that the clinical governance structure will be implemented with appropriate supports by 1 July 2018

APPENDIX 1 – CLINICAL GOVERNANCE COMMITTEE STRUCTURE – Original version as at June 2017



APPENDIX 2 – CLINICAL GOVERNANCE COMMITTEE STRUCTURE – Proposed revised version March 2018



Pending appointment of new Executive Director

APPENDIX 3: CLINICAL GOVERNANCE STRUCTURE - MANAGEMENT & ADMINISTRATION REQUIREMENTS

1. CURRENT SUPPORT FOR CLINICAL AND CONSUMER COUNCILS

1.1 Management

- Ken Foote (Company Secretary)
  Governance and administration, including maintenance of ToR, work plans, membership, tenure, payments, cost centre, ensuring appropriate agendas, minutes and reports are prepared etc.
- Kate Coley (ED People & Quality)
  Operational support and guidance, including submission of reports, actioning outcomes, coordinating activities, responding to request etc.
- Consumer Engagement Manager key contact / support for Consumer Council

1.2 Administration

- Brenda Crene – Board Administrator and PA
- Maintenance of ToRs, membership schedules, contacts, interests, coordination of workflow (linked to Corporate governance), payment of fees and expenses, Diligent Boardbooks, filing of agendas and minutes etc
- Tracy Fricker – EA to ED People & Quality
- Preparation of agendas, Diligent Boardbooks, minutes and board reports.

1.3 Other

Current support for existing committees is provided by some members of the quality team, EAs and PAs of current chairs/members, and other service based administrative resources.

2. SUPPORT FOR THE AGREED CLINICAL GOVERNANCE STRUCTURE

The clinical governance structure will require administrative support to ensure that it is both effective and delivering good “value”.
Good governance practice requires the following:

2.1 Management Leadership Responsibility

- Structures and processes to be appropriately designed, implemented, monitored and adequately resourced
- An environment is created such that clinical governance is visible and valued by all key stakeholders.
- Roles, responsibilities, accountabilities and expectations are clear and well understood.
- Trust and mutual respect is developed, with Clinical, Consumer and Management leaders working in partnership to ensure the “structure” achieves the desired outcomes.
- Develop outcome measures / measures of success.

2.2 Management Responsibility / Resources (Whole structure)

- Terms of reference to be maintained, updated and amended as necessary
- New appointments/reappointments to be appropriately approved and membership schedules maintained
- Chairs appointed/briefed and ‘trained’ as necessary
- Details of any payments to members and approval processes to be agreed, documented and actioned
- Management of budget and cost centre
- Workplans to be coordinated and maintained
- Ensure appropriate reports are prepared, submitted, distributed and filed as appropriate
- Committee/Advisory group secretaries to be appointed, coordinated and ‘trained’ as necessary

- Standard templates developed for minutes/actions plans/reports etc.
- Overall coordination/management of structure.

2.3 Administration Responsibility/Resources ((Individual advisory groups/committees)

- Meetings to be set up/rooms booked etc
- Agendas prepared and distributed
- Attendance registers completed
- Any payments to members to be actioned
- Minutes to be taken, approved and distributed
- Action plans to be recorded, followed up and completed actions noted.
- Liaison with Advisory group/Committee Chair maintained
- Reports to be written/presented as required.

2.4 Minutes

- 'Action Minutes' templates to be developed/distributed
- Training for minute taking to achieve standardisation, efficiency and effectiveness

2.5 Communication Plans

- How to advise health sector that this is happening
- Encourage nominations/participation/ownership/confidence
- Ensure effective flow of information and sharing of learnings.

3. SECTOR WIDE RESPONSIBILITY

Two of the principal strategic changes to be embedded into this updated clinical governance structure are:

- Expanding the mandate of each committee and advisory group to be sector wide (where appropriate).
- Including consumer representation on all committees and relevant advisory groups.

These changes will have implications as follows:

- The timings and venues for meetings will need to take account of primary care clinician and consumer involvement
- Relevant policies will need to be updated/developed to recognise this involvement with appropriate payments/compensation.

4. RESOURCE REQUIREMENTS

To implement appropriate 'good governance practice' to ensure the new structure is both effective and efficient, it has been identified that the following support / resources will be required.

- Company Secretary and ED People & Quality continue to provide management leadership
- Board Administrator continues with overall responsibility for Administrative issues
- A new positon is created (Clinical Governance Administrator) to assume responsibility for directly supporting Clinical and Consumer Councils and Whole of Structure' management and administration (estimated $50k per annum)
- Members of the quality team EA & PAs and other service based administrative resources continue to provide secretarial support to individual committees and advisory groups with 'system' support guidance and coordination from the Board and Clinical Governance Administrators.
- Budget allowance for fees and expenses of 'primary care' (non-HBDHB/HHB staff) and consumers (on approval of new policy) will need to be provided (estimated $45k per annum.

A business case will need to be developed to seek approval for this additional $95k per annum budget.

HAWKE'S BAY District Health Board Whakawāteatia	**Update on Establishing Health and Social Care Localities in Hawke's Bay**
	For the attention of: **Clinical and Consumer Council; HBDHB Board** **Māori Relationship Board (April), Pasifika Health Leadership Group** (May)
Document Owner	Chris Ash – Executive Director Primary Care
Document Author(s)	Jill Garrett – Strategic Services Manager – Primary Care Te Pare Meihana - Manager, Wairoa Hospital and Health Centre
Reviewed by	Executive Management Team
Month/Year	February, 2018
Purpose	For Information
Previous Consideration Discussions	Regular update for monitoring
Summary	This paper outlines: • Progress in the two existing localities over the last 6 months • Planned activities over the coming 6 month period • Commentary on how the Health & Social Care Localities programme is being aligned with broader work relating to Primary Care Development
Contribution to Goals and Strategic Implications	Improving Health and Equity for all populations Improving value from public health system resources
Impact on Reducing Inequities/Disparities	Focus of the work in localities is on eliminating and preventing the inequity gap within health outcomes – whole of population
Consumer Engagement	Consumer representation within both locality groups
Other Consultation /Involvement	Not applicable
Financial/Budget Impact	Not applicable
Timing Issues	Not applicable
Announcements/ Communications	Not applicable

RECOMMENDATION

It is recommended that the Clinical and Consumer Council:

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

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HAWKE'S BAY
District Health Board
Whakawāteatia

Update on Establishing Health and Social Care Localities in Hawke's Bay

Author(s):	**Jill Garrett – Strategic Services Manager – Primary Care** **Te Pare Meihana - Manager, Wairoa Hospital and Health Centre**
Date:	**February, 2018**

1.0 Locality Development in the Context of Primary Healthcare Development

1.1 A commitment has been made to reinvigorate the Alliance Agreement for Hawke's Bay by means of a Primary Care Development Partnership ('PCDP'). The need for this development has been identified on the back of longstanding and widely-held frustrations about the inability to secure care integration and modernisation at pace in primary healthcare.

1.2 As the draft working plan for the PCDP has become clearer, it is increasingly evident that there are a number of crucial intersects with the Localities programme. The PCDP will rely on a strong, and increasingly stronger and more coordinated local voice to drive prioritisation, community leadership, and the adoption and spread of best practice. At the same time, there are a number of themes common to development in a number of localities (such as the development of sustainable service delivery models for rural communities) that will benefit from a more centrally-sponsored approach.

1.3 At present, the programme has focused solely on the establishment of a 'localities approach' in the rural areas of Wairoa and Central Hawke's Bay. In two relatively self-defining rural communities, this approach has generated significant benefits. Work on the proposed 'Hastings' and 'Napier' localities has not, to date, been initiated. The approach will be reviewed in consultation with stakeholders, and in line with the establishment of the PCDP.

1.4 In both existing locality areas, however, the breadth and depth of the work undertaken has been markedly different. This has largely fallen into the domain of three core activities, those being:

- Integration of local provider management arrangements, supported by devolved decision rights for DHB services, with the goal of transformation in the delivery of clinical services
- Progressing and supporting local innovation in support of community health and wellbeing priorities, particularly in the intersectoral sphere
- Promoting an enhanced local dimension to health planning, funding and market development

1.5 Collective impact modelling has been used in both localities, Wairoa and Central Hawke's Bay (CHB) to build form and function into the task of preparing localities to drive local developments, and as a framework to evaluate progress to date. Implementing collective impact focuses on four key areas, namely, governance and infrastructure, strategic planning, community involvement and evaluation and improvement. However, in the context of 1.4 (above), collective impact does not define the breadth of the endeavor to which it is applied.

1.6 Under the framework, there are five stages on the road to achieving full collaboration.

The Five Levels of **Collaboration**

	1	2	3	4	5
	Networking	**Cooperation**	**Coordination**	**Coalition**	**Collaboration**
Relationship Characteristics	• Aware of organisation loosely defined roles. • Little communication. • All decisions are made independently.	• Provide information to each other. • Somewhat defined roles. • Formal communication. • All decisions are made independently.	• Share information and resources. • Defined roles. • Frequent communication. • Shared decision making.	• Share ideas. • Share resources. • Frequent and prioritised communication. • All members have a vote in decision making.	• Members belong to one system. • Frequent communication is characterised by mutual trust. • Consensus is reached on all decisions.

Source: Frey, B.B., Lohmeier, J.H., Lee, S.W., & Tollefson, N. (2006). Measuring collaboration among grant partners. American Journal of Evaluation, 27, 3, 383-392

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1.7 In Wairoa, the emergence of the Community Partnerships Committee (He Reo Ngātahi: One Voice, Our Voice) pushes the overall assessment of progress towards Level 3 of the model, with some evidence of function at Level 4. Particularly important has been the definition of the community vision that 'All whānau in Wairoa are thriving', and the solid commitment of leadership from iwi, government agencies, and local community organisations to the work of the committee. In the primary healthcare service integration space, intensive activity is taking place to secure rapid progression from Level 2.

1.8 In CHB, assessment across all four areas of the model places overall progress at Level 2 of the model, with some aspects of Level 3 exhibited. CHB is growing its governance function, using strategic planning to create direction and vision, has strong community involvement, and now with greater emphasis on data sharing will be better positioned to plan health improvement initiatives.

2.0 Wairoa

2.1 Activity Completed (Last 6 months)

- Established senior nursing roles – The Rural Nurse Specialist and Clinical Nurse Specialist (Long Term Conditions) roles will support innovation in primary healthcare model development.
- Health of Older Persons stakeholder meetings – These support identification of local service gaps and guide development and resourcing of the care pathway.
- Case management and governance – Work is progressing with sector partners to join up approaches to supporting local whānau who are most in need of services and support.
- Integrated renal service model – Planning is underway to relocate the existing renal chairs.
- General Practice alliance agreements – These continue to evolve, and have supported project work to deliver free under 18 care, diabetes support and Cornerstone accreditation.

2.2 Activity in Progress (Next 6 months)

- Progress towards a single integrated general practice model for Wairoa
- Continued focus on more integrated primary and secondary care patient pathway
- Extension of EngAGE to include Wairoa, as part of strategy for rural provision of this service
- Further develop senior nursing opportunities, including establishment of a shared care model across providers, and a nursing workforce development approach for Wairoa.

- Achieve a “go live” date for Oranga Whānau single case management and governance within services for vulnerable tamariki and whānau
- Join up health projects and strengthen rangatahi leadership, in support of the wellbeing of young people in Wairoa
- Project to reduce the incidence of diabetes through a collaborative initiative between general practice and Kahungunu Executive.

3.0 Central Hawke’s Bay

3.1 Activity Completed (Last 6 months)

- Choose Well
  - Signage and local materials now developed and in use in Waipawa and Waipukurau
  - Flyers and fridge magnets advertising Health Services have been developed by the Health Liaison Group and distributed to households, schools and services within CHB
- Whānau Wellness – The first programme in CHB is now in place with 58 individuals signed up in December 2017. Of those registered, 15% live in Porangahau, 15% in Waipawa, and the remaining 70% in Waipukurau.
- Workplace Wellness – A population health-based programme of support has been developed and provided to the largest employer in CHB (Silver Fern Farms).
- Shared electronic health record – This is now available to support collaborative patient management across general practice, pharmacy and the hospital services

3.2 Activity in Progress (Next 6 months)

- In-depth analysis of the CHB Health Status review to inform priorities for 2018-19 and potential operational partnerships to achieve improved health outcomes.
- VMR network enabling virtual health clinics to be provided in outreach settings.
- Extension of EngAGE to include CHB, as part of strategy for rural provision of this service
- Creation of an Lead Maternity Carer (LMC) Hub in CHB.
- Extending workplace wellness programme to support five major local employers.
- Supporting the Ministry of Education Communities of Learning (COLs) with their local achievement of health and wellbeing-related objectives (linked to readiness for learning).

RECOMMENDATION

It is recommended that the Clinical and Consumer Council:

Note the content of this report**.**

Clinical Services Plan Sector Update March 2018

BACKGROUND
The Clinical Services Plan (CSP) process has been underway for some months now, with progress reports and relevant documents delivered and posted to the Our Health website.

An initial draft of the CSP was planned for late March 2018. However, with general workload pressures, and to ensure feedback from workshops were well reflected within the initial draft, a decision was made late last year to dedicate more time to this crucial stage of the project, to make sure we "get it right".
In late January, a revised plan and timeline was agreed between Hawke's Bay District Health Board's Executive Management Team, Consultant group Sapere and the CSP project team, to complete the first draft by 30 June 2018 ready for extensive sector and community consultation with the final CSP tabled to Hawke's Bay District Health Board for approval at its October 2018 meeting.

REVISED PLAN
A summary of the revised plan includes:

- Baseline document and summary statement approved 28 February 2018
- Documentation for future options workshops distributed mid-March 2018
- Future options workshops to be held early April 2018
- Integrated workshop held early May 2018
- First draft completed 30 June 2018
- Draft CSP reviewed and updated July 2018
- Wide sector and community engagement on draft CSP – August / September 2018
- Final CSP completed early October 2018
- Final CSP adopted by HBDHB Board 31 October 2018

BASELINE DOCUMENT & SUMMARY STATEMENT
Two background development documents have recently been completed.

The *Baseline Document* provides a summary of the current state of services delivered across general practice and other community providers, as well as district health board health services provided both in the community and hospital.

The *Summary Statemen*t summarises findings from the *Baseline Document*. It also integrates findings from the patient journey workshops held in September 2017.

Both these documents will be used to inform the next part of the process and will be incorporated as appropriate into the final CSP.

FUTURE OPTIONS WORKSHOPS
Four key themes have been identified for workshops in April, that will have health professionals and consumers working together to produce a long list of options for the future design and delivery of relevant services. These themes are:

- Looking after frail people in our care
- Supporting our people in vulnerable situations
- Reorganising primary care for the challenge
- What is the character of our hospital in 10 years' time?

These workshops will be led by our senior clinicians and will be limited to 30 participants each. Discussions will be informed by the above documents, along with other reference material and personal experience.

The output from these workshops will feed into the Integrative Workshop, to be held in May 2018.

SECTOR AND COMMUNITY ENGAGEMENT

There will be comprehensive engagement both within the health sector and with the wider Hawke's Bay community once we have a draft CSP. Consultation will take place throughout August and September 2018 and details of how this will occur will be extensively promoted once we are closer to a finalised draft CSP.

CLINICAL SERVICES PLAN (CSP)

Just a reminder, the CSP will:

- Describe the current capability and capacity of services (Baseline)
- Describe the challenges and opportunities facing service provision now and in the future.
- Describe high-level options that will help meet those challenges and take advantage of those opportunities.
- Provide an indication of strategic direction and important areas for investment.
- Inform Hawke's Bay District Health Board's five year strategic plan

The CSP will not:

- Address details of implementation
- Provide detailed financial modelling
- Provide a workforce strategy and plan
- Include a facilities master plan

FURTHER INFORMATION

For further information, please visit: http://ourhealthhb.nz/news-and-events/clinical-services-plan-transforming-our-health-services/
Alternatively you can email:
clinicalservicesplan@hbdhb.govt.nz

HAWKE'S BAY HEALTH CONSUMER COUNCIL
ANNUAL PLAN 2017/18

Purpose	Provide a strong viable voice for the community and consumers on health service planning and delivery	Advise and encourage best practice and innovation in the areas of patient safety, consumer experience and clinical quality	Promote and support the enhancement of consumer engagement
FUNCTIONS	• Identify and advise on and promote, a 'Partners in care' approach to the implementation of 'Person and Whānau Centred Care' into the Hawkes Bay health system, including input into: - Development of health service priorities - Strategic direction - The reduction of inequities • Participate, review and advise on reports, developments and initiatives relating to health service planning and delivery. • Seek to ensure that services are organised around the needs of all consumers	• Identify and advise on issues that will improve clinical quality, patient safety and health literacy. • Seek to enhance consumer experience and service integration across the sector. • Promote equity of access/treatment • .Seek to ensure that services are responsive to individual and collective consumer needs.	• Facilitate and support the development of an appropriate Consumer Engagement Strategy for the Hawkes bay health system • Ensure, coordinate and enable appropriate consumer engagement within the health system - across Hawke's Bay - within the Central region - at National level • Receive, consider and disseminate information from and to HBDHB, Health Hawke's Bay, Consumer groups and communities. • Ensure regular communication and networking with the community and relevant consumer groups. • Link with special interest groups as required for specific issues and problems solving.
STRATEGIES	• Proactively raise and promote issues of importance and/or concern to consumers generally, for consideration and/or resolution by relevant organisations within the health system. • Engage early with project and planning teams, and standing committees, to ensure the consumer perspective is included in all outcomes and recommendations. • Review and comment on all relevant reports, papers, initiatives to the Board. • Ensure robust complaint/feedback systems are in place and that consumers are well informed and easily able to access these • Consumer Council members to be allocated portfolio/areas of responsibility.	• Work with Clinical Council to develop and maintain an environment that promotes and improves: - Putting patients / consumers at the centre - Patient safety - Consumer experience - Clinical quality - Health literacy - Equity • Promote initiatives that empower communities and consumers to take more responsibility for their own health and wellness. • Promote a clinical culture which actively engages with patients / consumers at all levels, as 'partners in care'. • Advocate / promote for Intersectoral action on key determinants of health.	• Raise the profile and community awareness of Consumer Council and the opportunities / options for enhanced consumer engagement in decision making. • Ensure good attendance and robust discussions at monthly Consumer Council meetings • Co-ordinate consumer representation on appropriate committees and project teams: - Within Hawke's Bay - At Central Region and National levels • Engage with HQSC programmes around consumer engagement and 'partners in care'. • Maintain current database and regular communications with all Hawke's Bay health consumer groups/organisations. • Provide regular updates on both the HBDHB and Health Hawke's Bay websites • Ensure Consumer Council members continue to be well connected and engaged with relevant consumer groups and communities
OBJECTIVES 2017/18	• Actively promote and participate in' co-design processes for: - Mental Health, Youth • Participate in the development of Health and Social Care Localities • Initiate work on development of a disability strategy for HB Health Sector • Hold active membership in Clinical Council committees including Patient Experience Committee • Actively participate in Peoples Strategy and Clinical Services Plan development	• Promote and assist initiatives that will improve the level of health literacy within the sector and community. • Facilitate and promote the development of a 'person and whānau centred care" approach and culture to the delivery of health services, in partnership with the Clinical Council. • Promote the provision of consumer feedback and 'consumer stories'. • Monitor all 'Patient Experience' performance measures/indicators as co-sponsor of the 'patient experience Committee' within the clinical governance structure. • Facilitate a focus on disability issues	• Facilitate and support the development and implementation of a consumer engagement strategy and principles in Hawkes Bay • Establish a connection with Youth within the community • Influence the establishment and then participate in regional and national Consumer Advisory Networks.

Portfolios and areas of interest		HB Health Consumer Council Members:	
AREAS OF INTEREST			
- Women's health	Sami, Olive, Leona	**Rachel Ritchie (Chair (from 1/9/17))** HAVELOCK NORTH	rachel.ritchie@hawkesbaydhb.govt.nz
- Child health	Sami, Malcolm	**Jim Henry** NAPIER	jimbhenry@hotmail.co.nz
- Youth health	Dallas, Kylarni	**Jenny Peters** NAPIER	peters.jenny26@gmail.com
- Older Persons health	Jenny, Heather	**Olive Tanielu** HASTINGS	olivetanielu@rocketmail.com
- Chronic conditions	Rosemary, Terry, James	**Heather Robertson** NAPIER	Heather.hb@xtra.co.nz
- Mental Health	Deborah, Terry	**Leona Karauria** NUHAKA	Info@s-a-s.co.nz
- Alcohol and other drugs	Dallas, Kylarni, Rosemary	**Rosemary Marriott** HASTINGS	roseandterry@xtra.co.nz
- Sensory and physical disability	Sarah, Heather, Tessa	**Terry Kingston** WAIPAWA	terrykingston@xtra.co.nz
- Intellectual and neurological disability	Heather, Olive, Diane	**Tessa Robin** NAPIER	tessa.robin@tkh.org.nz
- Rural health	Leona, Terry, Deborah	**Malcolm Dixon** HAVELOCK NORTH	dixonmj24@icloud.com
- Māori health	Tessa, Leona, James, Sami	**Sarah Hansen** HASTINGS	hansennorsemen@xtra.co.nz
- Pacific health	Olive, Sami, Tessa	**Samitioata (Sami) McIntosh** HASTINGS	smkoko@live.com
- Primary health	Jenny, Rosemary	**Dallas Adams** HASTINGS	dallasadams31@gmail.com
- High deprivation populations	Jenny, Leona	**Kylarni Tamaiva-Eria**	kylarnitamaivaeria@hotmail.com
2017-18 PORTFOLIOS		**Deborah Grace**	deborah@isect.com
- Co-Design Youth – Dallas, Kylarni		**Diane Mara**	diane.mara@ecnz.ac.nz
- Co-Design Mental Health – Deborah, Terry & PAG			
- Health and Social Care Localities - Tessa, Jenny, Leona, Terry			
- Customer Focussed Booking – Tessa, Sarah			
- Making the Health System Easier to Understand – James, Leona, Olive			
- Person and Whānau Centred Care – Rosemary, Leona			
- Disability Strategy – Sarah, Heather, Terry			
- Consumer Engagement Strategy - ALL			
- Clinical Council Committees and consumer council members on them:			
o Patient Experience – James, Terry, Deborah, Rosemary			
o Professional Standards & Performance – Sami			
o Patient Safety & Risk - Heather			
o Clinical Effectiveness and Audit – Malcolm (Terry as backup)			
o Information Management – Leona			
Support:			
Operational and Minutes			
Kate Coley Executive Director – People & Quality (EDP&Q) kate.coley@hbdhb.govt.nz	Tracy Fricker Council Secretary and EA to EDP&Q tracy.fricker@hbdhb.govt.nz		
Vacant Position Consumer Engagement Manager	Anna Kirk Communications Manager anna.kirk@hbdhb.govt.nz		
Governance			
Ken Foote Company Secretary ken.foote@hbdhb.govt.nz	Brenda Crene Board Administrator and PA to Co-Sec brenda.crene@hbdhb.govt.nz		
Clinical Council Liaison	Debs Higgins		

HB HEALTH SECTOR LEADERSHIP FORUM

Reflections

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TOPICS OF INTEREST

MEMBER ISSUES / UPDATES

Verbal