DISTRIBUTION:

Committee Members

- ☐ Mr C Wade (Chair)
- ☐ Ms T Hodges (Deputy Chair)
- ☐ Mr B Simcock
- ☐ Ms S Webb
- ☐ Ms S Mariu
- ☐ Mrs P Mahood
- ☐ Ms C Beavis
- ☐ Ms TP Thompson-Evans (IMC representative)
- ☐ Mr F Mhlanga (Consumer Council to confirm)
- ☐ Mr J McIntosh (Consumer Council to confirm)
- ☐ Mr D Slone (Consumer Council to confirm)
- ☐ Mr R Vigor-Brown (Lakes DHB representative) (Consumer Council to confirm)
- ☐ Mr M Arundel (BoP DHB representative) (Consumer Council to confirm)

Management

- ☐ Dr N Murray, Chief Executive
- ☐ Mr B Paradine, Executive Director, Waikato Hospital Services
- ☐ Ms M Chrystall, Executive Director, Corporate Services
- ☐ Ms L Aydon, Executive Director, Public and Organisational Affairs
- ☐ Mr D Hackett, Executive Director, Virtual Care and Innovation
- ☐ Mr N Hablous, Chief of Staff
- ☐ Mrs S Hayward, Director of Nursing & Midwifery
- ☐ Ms L Elliott, Executive Director, Māori Health
- ☐ Dr T Watson, Chief Medical Advisor
- ☐ Mr I Wolstencroft, Executive Director, Strategic Projects
- ☐ Dr D Tomic, Clinical Director Primary and Integrated Care
- ☐ Dr D Wright, Executive Director, Mental Health & Addictions Service
- ☐ Mr M Spittal, Executive Director, Community & Clinical Support
- ☐ Ms M Neville, Director, Quality & Patient Safety
- ☐ Mrs B Garbutt, Rehabilitation and Allied Health
- ☐ Ms J Wilson, Executive Director, Strategy & Funding
- ☐ Prof R Lawrenson, Clinical Director, Strategy & Funding
- ☐ Ms T Maloney, Commissioner of the taskforce for the Women's Health transformation project
- ☐ Mr M ter Beek, Executive Director, Operations and Performance
- ☐ Mr C Cardwell, Executive Director, Facilities and Business
- ☐ Mr P Mayes, Ministry Of Health
- ☐ Minute taker
- ☐ Board Records

Contact Details:
Telephone 07 834 3600
www.waikatodhb.health.nz

Next Meeting Date: 9 August 2017

Waikato District Health Board

WAIKATO DISTRICT HEALTH BOARD

Agenda

Health Strategy Committee

Date: **14 June 2017**

Time: **12:30pm**

Place: **Board Room**
Level 1
Hockin Building
Waikato Hospital
Pembroke Street
HAMILTON

Waikato District Health Board

Meeting of the Health Strategy Committee
to be held on Wednesday 14 June 2017, at 12:30pm
Board Room, First Floor, Hockin Building

AGENDA

1 APOLOGIES

2 LATE ITEMS

3 INTERESTS

3.1 Schedule of interests
3.2 Conflicts related to items on the agenda

4 MINUTES AND MATTERS ARISING

4.1 Waikato DHB Health Strategy Committee; 12 April 2017
4.2 Lakes DHB Community & Public Health Advisory Committe; 18 April 2017
4.3 Bay of Plenty DHB combined Community & Public Health Advisory Committee and Disability Support Advisory Committee; not available

5 WORKPLAN

6 STRATEGY AND FUNDING OVERVIEW REPORT

7 PAPERS FOR ACTION

8 PAPERS FOR INFORMATION

9 STRATEGIC PROGRAMMES UPDATE

9.1 eSPACE (June)
9.2 Mental Health and Addictions Model of Care (next update to be confirmed)
9.3 SmartHealth (next update to be confirmed)
9.4 Rural Project (next update to be confirmed)
9.5 Women's Health Transformation (June)
9.6 Elective Services Improvement (June)
9.7 Patient Flow (June)
9.8 Quality Account (June)
9.9 Medical School (June)
9.10 CBD Accommodation Projects (June, public excluded)
9.11 Primary Care Integration (June)

10 PRIORITY PROGRAMME PLANS

10.1 PPP 1.4: Enable a workforce to deliver culturally appropriate services

10.2 Priority Programme Plan Project Update

11 GENERAL BUSINESS

12 DATE OF NEXT MEETING

9 August 2017

RESOLUTION TO EXCLUDE THE PUBLIC
NEW ZEALAND PUBLIC HEALTH AND DISABILITY ACT 2000

THAT:

(1) The public be excluded from the following part of the proceedings of this meeting, namely:

Item 13: Minutes of the Health Strategy Committee: 12 April 2017

Item 14: CBD Accommodation Projects

(2) The general subject of each matter to be considered while the public is excluded, and the reason for passing this resolution in relation to each matter, are as follows:

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED		REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER
Item 13:	Minutes public excluded	Minutes taken with the public excluded.
Item 14:	CBD Accommodation Projects	Contract negotiations will be required.

(3) This resolution is made in reliance on Clause 33 of Schedule 3 of the NZ Public Health & Disability Act 2000 and the grounds on which the resolution is based, together with the particular interest or interests protected by the Official Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the proceedings of the meeting in public are as follows:

Item 13	**As shown to exclude the public in minutes.**
Item 14	**Section 9(2)(j) of the Official Information Act 1982 – To enable the Waikato DHB to carry on negotiations without prejudice or disadvantage.**

Item

13 MINUTES PUBLIC EXCLUDED
Health Strategy Committee held 12 April 2017

14 CBD ACCOMMODATION PROJECTS

RE-ADMITTANCE OF THE PUBLIC

THAT:

(1) The Public Be Re-Admitted.

(2) The Executive be delegated authority after the meeting to determine which items should be made publicly available for the purposes of publicity or implementation.

Waikato District Health Board

Apologies

Waikato District Health Board

Late Items

Waikato District Health Board

Interests

SCHEDULE OF INTERESTS AS UPDATED BY COMMITTEE MEMBERS TO JUNE 2017

HEALTH STRATEGY COMMITTEE MEMBERS

Clyde Wade (Chair)
Board member, Waikato DHB
Shareholder, Midland Cardiovascular Services
Trustee, Waikato Health Memorabilia Trust
Trustee, Waikato Heart Trust
Trustee, Waikato Cardiology Charitable Trust
Patron, Zipper Club of New Zealand
Emeritus Consultant Cardiologist, Waikato DHB
Cardiology Advisor, Health & Disability Commission
Fellow Royal Australasian College of Physicians

Tania Hodges (Deputy Chair)
Board member, Waikato DHB
Iwi: Ngati Pahauwera, Ngati Ranginui, Ngati Haua, Tuwharetoa, Maniapoto
Director/Shareholder, Digital Indigenous.com Ltd (contracts with Ministry of Health and other Government entities)
Trustee/Shareholder, Whanau.com Trust
Director, Ngati Pahauwera Commercial Development Ltd
Director, Ngati Pahauwera Development Custodian Ltd
Director, Ngati Pahauwera Tiaki Custodian Limited
Trustee, Ngati Pahauwera Development and Tiaki Trusts (Deputy Chair)
Justice of the Peace

Bob Simcock
Chairman, Waikato DHB
Chairman, Orchestras
Member, Waikato Regional Council
Director, Rotoroa LLC
Director, Simcock Industries Ltd
Trustee, RM & AI Simcock Family Trust
Wife is the CEO of Child Matters, Trustee of Life Unlimited which holds contracts with the DHB, Member of Governance Group for the National Child Health Information Programme and Member of the Waikato Child and Youth Mortality Review Group

Sally Webb
Deputy Chair, Waikato DHB
Chair, Bay of Plenty DHB
Member, Health Workforce NZ
Member, Capital Investment Committee
Director, SallyW Ltd

Sharon Mariu
Board member, Waikato DHB
Director/Shareholder, Register Specialists Ltd
Director/Shareholder, Asher Group Ltd
Director, Hautu-Rangipo Whenua Ltd
Owner, Chartered Accountant in Public Practice
Daughter is an employee of Puna Chambers Law Firm, Hamilton
Daughters are employees of Deloitte, Hamilton

Pippa Mahood
Board member, Waikato DHB
Life Member, Hospice Waikato
Member, Institute of Healthy Aging Governance Group
Board member, WaiBOP Football Association
Husband retired respiratory consultant at Waikato Hospital

Crystal Beavis
Board member, Waikato DHB
Director, Bridger Beavis & Associates Ltd, management consultancy
Director, Strategic Lighting Partnership Ltd, management consultancy
Life member, Diabetes Youth NZ Inc
Trustee, several Family Trusts
Employee, Waikato District Council

John McIntosh
Disability Information Advisor, LIFE Unlimited Charitable Trust. A national Health & Disability Service Provider, contracts to Ministry of Health. (Currently no Waikato DHB contracts)
Coordinator, SPAN Trust. A mechanism for distribution of specialised funding from Ministry of Health in Waikato
Trustee, Waikato Health and Disability Expo Trust.

David Slone
Employee CSC Buying Group
Director and Shareholder Weasel Words Ltd
Trustee NZ Williams Syndrome Association
Member of Executive, Cambridge Chamber of Commerce
Committee Member, Waikato Special Olympics
Wife employed by CCS Disability Action and Salvation Army Home Care, both of which receive health funding
Disability issues blogger (opticynic.wordpress.com).

Fungai Mhlanga
Employee, Hamilton City Council
Member, Public Health Association.

Iwi Maori Council representative
Te Pora Thompson-Evans
Interests to be advised

Lakes DHB representative
Rob Vigor-Brown
Interests to be advised

Bay of Plenty DHB representative
Mark Arundel
Interests to be advised

Consumer Council representative

Waikato District Health Board

Conflicts related to items on the agenda

Waikato District Health Board

Minutes
and
Matter Arising

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
14 JUNE 2017

AGENDA ITEM 4

COMMITTEE MINUTES

Attached are the following minutes from the Committee meeting:-

- Waikato DHB, Health Strategy Committee; 12 April 2017;
- Lakes DHB, Community & Public Health Advisory Committee and Disability Support Advisory Committee; 18 April 2017.

Recommendation
THAT
The minutes be noted.

CLYDE WADE
CHAIR, HEALTH STRATEGY COMMITTEE

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Health Strategy Committee held on Wednesday 12 April 2017 commencing at 12.30pm

Present:
Mr C Wade (Chair)
Ms T Hodges (Deputy Chair)
Mr B Simcock
Ms S Webb
Ms S Mariu
Mrs P Mahood
Mr F Mhlanga
Mr D Slone

In Attendance:
Ms J Wilson, Executive Director, Strategy & Funding
Ms N Middleton (Minutes)
Dr N Murray, Chief Executive
Ms MA Gill, Waikato DHB Board member
Ms S Christie, Waikato DHB Board member
Mr M Gallagher, Waikato DHB Board member
Prof R Lawrenson, Clinical Director, Strategy and Funding
Mr M ter Beck, Executive Director, Operations and Performance
Ms L Aydon, Executive Director, Public and Organisational Affairs
Ms T Maloney, Commissioner, Women's Health Transformation Taskforce
Mr D Hackett, Executive Director, Virtual Care and Innovation
Mr D Tomic, Clinical Director, Primary and Integrated Care
Mr M Spittal, Executive Director, Community and Clinical Support
Ms E McKenzie Norton, Strategy and Funding
Ms J Hudson, Strategy and Funding
Ms F Dibley-Mason, Strategy and Funding
Ms N Parker, Change Team
Ms B Wills, Commissioner

IN THE ABSENCE OF DELEGATED AUTHORITY ALL ITEMS WERE FOR RECOMMENDATION TO THE BOARD

ITEM 1: APOLOGIES

Apologies from Mr J McIntosh and Ms C Beavis were received.

Resolved
THAT
The apologies were received.

ITEM 2: LATE ITEMS

There were no late items raised at the meeting.

ITEM 3: INTERESTS

3.1 Register of Interests

There were no changes made to the Interests register.

3.2 Conflicts Relating to Items on the Agenda

No conflicts of interest relating to items on the agenda were foreshadowed.

ITEM 4: MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

Resolved
THAT

1. The minutes of a meeting of the Waikato DHB Health Strategy Committee held on 8 March 2017 be confirmed as a true and correct record.

2. The minutes of a meeting of the Lakes DHB Community & Public Health Advisory Committee held on 13 February 2017 be noted.

3. The minutes of a meeting of the Bay of Plenty DHB combined Community & Public Health Advisory Committee and Disability Advisory Committee held on 1 March 2017 be noted.

ITEM 5: WORKPLAN

Discussion about the year plan, all agreed the items listed. It was noted that the priority programme plans and updates on these would be included routinely in future agendas. These was particular interest in including a focus in the workplan around the Priority programme plan for Radical improvement in Maori Health outcomes by eliminating Health inequities for Maori.

Resolved
THAT

1. The Committee received the report;
2. Addressing inequities in Maori health outcomes to be added to the workplan for 2017 with timeframes for this to be determined.

ITEM 6: STRATEGY AND FUNDING OVERVIEW REPORT

Annual Plan

The annual plan has been greatly reduced in size to 33 pages as a directive from the Ministry of Health. A draft annual plan has been submitted to the Ministry of Health. The funding envelope is expected to be released in June and will likely alter our annual plan. An annual plan update will be presented

to the Committee in June 2017. This may be a late paper due to the short turn around.

Youth Alcohol and Other Drug (AOD) services
An evaluation report for this programme has been commissioned and is estimated for release in March 2018.

Community Health Forum
A steady turnout was recorded for March with a number of items raised. . Good turn out and a number of items were raised.

Of note:

- Booking clerks continue to assign difficult appointment times for those out of the Hamilton area. All have been educated on this issue. Language can be a barrier;
- The location of Carpark full signs – Dr N Murray signal at the Community Health Forum that this will be looked into by Facilities and Business.

Resolved
THAT

1. The report be received;
2. A breakdown of providers and community participants be included within future reports.

ITEM 7: PAPERS FOR ACTION

No papers for action.

ITEM 8: PAPERS FOR INFORMATION

No papers for information.

ITEM 9: STRATEGIC PROGRAMME PLANS

9.2 Mental Health and Addictions Model of Care

Prof R Lawrenson presented the Health Needs Analysis undertaken for Waikato DHB by the University of Waikato.

As part of the Health Needs Analysis a questionnaire for GPs around Mental Health services, their services offered and capacity was being undertaken. To date there have been responses from 35 General Practices. Stakeholder interviews have occurred. A presentation was given to the Committee.

Of note:

- Mental Health Review Group are meeting monthly;
- Current review by provider arm of their services;
- Health Needs Analysis has provided a view of the burden of disease and current management;
- Next step is to review models of care.

Discussion occurred on the value of including items such as this Needs Analysis in a resource centre within Diligent books for easy

future access for committee members. This would be explored prior to the next for meeting.

9.3 SmartHealth

Mr D Hackett and Dr D Tomic attended for this presentation agenda item.

Of note:

- A key learning to date has included how the SmartHealth product is marketed to the population;
- There has been success at people choosing to sign up at community events;
- A connection with Healthline is being established;
- A SmartHealth kiosk located in the emergency department of Tokoroa hospital is due to go live in May 2017;
- User account creation using RealMe account validation has been approved;
- Ideas for events and promotion are welcomed.

9.4 Rural Project

Mr M Spittal attended for this agenda item.

This project has not made progress as intended due partly to resourcing and not being clear at a strategic board level as to how we work with providers and other key contacts in the communities.

Key issues:

- Work on a model of service for Taumarunui had not yet commenced.
- Retrievals – working down a track by solving at an ED level and ICU – difference of skill set. Will achieve in 2017 –
- Definitions of rural and urban to inform analysis were being clarified and would be reported back to the committee.

A Primary Care Strategy workshop Inter Alliance partners would be occurring in the coming months.

9.5 Women's Health Transformation

Ms T Maloney attended for this agenda item.

Of note:

- 3 main areas – workforce, model of and care and education programme – all progressing well. A Clinical Director has been appointed and will start in May.

RANZCOG happy with progress.

9.6 Elective Services Improvement

Ms B Wills attended for this agenda item.

Of note:

- In March both key ESPI requirements were met;
- Volumes will not met the expected volumes in orthopaedics for the current year;

- Intervention rates at the Waikato DHB are behind the national average in some specialties/procedures, particularly orthopaedics (excluding hip and knee operations);
- The timeframe for moving to national intervention rates for some specialties could take some time.

Resolved
THAT
The updates be received.

ITEM 10: PRIORITY PROGRAMME PLANS

Ms E McKenzie-Norton and Ms N Parker attended for this agenda item to present an update in identified progress.

Priorities 1.1 – 1.3 have been assigned 200 delivery days, the remaining priorities have 70 delivery days.

Questions were raised from the Committee members in relation to how priorities 1.4 - 6.4 are incorporated and fit within priorities 1.1 – 1.3. The need for prioritisation across areas was suggested.

Resolved
THAT
The update be received.

ITEM 11: GENERAL BUSINESS

A strategy to prevent Suicide in New Zealand had been received and will go out for public consultation. A copy of this document would be forwarded to committee members and discussed at the June committee meeting.

Resolved
THAT
The update be noted and documents circulated to Committee members

ITEM 12: DATE OF NEXT MEETING

14 June 2017.

LAKES DISTRICT HEALTH BOARD

MINUTES OF A MEETING OF THE COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE HELD TUESDAY 18TH APRIL 2017 LAKES DHB BOARD ROOM

Meeting: **[140]**

Present: L Thurston (Chair), W Webber (Deputy Chair), D Shaw (Board Chair - ex Officio), M Raukawa-Tait, J Morreau, S Te Moni (Te Ropu Hauora o Te Arawa) and A Pedersen

In Attendance: R Dunham**,** J Hanvey, M Smith, K Rex, S Andrews, S Wilkie (to 2.00pm), P Tangitu (from 1.35pm) and T Fraser (EA to Chief Executive)

1.0 MEETING CONDUCT

The Chair welcomed everyone to the meeting.

1.1 Apologies: D Epp, B Bayne, Dr Miller, Dr Shoemack

Resolution:
THAT the apologies be received.
L Thurston : J Morreau
CARRIED

1.2 Schedule of Interests Register
The register was circulated during the meeting with no entries made.

1.3 Conflict of Interest related to items on the agenda : Nil

1.4 Items for General Business
D Shaw provided an update on the meeting that members of the Lakes DHB Board and Executive Team had held with Te Ariki Sir Tumu Te Heuheu on 18 April 2017 in Turangi. The meeting was a high level strategic meeting that focused on resetting relationships and looking at an integrated model for the future. The meeting was very positive and D Shaw looks forward to a high level of cohesiveness in the future.

1.5 Presentation:
Doctor Alistair and Mary McLean from Western Heights Community Heath Centre presented on the programmes that the centre has underway. Current issues were identified as being:

- Cultural dislocation
- Unemployment
- Substance and gambling issues
- Family violence
- Poverty
- Gangs
- Chaos
- Absent male figures

Programmes (Nurse led) that the centre has underway include:

1. Holding the Hope- Smoking Cessation Solutions
    - 70-100 people per quarter start on the programme
    - There is intensive follow-up via phone / text
    - Script fees are paid for by the centre

2. Tipu Ora and Western Heights Health Centre – An Effective Maori / Mainstream Partnership

3. School-based clinics – 'Rheumatic fever be gone'
    - 200 swabs in the March quarter
    - Clinics held 3.00pm to 6.00pm at night
    - Some children are enrolled but never seen by a GP i.e. no ongoing relationship with a GP
    - Hoping to see a reduction in ASH rates
    - Skin conditions also seen include impetigo, head lice, scabies, infected eczema
    - Level of poverty is now significantly higher.
    - Employment rate higher but as a result more children are not being seen due to parents working

4. School for Young Parents
    - 30 young women (14 years plus)
    - Bridges into health services
    - Is run on standing orders
    - Centre pay their script fees
    - Access to good food, physical education etc.
    - Social worker access available

5. Healthy Homes
    - Has been running for two years
    - Programme focuses on people with crowded home or no home
    - Grants have been provided from Sovereign Trust and RECT
    - The centre works with MSD and power authorities on behalf of some families
    - Noted that social housing in Rotorua is full
    - 240 homes have been seen in the last two years with over 400 interventions and assistance
    - A number of agencies support the Healthy Homes Programme

6. Te Oho Mauri Service – alcohol, drugs and mental health within Western Heights
    - Engagement is initially with a nurse and then free access to the GP
    - This group is in survival mode and does not access services
    - Linkages to families have been established through Early Childhood Centres
    - Aim is for intervention at the earliest possible time
    - It was asked of Dr McLean and Mrs McLean what Iwi leaders can do to assist. The excellent programmes that Korowai Aroha ran was noted and Dr McLean and Mrs McLean were very thankful for Korowai Aroha's support

In summary, D Shaw asked what should Lakes DHB be responsive to? Dr A McLean advised that Lakes DHB needs to make services closer to the community and make the community take some responsibility for their health.

P Tangitu noted the leadership that Dr Mclean and Mrs McLean have demonstrated in their centre and in the community which has contributed to the success of the programmes. D Shaw advised that the new Board members would be interested in visiting the Western Heights Medical Centre.

L Thurston and M Smith thanked Dr McLean and Mrs McLean for their presentation to the CPHAC committee members.

2.0 SIGNIFICANT ISSUES

2.1. Public Health

2.1.1 Toi Te Ora Public Health Service

2.1.1.1 Toi Te Ora Public Health Service report : April 2017

Items covered from this report included:-

- Toi Te Ora have been assisting with the Edgecumbe recovery

Resolution:
THAT the report be received.
J Hanvey : M Raukawa-Tait
CARRIED

2.1.1.2 Toi Te Ora Medical Officer of Health report : March 2017
J Hanvey updated on the report on behalf of the Medical Officer of Health.

Resolution:
THAT the report be received.
J Hanvey : L Thurston
CARRIED

2.2 Primary Health

2.2.1 Healthy Families Rotorua

- M Smith updated on the report.

2.3 Maori Health

2.3.1 Maori Health Report
2.3.2 Kia Ora Hauora
2.3.2.1 Kia Ora Hauora Midland Work Plan
2.3.2.2 Kia Ora Quarter Two 1st October to 31 December 2016

P Tangitu provided an update on the reports.
Resolution:
THAT the Maori Health information and the Healthy Families Rotorua report be received and noted.
D Shaw : J Morreau
CARRIED

Following the presentation on the Western Heights Initiative M Raukawa-Tait asked what mechanisms were in place (e.g. audit/monitoring) to ensure GPs were looking after the health needs of Maori and promoting equitable outcomes?

M Smith noted this was an area that was difficult to measure, however there are minimum requirements for PHOs and some could be seen as proxy measures for responsiveness to Maori.

M Smith and K Rex to bring the relevant minimum requirements to the next CPHAC meeting for discussion.

M Smith and K Rex will also bring a list of targeted services in primary care to improve access for high needs groups and will seek a breakdown from the PHO on Maori utilisation of these services.

3.0 SECRETARIAL

3.1 Minutes of Community and Public Health Advisory Committee meeting : 13th February 2017
Resolution:
THAT the minutes of the Community and Public Health Advisory Committee meeting of 13th February 2017 be confirmed as a true and accurate record.
M Raukawa-Tait : D Shaw
CARRIED

3.2 Matters arising
3.3 Schedule of Tasks

- Healthy Home / Rheumatic Fever Programme – presentation occurred at CPHAC meeting today so can be removed from the schedule of tasks.
- Community initiatives – decision to remove from the schedule of tasks
- Population Health Survey Report – to remain on schedule of tasks
- Breast Feeding – to remain on schedule of tasks
- HPV vaccine – decision to remove from the schedule of tasks
- MHN – to remain on the schedule of tasks with a change in presentation date to 19 June

4.0 REPORTS

4.1		0-4 Ambulatory Sensitive Hospitalisation (ASH) **Resolution:**

		THAT the 0-4 Ambulatory Sensitive Hospitalisation (ASH) be received and noted. **J Morreau : L Thurston** CARRIED
4.2		Midland DHBs New Regional Service: Hepatitis C – Community Based
		Resolution: THAT the Midland DHBs New Regional Service: Hepatitis C – Community Based report be received and noted. **J Hanvey : M Raukura-Tait** CARRIED
4.3		National Bowel Screening Programme **Resolution:** THAT the National Bowel Screening Programme report be received and noted. **L Thurston : D Shaw** CARRIED
4.4		Planning & Funding key activities first six months 2016/17 report **Resolution:** THAT the Planning & Funding key activities first six months 2016/17 report be received and noted. **D Shaw : W Webber** CARRIED
		Community representative reports : A Pedersen updated on the key activities in the Mangakino area as well as details of the new health centre recently opened which is supported by the community and GPS.

5.0 INFORMATION AND CORRESPONDENCE

5.1 Women's Health Research Review Issue 22

5.2 Configuration – Kaupapa Maori Services

P Tangitu provided an update on the staff consultation processes. A visit to Counties Manukau is planned to review its Kaupapa Maori Services as it has been running for eight months. M Raukawa-Tait noted that there had been some concerns raised to her regarding the change in our Kaupapa Maori Service. R Dunham noted that one change will be that support will be provided in the home once the patient is discharged.

Resolution:

THAT the above items of information be noted.

L Thurston : D Shaw

CARRIED

6.0 PUBLIC EXCLUDED

Resolution:

THAT the committee move into Public Excluded at 3.10pm

L Thurston : D Shaw

CARRIED

L Thurston QSO JP……19th June 2017

Chair

LAKES DISTRICT HEALTH BOARD

SCHEDULE OF TASKS FROM THE
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE
18th April 2017

Agenda Item	Action	Responsibility of	Timeframe
PRESENTATIONS			
Population Health Survey Report	Presentation by Toi Te Ora	Janet Hanvey	19th June 2017
Breast Feeding	Presentation on Breast Feeding	Leonie Pritchard	14th August 2017
ITEMS			
PHO audit and monitoring mechanisms	Following the presentation on the Western Heights Initiative M Raukawa-Tait asked what mechanisms were in place (e.g. audit/monitoring) to ensure GPs were looking after the health needs of Maori and promoting equitable outcomes. M Smith and K Rex to bring the relevant minimum requirements to the next CPHAC meeting for discussion. M Smith and K Rex to bring to the next CPHAC meeting a list of targeted services in primary care to improve access for high needs groups and will seek a breakdown from the PHO on Maori utilisation of these services.	Mary Smith / Kathy Rex Mary Smith / Kathy Rex	19th June 2017 19th June 2017
RAPHS	Update on Retinal Screening Peer Review to be provided to next meeting	M Davies	19th June 2017

Workplan

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
14 JUNE 2017

AGENDA ITEM 5.0

WORKPLAN 2016

The proposed Health Strategy Committee workplan for 2017 is attached for your information.

As discussed at the March Health Strategy Committee there will be standard items on the workplan in relation to

- updates around the DHBs strategic projects and
- implementation of the strategy and development of priority programme plans.

There were however a a number of other items the committee had indicated it would be seeking to include within a future agenda separate from these areas.

An initial workplan has been developed at attached. This recognises that a significant portion of the committee agenda will be focussed on the above items restricting other activity to one or two items per meeting.

Recommendation
THAT
The workplan be received.

CLYDE WADE
CHAIR, HEALTH STRATEGY COMMITTEE

HEALTH STRATEGY COMMITTEE
FUTURE WORK PLAN 2017

	Report	When
1.	Pharmacy Plan Translation services Tobacco Plan	August 2017
2.	Understanding our population profile	October 2017
3.	Prevention programme assessment Health of Older people Strategy	December 2017

Joint workshops with the Performance Monitoring Committee are also proposed in relation to the following items:

- Child health
- Managing demand

Items with date to be confirmed (subject to availability of presenters):

- Government Disability Strategy *Note A
- Younger people in resthomes *Note A
- Support for immigrants and refugees with disabilities * Note A
- Improving access to primary care for the intellectual disability community.

*A – Ministry of Health will be invited to discuss these items

Waikato District Health Board

Strategy and Funding Overview Report

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
14 JUNE 2017

AGENDA ITEM 6.0

STRATEGY AND FUNDING REPORT

Purpose	1) For information

Appointment of Senior Planning Manager
Wayne Skipage commenced in the role of Senior Planning Manager in Strategy and Funding on Monday 22 May 2017. Wayne has had significant previous experience in similar roles most recently covering the Capital and Coast, Hutt Valley and Wairarapa DHBs.

Waikato Annual Plan and Budget submission 2017/18
As previously noted the 2017/18 Annual Plan was required to be a significantly shortened document. The new format required is for a document of 30-33 pages which includes Maori health indicators as a separate Maori Health plan is no longer required by the Ministry of Health.

The draft Waikato DHB Annual Plan 2017/18 was submitted to the Ministry of Health on 31 March 2017, following presentation at the March board meeting and updating the tables to reflect their alignment with the key imperatives in the Waikato DHB strategy. Initial feedback on the draft plan was and in general most items required minor change/clarification only and there has been good progress in addressing this feedback over the last few weeks.

Revised funding advice was received from the Ministry of Health on 26 May 2017 however a further update is expected to be received within the next few weeks as there were concerns in relation to the underlying allocations across DHBs.

Finalisation of the budget for 2017/18 has been difficult in the absence of final revenue information. For this reason there will be a delay in submitting the financial templates until final revenue information is received and considered. The date for submission of our final draft Annual Plan 2017/18 is therefore yet to be confirmed.

System Level Measures (SLM) Plan
As noted in previous reports the approach to the system level measures plan for 2017/18 has changed with an increases focus on local priorities and engagement across primary, secondary and other service groups.

Attached as appendix A is the copy of the current draft document (yet to be endorsed).

Feedback from alliance partners and final revisions of the plan are expected to be received over the next fortnight with the final copy presented to Board and submitted to the Ministry of Health by the 30th of June 2017.

Demand Management Advisory Group (DMAG*)*
The demand management advisory group was developed in 2015 and includes representation from all PHOs along with representatives of Waikato and rural hospitals, St Johns and pharmacy. The areas of focus in the demand management group will be detailed in the August 2017 meeting.

Community Health Forum
The next round of Community Health Forum is scheduled for to occur between 17 July and 15 August 2017. In response to feedback an additional forum has been included in Raglan which will be piloted over the next year to identify if there is a high community attendance.

A schedule of these meetings will be circulated to all members. Reports from these meeting will be included following each round of forum.

Mental health and Addictions programme of work – Te Pae Tawhiti
Te Pae Tawhiti is a programme of work that will develop new models of care and outcome frameworks for Adult Addictions, Adult Mental Health, mental health and addictions for Older People and Child and Youth Mental Health and Addictions.

It is over seen by a steering group chaired by Professor Ross Lawrenson with membership including Strategy and Funding, Te Puna Oranga, Waikato DHB mental health and addictions service, NGO and primary care. Included within the membership is a consumer representative with links to the mental health consumer groups and a nominee from Te Roopu Tautoko Ki Waikato (the Maori mental health forum).

Four working groups are being set up. The working groups will be guided by the recently completed Mental Health and Addictions Health Needs Analysis and will encompass the spectrum of care spanning from health promotion/prevention to secondary/tertiary care.

The first working group Adult Addictions has commenced meeting. This work will be informed by the provider arm.

The work that has been undertaken within by the provider arm on Creating our futures work will be an input into these working groups. Again there will be co-designed development with stakeholders, in particular service users and their families/whanau to design mental health and addiction services into the future.

The project managers for the two programmes are working closely together to identify and reduce any duplication of effort and ensure the two streams of work are linked, consistent and complimentary.

Strategic Service Plans
Work will soon commence in relation to the structure for the development of strategic service plans. These plans will have a system wide focus and both embed the strategy implementation outcomes alongside the metrics and service opportunities within each service area.

Pay Equity Settlement for Home and Community Support Services (HCSS) and Community Residential Living (CRL)
A significant focus of activity for all DHBs over the recent months has been the implementation of the pay equity settlement for Home and Community Support services.

New funding will be made available from the Ministry of Health to cover the cost of this settlement however there are a number of complexities in terms of implementation and potential impacts on services not covered by the national pay equity settlement.

Suicide Prevention and Postvention Plan Refresh
Waikato DHB is updating its Suicide Prevention and Postvention Plan to take us through the next three year period 2018-2021.

There has been good progress made over the last three years. We have a DHB Advisory Group and have employed a Suicide Prevention/Postvention Co-ordinator who has worked hard with communities and within the DHB to ensure there are supports available for those who are affected by suicide and that prevention activities are occurring in primarily, the areas of greatest need. However there is still more to be done and improvements to be made.

In order to elicit community input into our focus for the next three years, presentations about the refresh were made at all Community Health Forums in March 2017; a well-publicised survey ran on the DHB website (11 April to 19 May), and a series of focus groups are being held around the DHB area over June.

Focus Groups
Focus groups are particularly representative of those who have been identified as at risk populations:

- The rainbow community
- Young Māori men under 25 years
- Those 65 years and older
- Mental health and addictions service users
- Pacific community
- Rural men

Three focus groups have been held so far and have identified a service gap for those in distress whose need is not 'crisis' or even necessarily clinical, but simply 'someone to talk to'. Help lines while sometimes helpful were not seen to be adequate; a personal interaction was preferred. Other issues included:

- Understanding the underlying problems that people are facing
- More prevention work and strategies
- Clearer referral pathways
- Rapid follow up after discharge from inpatient services

Survey
There were 56 responses to the survey and key messages included:

- Give the public information about the signs of distress in family/whānau/friends and how to get help
- Hold wellness days in communities where people can pick up resources or talk to a Mental Health clinician
- Hold wellness days in communities where people can pick up resources or talk to an Addictions clinician

Ministry of Health
In April this year the Ministry of Health released A Strategy to Prevent Suicide in New Zealand – draft for consultation. Submissions closed on 12 June.

The Board was updated in May on the call for submissions and the resulting feedback.

Feedback from the Suicide Prevention and Postvention Health Advisory Group was generally supportive of the document as a national strategy whilst clearly recognising that the document is very broad (in order to be inclusive) and accordingly prioritisation of focus would need to occur at local level. The community focus of the strategy was seen as encouraging and it was confirmed that our more specific local action plan could comfortably incorporate the principles listed in the MoH's draft strategy.

Next Steps
Three further focus groups are scheduled over June and a consultation report will be developed.

A draft Waikato DHB Suicide Prevention/Postvention Plan for 2018-21 will be submitted to the Health Strategy Committee in August 2017

Recommendation
THAT
The Committee notes the content of the report

JULIE WILSON
EXECUTIVE DIRECTOR, STRATEGY AND FUNDING

System Level Measures Improvement Plan

2017/18

Contents

Introduction

The creation of the System Level Measures in 2016/17 and their accompanying contributory measures provided the Waikato Health System as a whole with a fantastic opportunity to address key local health priorities for our population. As a system we are making progress with ASH 0-4 and acute bed days for 'other', however we are committed to improving the health outcomes of all of our population, in particular, radically improving the health outcomes of our Maori population. This second Improvement Plan for 2017/18 has been developed in response to the Ministry of Health's requirements for continuing System Level Measures improvement, along with our desire to address equity.

Our district alliance and individual clinically led SLM working groups have worked collaboratively to set and agree our improvement milestones, contributory measures and activity for 2017/18 in order to contribute to the national outcomes and also align with our priority areas. They are based on analysis of local trends, while considering the needs and priorities of our population.

While the Inter Alliance will oversee and monitor this improvement work, the working groups will be the vehicles for driving improvement against the measures.

Dr Nigel Murray Chief Executive Officer Waikato DHB	John Macaskill-Smith Chief Executive Officer Pinnacle Midlands Health Network	Hugh Kininmonth Chief Executive Officer Hauraki PHO	Simon Royal Chief Executive Officer National Hauora Coalition	Cath Knapton Chief Executive Officer Midlands Pharmacy Group

Background

System Level Measures are high level aspirational goals for the health system that align with the five strategic themes of the Health Strategy and other national strategic priorities such as Better Public Service Targets. They have a focus on children, youth and vulnerable populations. System Level Measures are part of Waikato DHB's annual planning process and provide an opportunity to work across our primary, secondary and community care providers to improve health outcomes of our local populations. The Ministry of Health worked with the sector to co-develop a suite of system level measures to support this whole-of system view of performance.

This Improvement Plan includes the addition of two developmental System Level Measures - Proportion of babies who live in a smoke-free household at six weeks postnatal and youth.

The Plan includes the following:

- Improvement milestones that are a number that shows improvement in performance, for each of the six SLMs.
- A suite of contributory measures for each of the six SLMs along with the end of year quantitative goals for each contributory measure, where appropriate
- Description of specific activities to be undertaken by primary, secondary and community providers to achieve the SLMs
- District alliance stakeholder agreement with the Improvement Plan
- Reporting and accountability framework

System Level Measures

The six System Level Measures (SLMs) are:

- Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds
- Acute hospital bed days per capita
- Patient experience of care
- Amenable mortality rates less than 75 years.
- Proportion of babies who live in a smoke-free household at six weeks postnatal (developmental)
- Youth access to and utilisation of youth appropriate health services (developmental)

SLM Plan Development 2017-18

Collaborative Development

2016/17 saw a development phase for the System Level Measures work with a regional focus for Waikato. Because of this a number of the 2016/17 contributory measures have remained.

For 2017/18, a more district focused approach has been undertaken with clinically led working groups engaged in reviewing the available data, determining milestone improvement targets, contributory measures, activity that would likely support improvement and advising on the key metric to be used to monitor performance.
To decide the most effective approach to the issues identified by the data, the groups looked to ensure:

- Alignment to current Alliance work programmes and activities
- Information was available and already collected; and where possible aligned across the region
- Relevance to family and whanau, clinicians and managers
- A focus on reducing inequity
- Relevance to vulnerable populations including but not limited to older people and children
- Impacting on a reasonable sized population

The three Primary Health Organisations (PHO's) – Pinnacle Midlands Health Network, Hauraki PHO and National Haora Coalition, Midland Community Pharmacy Group, along with our Maori Health Team (Te Puna Oranga) and appropriate stakeholder groups, provided representation within the SLM working groups and were all involved in the development of the plan.
Having clinical leads for each SLM was also instrumental in the development of an action-focused improvement plan, with endorsement across the district.

Once the draft plan was developed it was taken to Inter-Alliance for review and approval.
Following approval by the Ministry of Health, appropriate implementation, monitoring and governance for the Improvement Plan for 2017/18 will be carried out.

System Level Measure Overview

System Level Measure	Improvement Milestone 17/18 Target	Contributory Measures
1. ASH 0 – 4 years	• Reduce ASH admissions for 0-4 year olds by 4% for Maori and Pacific 2% for other • Reduce ASH admissions for 0-4 year olds by 2% for other across the DHB in order to reduce inequity	• Eligible children provided flu vaccination • Influenza and boostrix vaccines for pregnant women • 0-4 ASH condition of cellulitis or dermatitis/eczema • Children with a Lift the lip score of 2-6 are referred to an oral health provider • Number of ECE with water and milk only policies • The number of new-borns fully enrolled in a PHO by 6 weeks • Gastro conditions supported in primary care
2. Acute Bed days	• Reduce acute bed days by 2% and maintain for Maori and Pacific by 30 June 2018 • Reduce acute bed days by 1% and maintain for 'other' by 30 June 2018	• ED presentation rates • Hospitalisation rates for people with COPD conditions • Hospitalisation rates for people with cellulitis • Hospitalisation rates for people with cardiac/heart failure • Occupied bed days for patients 75 years and over who had two or more emergency admissions within a calendar year • Inpatient average length of stay for acute admission
3. Patient Experience of Care	• Achieve 80% of GP Practices using the National Enrolment Service (TBC) • Achieve 80% of GP Practices using the primary care patient survey • Achieve 30% of patients completing the primary care patient experience	• GP practices using the National Enrolment Service • GP Practices using the primary care patient survey • Patients completing the primary care patient experience survey • Improving patient experience – medication safety and health literacy
4. Amenable Mortality	• Reduce total amenable mortality rate by 4% for Maori and Pacific	• PHO eligible population who have had a CVD risk recorded within the last five years

	• Reduce total amenable mortality rate by 2.5% for 'other' across the DHB in order to reduce inequity	• PHO population achieving a 5 year cardiovascular risk of less than 15% • PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months • Registered smokers who have been referred to a smoking cessation service (hospital) • Proportion of patients assessed for risk of deliberate self-harm in primary care • PHO population estimated to have diabetes that have been identified and coded • PHO eligible population with a record of a Diabetes Annual Review during the reporting period whose HbA1c test result is 8% or less or 64 mmol/mol or less • Maori women who have had a mammography within 2 years • Patients receive 1st cancer treatment within 62 days of being referred with high suspicion of cancer
5. Smokefree Infant (Developmental)	The Ministry has agreed to final improvement milestone targets being agreed by 20 October 2017**.**	Draft contributory measures have been identified across stakeholder groups influencing smoke free households at six weeks. Prioritization of the measures and finalization of activity and milestones/targets is still to occur. As these measures are developmental the Ministry has agreed to final contributory measures and activity being agreed by 20 October 2017.
6. Youth Access (Developmental)	The Ministry has agreed to final improvement milestone targets being agreed by 20 October 2017**.**	• Alcohol-related ED presentations for those aged 10-24 years • Self-harm-related ED presentations for those aged 10-24 years Please note these are draft contributory measures, finalization of activity and milestones/targets is still to occur. As these measures are developmental the Ministry has agreed to final contributory measures and activity being agreed by 20 October 2017.

System Level Measure 1: ASH rates in 0-4 year olds: Reduce hospital admissions rates for conditions avoidable through prevention or management in primary care

Improvement Milestones:

- Reduce by 4% for Maori and Pacific and
- Reduce by 2.0% for 'other' across the DHB in order to reduce inequality

Baseline data analysis:

- ASH rate remain steady throughout the year for all ethnicities measured
- By volume 0-4 year olds are the biggest age group for ASH. Respiratory infection, Dental Conditions, skin infections and Gastroenteritis/ Dehydration being the top issues for the age group.
- 'Other' show a higher rate per 1,000 of population than the other ethnicities measured with the exception of Asthma

		Respiratory				
		Contributory measures	**Rationale**	**Activity**	**Target (TBC for local Improvement Plan)**	**PHO measures** [i]
	1.	Eligible children provided flu vaccination	Respiratory in top 10 0-4 ASH condition. Rates of these immunisations remain low. No system in place to identify and vaccinate in primary care Influenza vaccination rates for children hospitalized for respiratory illnesses remain low.	Program to identify and vaccinate all children 0-5 who qualify for the free influenza vaccine. a) Systems in place to identify and vaccinate o Defining denominator (who would qualify) o primary care system recall for eligible population o disease register to monitor performance b) Review current performance to maintain and improve practice c) Review childhood map of medicine respiratory pathway d) Raising awareness; update professionals on current activity and resources and offer education and resource support as required e) Align and promote pharmacy options	…% of all 'eligible' children are provided the flu vaccination	✓

2	Influenza and boostrix vaccines for pregnant women	Influenza and boostrix vaccines in pregnancy prevent serious communicable illness in newborn children.	Build on work already developed a) Data activity to be defined b) Review current performance to maintain and improve practice c) Raising awareness; update professionals on current activity and resources and offer education and resource support as required d) Align and promote pharmacy program	…% of all pregnant Maori women are provided the flu vaccination …% of all pregnant 'other' women are provided the flu vaccination	x
	Skin infections				
	Contributory measures	**Rationale**	**Activity**	**Target (TBC for local Improvement Plan)**	**PHO Measures**
3	0-4 ASH condition of cellulitis or dermatisi/eczema	Skin infections in top 10 0-4 ASH condition. There is high and growing rate of hospitalizations for serious skin infections. There is a lack of consistent messaging and educational resources for families on how to manage skin infections.	Develop a new primary care system of care around childhood skin infections a) Data analysis to identify self-referral vs primary care referral for ASH admission and enrolled vs not enrolled to provide targeted support and consistent pathways b) Build on midland work already developed including updating the child map of medicine or agreed pathway and distribution of education and resource as required. c) Work with CHAG to review tools and resource available and carry out analysis on local admissions against resource support available (iMOKO, Hauraki using GASP, smart health, pharmacy) d) Expansion of paediatric business rules for primary options	…% ↓ in dermatitis/ eczema ASH admissions for Maori ...%↓ dermatitis/ eczema acute admissions for 'other'	✓

	Oral health				
	Contributory measures	**Rationale**	**Activity**	**Target (TBC for local Improvement Plan)**	**PHO Measures**
4	Children with a Lift the lip score of 2-6 are referred to an oral health provider	Oral Health in top 10 0-4 ASH condition. Hospitalizations due to dental conditions in the 0-4 age group are significant and increasing 2016/17 contributory measure with focus for 2017/18 on assessment being carried out earlier than B4SC check up	To be defined, notes • The majority of referrals are currently thru BPAC from B4SC. Need to be captured before B4SC i.e. 15 month imms or wellchild checks • Upskill primary care, well child and secondary providers in lift the lip assessments, knowledge of dental services and how to refer • Preferred referral process for providers to call COH at time of assessment to review oral health status (enrolled, DNA, decay being managed already) and set up appointment at the same time	% ↑ referrals for Maori children to oral health for a lift the lip score of 2-6 % ↑ referrals for 'other' children to oral health for a lift the lip score of 2-6 ↑ Number of referral seen by Community Oral Health by …	✓
5	Number of Early Childhood Education (ECE) Centres with water and milk only policies	Primary prevention oral health focus Opportunity to align and drive primary prevention work across the sector	To be defined, notes • Capture baseline data of current number of ECE with water and milk only policies in Waikato • Opportunities for three key partners (Population Health, Community Oral Health & Sport Waikato) to pool resources and reduce double up • Program in place across the 3 partners to promote and support the adoption of water and milk only policies in ECEs	TBC once baseline data is captured % of ECE's in the Waikato have water and milk only policies % of Kohanga Reo in the Waikato have water and milk only policies	x
	Newborn enrolment				

	Contributory measures	Rationale	Activity	Target (TBC for local Improvement Plan)	PHO Measures
6	The number of new borns fully enrolled in a PHO by 6 weeks	2016/17 contributory measure Inter-alliance primary prevention priority aligning with 8 month immunisation activity Access to healthcare is key equity focus	• Link activity agreed for Immunisation 8 month coverage • Monitor and reduce proportion of children not enrolled by 6 weeks with a particular focus on Maori.	..% of Maori new borns are enrolled with a PHO by 6 weeks …% of 'other' new borns are enrolled with a PHO by 6 weeks	✓
	Gastroenteritis				
7	**Milestones**	**Rationale**	**Activity**	**Target (TBC for local Improvement Plan)**	**PHO Measures**
	Gastro conditions supported in primary care	Gastroenteritis in top 10 0-4 ASH condition.	• Fit for purpose: capacity in GP facilities • Expansion of paediatric business rules for primary options • Align and link in with pharmacy options	..% ↓ in gastro acute admissions for Maori ..% ↓ gastro acute admissions for 'other'	✓

System Level Measure 2: Acute Bed Days: Improved management of demand for acute care

Improvement Milestone:

- Reduce acute bed days by 2% and maintain for Maori and Pacific by 30 June 2018
- Reduce acute bed days by 1% and maintain for 'other' by 30 June 2018

Baseline data analysis:

- The overall 3 top issues by bed duration are Congestive heart failure, Pneumonia and Acute subendocardial myocardial infarction.
- Each ethnicity show a different duration per visit with Maori being the shortest durations per visit, in some conditions up to 10 day shorter
- Top issues for each ethnicity vary from the total and includes Cellulitis of lower limbs for Maori and Chronic obstructive pulmonary disease with acute lower respiratory infection for Pacific population

		ED Presentations				
		Contributory measures	**Rationale**	**Activity**	**Target (TBC for local Improvement Plan)**	**PHO measures** [ii]
	1.	ED presentation rates	COPD is a top reason for ED presentations and admissions for Pacific, cellulitis for Maori and cardiac/heart failure is in the top 3 overall.	• Focus on COPD, cellulitis and cardiac/heart failure via current initiatives (see below). • Roll –out of START phase two expansion – admission avoidance aimed at reducing geriatric admissions by utilizing assessment in the home in order to support clients in the primary care setting.	TBC	✓
		Acute Hospital Admissions and Readmissions				
		Contributory	**Rationale**	**Activity**	**Target (TBC for**	**PHO**

	measures			**local Improvement Plan)**	**measures**
2.	Hospitalisation rates for people with COPD conditions	COPD is a top reason for ED presentations and admissions for Pacific, along with pneumonia being in the top 3 overall.	• Work with operation and support team and Te Puna Oranga to review the Maori/Pacific patient journey in emergency department. Analysis of journey to identify key action areas to improve equity. • COPD Homebased Support Team (CHEST) new care model initiative in the community initiation by Q2, implemented change by Q3 and imbedded by Q4. - Provide education to local GP and nursing staff - More focused case management during the Winter months - Aim is for practices with high needs patients to be more appropriately supported by dedicated specialist staff	TBC	✓
3.	Hospitalisation rates for people with cellulitis	Cellulitis is a top reason for ED presentation and admission for Maori	• PHO review of primary options cellulitis pathway in Q1, • Design of new pathway Q2, • Implementation in Q 3 • Review in Q4	TBC	✓
4.	Hospitalisation rates for people with cardiac/heart failure	Cardiac/heart failure is in the top 3 overall for admissions/ hospitalizations	• Rural accelerated chest pain pathway trial to roll out in October 2017 -Will include the introduction of a chest pain assessment tool and point of care machine into 12 rural GP practices across the Waikato region to reduce unnecessary ED admissions and hospital admissions	TBC	✓
5.	Occupied bed days for patients 75 years and over who had two or more	The readmission rate is a marker of the quality of care being provided and the level of integration between service providers. This measure is also	• Roll –out of START phase two expansion – admission avoidance falls prevention project to avoid readmissions - Development of clear criteria and pathway for patients who meet the guidelines and	TBC	✓

	emergency admissions within a calendar year	a good balancing metric for the reduced length of stay for acute admissions. Waikato has the second highest readmission rate in the country with one the top reasons being falls.	have the potential for rehab with the aim of being discharged home rather than being admitted. - Further work identifying complexity through the patient journey - The further use of InterRAI data and assessment tools to identify complexity early on and inform a more targeted approach and older friendly services to support clients in a primary care setting, pulling from ED and acute services.		
	Average length of stay				
	Contributory measures	**Rationale**	**Activity (draft)**	**Target (TBC for local Improvement Plan)**	**PHO Measures**
6.	Inpatient average length of stay	The efficient flow of patients through and out of hospital supports the focus of keeping people in the community.	• Progressing the '*Patient Flow Programme'*, including projects for production planning, ward management and improving bed availability, • Rollout of iMPACT patient flow manager IT project. It will have the effect of shortening length of stay, provide better visibility of patient status in the hospital, and workflow management associated with inpatient care	TBC	

System Level Measure 3: Patient Experience of Care: Improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience of care

Improvement Milestones:

- Achieve 80% of GP Practices using the National Enrolment Service (TBC)
- Achieve 80% of GP Practices using the Primary Care Patient Experience Survey (TBC)
- Achieve 30% of patients completing the Primary Care Patient Experience Survey (TBC)

Baseline data analysis:

Waikato inpatient patient experience survey scores are similar to the national weighted average scores for the last quarter – Q4, 2016. We have worked hard to improve our response rate for the survey and are now one of the highest response rates in New Zealand, typically above 40%.
The key themes from feedback are:
1. Not being told about medication side effects to look out for at home,
2. Not receiving enough information about how to manage conditions after discharge

Primary care survey to be rolled out.

		National Enrolment Service				
		Contributory measures	**Rationale**	**Activity**	**Target (TBC for local Improvement Plan)**	**PHO Measures**
	1.	GP practices using the National Enrolment Service	In order to roll out primary care surveys the practices need to have transitioned to the National Enrolment Service	• Support and training to all Practices to transition to the NES as and when respective Practice Management Systems are compatible.	80% of GP practices using the National Enrolment Service	✓
		GP Surveys				
		Contributory measures	**Rationale**	**Activity**	**Target (TBC for local Improvement Plan)**	**PHO Measures**
	2	GP Practices using the primary care patient survey	Provides the ability for practices to understand their customer	• Develop a high level plan to implement the Primary Care Patient Experience Survey • Training and support for general practice in use of Patient Survey	80% of GP Practices using the primary care patient survey	✓

			• Monitoring of uptake		
3	Patients completing the primary care patient experience survey	Provides the ability for practices to understand their customer in order to improve customer experience	• Communication and training plan with general practices, patients and community to encourage completion of survey • Monitor completion rate for surveys	30% Patients completing the primary care patient experience survey	✓
	Medication Safety				
	Contributory measures	**Rationale**	**Activity**	**Target (TBC for local Improvement Plan)**	**PHO Measures**
4	Improving patient experience – medication safety and healthy literacy	A key theme from inpatient survey	The communication and coordination categories has been selected to focus on from the inpatient survey, specifically around reducing harm from medicines. • Develop and implement quality improvement project targeting timely, informed discharge planning' to ensure patients aware of medications on discharge, and who to contact if any problems • Establish a medicines safety programme • Patient safety week (Oct) to support medicines safety • Improve discharge planning to include safe medication transfer Implementation of the Waikato DHB Consumer Council to advise the DHB Board	xx	

System Level Measure 4: Amenable mortality: Reduction in the number of avoidable deaths and reduced variation for population groups.

Milestone improvement:

- Reduce amenable mortality rate by 4% for Maori and Pacific
- Reduce amenable mortality rate by 2.5% for 'other' while reducing the equity gap across the district

Baseline data analysis

- There are significant inequities between Maori and 'other' which is also seen nationally. We have a higher rate of both Maori and other group compared to New Zealand. The area with the most significant equity gap is diabetes.
- The most common causes of premature death are coronary and cerebrovascular disease, COPD, suicide, diabetes and cancers. Injuries (unintentional and self-harm are also important causes
- Overall the highest number of preventable deaths is from Coronary disease

		Coronary/CVD				
		Contributory measures	**Rationale**	**Activity (draft)**	**Target (TBC for local Improvement Plan)**	**Influenced by PHOs**
	1.	PHO eligible population who have had a CVD risk recorded within the last five years	Cardiovascular disease represents a continuing major cause of premature mortality and in order to impact this it is important to modify risk factors early	**Equity data** • Implement and imbed the use of the Maori Health data dashboard by practices. The dashboard has a set of indicators for practices to understand health trends and progress for Maori health outcomes at a practice and network level. (Pinnacle)		✓
	2.	PHO population achieving a 5 year cardiovascular risk of less than		**Implementation of new guidelines** • Identify new CVRA guidelines and implement into practices **Self help services**		

		15%		• Develop and/or promote services to support self-management for people with known risk factors for chronic disease.		
		COPD – Smoking cessation				
		Contributory measures	**Rationale**	**Activity**		
	3. **4.**	PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months Registered smokers who have been referred to a smoking cessation service (hospital)	Smoking remains a significant causal factor for amenable mortality including COPD, cancer and cardiovascular disease Smoking is the most important cause of avoidable death for Maori	• Roll out 'onceandforall" smoking cessation referral program with a specific focus on Maori, Pacific and pregnant women • Implement the 3 year Tobacco Plan • Complete hospital audit on provision of Nicotine Replacement Therapy for inpatients who smoke. • Develop an intervention to improve smoking cessation support on the wards • Continue to support Tupeka Kore Framework targets at Waikato Hospital Maternity Services and Waikato Birthing units. • Review the current DHB smoke free policy with the goal of strengthening and invigorating a supported smokefree DHB. Emphasizing our commitment to the 2025 New Zealand smoke free goal.	TBC	✓
		Suicide				
		Contributory measures	**Rationale**	**Activity**		
	5.	Proportion of patients assessed for risk of deliberate self-harm, in primary care	A leading cause of amenable mortality	**Risk assessments for deliberate self harm in primary care** • Identify data source, track and analyze data	TBC	✓
		Diabetes				
		Contributory	**Rationale**	**Activity**		

	measures				
6. **7.**	PHO population estimated to have diabetes that have been identified and coded PHO eligible population with record of Diabetes Annual Review during the reporting period whose HbA1c test result is 8% or less or 64 mmol/mol or less	Diabetes represents a continuing major cause of premature mortality and in order to impact this it is important to modify risk factors early.	**Workforce education** • Clinical nurse specialist with Wintec to upskill practice nurses in type 2 management in the community • Grow GP's knowledge and confidence around managing diabetes by: - Investigate the use of a forum to review cases with diabetes specialist - Utilising smart health for GP/specialist advice **Equity** • Examine the possibilities of a Kaiwhina role to work with communities to promote healthy eating/exercise and engagement with healthcare to optimally manage diabetes • Investigate how Te Puna Oranga and Population Health may be able to influence healthy lifestyles at a population level within Marae based settings to enable optimal management of diabetes and support prevention of diabetes in the community		
	Cancers				
	Milestones	**Rationale**	**Activity (draft)**		
8 **9**	Target population who have had a mammography within 2 years Patients receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer	Cancers represent a continuing major cause of premature mortality and in order to impact this it is important to identify and treat early	• Roll out Waikato Hospital Inpatient and Outpatient Breast Screen Aoteroa Recruitment Project with a focus on unenrolled, unscreened and overdue screening for Maori women • Clinical Nurse Specialist – Equity and Access for high risk patients with potential of DNAing to follow the patient through the cancer pathway, ensuring they get seen on time. - Priority Maori and Pacific	•	✓

				• PHO's to roll out their support to screening programmes focusing on providing extra support for Maori and Pacific women who experience barriers accessing breast screening, assessment and treatment services		

System Level Measure 5: Proportion of infants who live in a smoke free household at 6 weeks postnatal (This measure is in development for 2017/18)

Improvement Milestone: TBC

Baseline data analysis

- ….

Draft contributory measures have been identified across stakeholder groups influencing smoke free households at six weeks. Prioritization of the measures and finalization of activity and milestones/targets is still to occur.

As these measures are developmental the Ministry has agreed to final contributory measures and activity being agreed by 20 October 2017.

System Level Measure 6: Youth Access to Health: Improved access to and utilization of youth appropriate health services (This measure is in development for 2017/18)

Improvement Milestones: TBC

Baseline data analysis:

- Strong indication show a drive towards Mental health and the ability to access services and remove stigma
- Data is not as robust as desired, but would be easy to collect given the appropriate directive.

		Mental Health and Wellbeing				
		Contributory measures	**Rationale**	**Activity (draft)**	**Target**	**Influenced by PHOs**
	1.	Alcohol-related ED presentations for those aged 10-24 years	Utilizing five prioritization features of burden of disease, impact on equity; feasibility of improvement; data availability; and fit with current work , the highest priority was placed on the two domains	TBC	TBC	TBC
	2.	Self-harm ED				

	presentations for those aged 10-24 years.	focused on Mental Health and ED-related measures			

Performance Monitoring and Reporting

System Level Measure	Data Source	Freq.	Governance Responsibility	Monitoring and Reporting Responsibility
SLM 1: Ambulatory sensitive hospitalisations, 0-4 years				
Milestone improvement 17/18 target: • Reduce ASH admissions for 0-4 year olds by 4% for Maori and Pacific 2% for other • Reduce ASH admissions for 0-4 year olds by 2% for other across the DHB in order to reduce inequity	Ministry of Health	Quarterly	TBC	TBC
SLM 2: Acute bed days				
Milestone improvement 17/18 target: • Reduce acute bed days by 2% and maintain for Maori and Pacific by 30 June 2018 • Reduce acute bed days by 1% and maintain for 'other' by 30 June 2018	Ministry of Health	Quarterly	TBC	TBC
SLM 3: Patient experience of care				
Milestone improvement 17/18 target: • • Achieve 80% of GP Practices using the primary care patient survey • Achieve 30% of patients completing the primary care patient experience	Ministry of Health	Quarterly	TBC	TBC

SLM 4: Amenable mortality				
Milestone improvement 17/18 target: • Reduce total amenable mortality rate by 4% for Maori and Pacific • Reduce total amenable mortality rate by 2.5% for 'other' across the DHB in order to reduce inequity	Ministry of Health	Quarterly	TBC	TBC
SLM 5: Smoke free infant				
Milestone improvement 17/18 target: • TBC	Ministry of Health	Quarterly	TBC	TBC
SLM 6: Youth access				
Milestone improvement 17/18 target: • TBC	Ministry of Health	Quarterly	TBC	TBC

Appendix

2017/18 SYSTEM LEVEL MEASURES (SLM)
WORKING GROUPTERMS OF REFERENCE
AND MEMBERSHIP

Purpose

The purpose of the SLM working group is to bring together local experts across the sector to collaborate and recommend the following for their 2017/18 measure by June 15 2017

- An improvement milestone[1][2];
- contributory measures and milestones;
- quality improvement activities to achieve contributory measures and therefore SLM.

Specific Responsibilities

- Review analysis of local data supplied by the TRG to identify main contributors
  (Where we are now)
- Identifying improvement milestone
  (Where we want to be)
- Selecting the most relevant contributory measures
- Identifying wider supporting measures which assist the delivery of the system level measure but are not the nominated contributory measures
- Identifying activity and provider that will impact the contributory milestones and supporting measures. This could be current, planned i.e. listed in annual plan or new activities ideas
  (How will we get there)
- Oversee activity agreed that will impact the milestones
- Report on activity progress to the identified governance group (this will be alongside the technical reference group who will report on performance)

[1] The youth SLM working group will also be asked to put forward their recommendation for the domain area
[2] To recommend quarterly improvement milestones if data frequency enables

Outside of Scope

- Waikato's System Level Measure Plan sign off
- Funding related decisions

Linkages

The improvement milestones chosen should take into consideration the strategic priorities across the region, particularly reducing inequity and should aim to:

- Align to current strategic priorities
- Align to current alliance work programmes and activities
- Information that is already collected and readily available; and where possible aligned across the region
- Relevant to family and whanau, clinicians and managers
- Relevant to vulnerable population including but not limited to older people and children
- Impacting on a reasonable sized population
- Desirable with regard to a return on input investment

Formation Details

The working group are established in May 2017

Terms of Membership

The length of term for each member (designated role) will be 13 months until end of June 2018. Each PHOs operating in the Waikato District have been asked to provide a representative. DHB representatives and wider providers are included as appropriate. Appendix one has a list of members as of 3 May 2017 for each working group. Membership may change dependent on each organisations desired attendees. A delegate may represent members on the proviso that the delegate has the ability to report to their own services/organisations and can make informed contribution to discussions.

Meetings

Meetings to be held fortnightly until the 17/18 Improvement Plan has been agreed and at a minimum quarterly thereafter. Working groups to report to their governance groups at a minimum quarterly.

Accountability

The working group are an expert advisory group and will make recommendations to either the Waikato Child Health Network, Demand Management Advisory Group or Inter-Alliance as determined below.

Waikato Child Health Network and DMAG make final recommendations to Inter-Alliance

Governance

Waikato DHB's executive leads for SLM are

- Damian Tomic - Clinical Director Primary and Integrated Care and
- Julie Wilson, Executive Director Strategy and Funding.

The Waikato Inter-alliance will have oversight for Waikato system level measures.

The working group will all report to one of the two following groups or straight to Inter-Alliance

1. Waikato Child and Youth Health Network
    - Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds;
    - Proportion of babies who live in a smoke-free household at six weeks post-natal (new 17/18)
    - Youth access to and utilisation of youth-appropriate health services (new 17/18)

2. Demand Management Advisory
    - Acute hospital bed days per capita;

Midlands Regional Linkages will be in the form of information sharing.

There may also be linkage with the Ministry team around data sources and SLM reporting

Decision Making

The working group are chaired by the DHB clinical lead for each SLM (see appendix one). If the Chair resigns from the working group during this period another member of working group will be appointed by the DHB SLM executives.

A quorum for the group will be at least the chair or delegated chair and 50% of permanent members.

Due to tight timeframes, engagement and agreement may be made via email as appropriate

The working group role is to put forward recommendation to the group they report to as above. The working group Chair will strive to seek consensus from the group on recommendations put forward. Final decisions on recommendations put forward to the Waikato Inter Alliance group will be decided by the Waikato Child health Network or DMAG as appropriate. Please note Patient experience of care and amenable mortality report directly to Waikato Inter-Alliance.

Issues with recommendation to be escalated through each organisations management structure

Technical Reference Group
Regan Webb
Katpaham Kasipillai/ Peter Hemming
Michelle Bayley
Jo Scott-Jones
Boudine Bijl
Reuben Kendall
NHC tbc

Acute hospital bed days per capita (ie, using health resources effectively)
Reports to Demand Management Advisory Group
Damian Tomic (Waikato DHB) –lead
Doug Stephenson (Waikato DHB)
Boudine Bijl (Hauraki)
Puamaria Maaka (MHN)
Susan (MHN)
Lorraine Hetaraka-Stevens (NHC)
Marc ter Beek (Waikato DHB)
Alex Gordon (Waikato DHB)
Julie Wilson (Waikato DHB)
Cath Knapton (Midland Pharmacy Group)
Kathryn Hugill (project manager)

Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0–4 year olds (ie, keeping children out of hospital)
Reports to Waikato Child and Youth Health Network
Dave Graham - chair (Waikato DHB)
Boudine Bijl (Hauraki)
Katie Ayers (Oral health, Midlands)
Bronwen Warren (MHN)
Karina Elkington (Waikato DHB)
Regan Webb (TRG Chair Waikato DHB)
Bryan Panopio (Waikato DHB analyst)

Kui White (Raukura – Wellchild provider)
Kath Yuill Proctor (project manager Waikato DHB)
Lorraine Heteraka-Stevens (NHC) teleconference/email feedback

Patient experience of care (ie, person-centred care)
Reports to Inter-Alliance
Mo Neville (Waikato DHB) lead
Trish Anderson (Hauraki)
Michelle Bayley (MHN)
Fiona Murdoch (Waikato DHB)
Lorraine Hetaraka-Stevens (NHC)

Amenable mortality rates (ie, prevention and early detection)
Reports to Inter-Alliance
Doug Stephenson (Waikato DHB) lead
Boudine Bijl (Hauraki)
Hayley Arnett (MHN)
Clare Simcock (Waikato DHB)
Fraser Hamilton (GP/Waikato DHB)
Ross Lawrenson (Waikato DHB)
Nina Scott (Waikato DHB)
Lorraine Hetaraka-Stevens (NHC)
Justina Wu (Waikato DHB)
Shona Haggart (Waikato DHB)
Loraine Elliot (Waikato DHB)
Kathryn Hugill (Fromont) (project manager)

Proportion of babies who live in a smoke-free household at six weeks post natal (ie, healthy start)
Reports to Waikato Child and Youth Health Network
Nina Scott – chair (Waikato DHB)
Michelle Rohleder (Hauraki)
Dallas Honey – Strategy and Funding (Waikato DHB)
Dave Graham (Waikato DHB)
Ruth Galvin – Women's Health (Waikato DHB)
Bronwen Warren (MHN)

Kelly Spriggs – TPO (Waikato DHB)
Karina Elkington – Strategy and Funding (Waikato DHB)
Kym Tipene (Wellchild provider)
Cass Gray (plunket)
Kate Dallas (Waikato DHB)
Cath Knapton (MCPG)
Kath Yuill Proctor (project manager)
Regan Webb (Chair TRG)
Shirley Hopping – Community and Clinical Support (Waikato DHB)
Lorraine Heteraka-Stevens (NHC) teleconference/email feedback
Primary Birthing Unit rep (tbc)

Youth System Level Measure (ie, youth are healthy, safe and supported)
Reports to Waikato Child and Youth Health Network
Polly Atatoa Carr (Waikato DHB) – Lead
Debi Whitham (Hauraki)
Karen McKellar (Hauraki)
Family planning – Karen Bennetar (Waikato DHB)
Rachel Haswell – Youth Intact
Child & Adolescent mental health Jolene Profitt
Katie Ayers (oral health)
Bronwyn Campbell MHN School based health service
Lorraine Heteraka-Stevens (NHC) teleconference/email feedback
Cath Knapton (MCPG)
Clare Simcock – suicide prevention (Waikato DHB)
Jane Morgan – sexual health (Waikato DHB)
Larry Clarke – Strategy and Funding (Waikato DHB)
Kath Yuill Proctor (project manager)

[i] Only those measures significantly influenced by PHOs will be considered in relation to funding on contributory measures
[ii] Only those measures significantly influenced by PHOs will be considered in relation to funding on contributory measures

Waikato District Health Board

Papers for Action

Waikato District Health Board

Papers for Information

Waikato District Health Board

Strategic Programmes Update

Waikato District Health Board

Verbal update

Waikato District Health Board

Next update to be confirmed

Waikato District Health Board

Next update to be confirmed

Waikato District Health Board

Next update to be confirmed

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
14 JUNE 2017

AGENDA ITEM 9.5

WOMEN'S HEALTH TRANSFORMATION PROGRAMME

Purpose	1) For information

OVERVIEW
The most significant highlights of the last two months have been the appointment and commencement of a new Clinical Unit Leader and the commencement of the new Director for Women's and Children's Health. The other key areas of focus over the last two months have been midwifery workforce development and the release of a proposal for change to the management of Women's and Children's Health services.

PROGRESS
Leadership
We were very pleased to make an appointment to the Clinical Unit Leader (CUL) position having received an application from a very strong internal candidate. The appointee commenced on 8 May 2017, and has the support and confidence of the Taskforce and the strong support of the Women's Health SMOs.

The other highlight with respect to leadership has been the commencement of the new Director for Women's and Children's Health in May.

Midwifery workforce development
As reported previously, a midwifery workforce survey was undertaken in February/March in order to ascertain what changes we could make to increase job satisfaction and encourage part time midwives to increase their hours of work. The survey found considerable interest in 12-hour shifts, as opposed to the 8-hour shifts that are currently available.

Following consultation with unions, a plan has been developed to trial the 12-hour shifts for two months commencing mid-June. Twelve midwives have volunteered to be part of the trial. As a result of the change in shifts for the midwives involved in the trial, there has been an increase in staffing by 2.0 FTE. This result was expected, and is very a very positive outcome for the service. There has been considerable interest from casual staff and LMCs in applying for positions in the DHB if the 12-hour shifts were to become available on a permanent basis. An evaluation will be completed at the end of the trial before making a decision about the continuation of this shift pattern.

Recruitment of midwives remains a priority; however the risk has reduced considerably over the last five months. The service has a residual vacancy level of around six FTE, compared to just over 20FTE in December 2016, although this will

reduce to just over two FTE by July (assuming no attrition). From February to May 2017, 12 new midwives have commenced employment, equating to an additional 9.8 FTE.

Medical Workforce
There have been no significant changes to the medical workforce numbers during the last two months. There was a delay in the commencement of a registrar from May to June which leaves the service with one vacancy. The service will have no registrar vacancies by September 2017.

Despite this very positive achievement, due to the limited experience of approximately half of the registrar workforce, SMOs continue to cover many registrar shifts, particularly after hours. The focus over the next few months will be to build the capability of the registrar workforce to allow SMOs to be removed from the registrar roster. This will allow full implementation of the SMO team-based clinical schedules; a requirement by RANZCOG for reaccreditation.

Proposal for change to Women's and Children's Health management structure
A proposal for change to the Women's and Children's Health management structure was released on 30 May 2017. The proposal seeks to strengthen the clinical managerial partnership, and the operational management and service development functions within both services. A consultation period will run for three weeks with a decision document expected on 23 June 2017.

RANZCOG accreditation
The regular six-monthly progress report will be submitted to RANZCOG in June for review at its Australasian Training Committee meeting in late July. Our intention is to request a reaccreditation visit in August or September depending on progress with the rosters and the implementation of any changes to the management structure (as per the proposal for change described above). It is of note that we had two non-trainee registrars accepted into the RANZCOG training programme in 2016, and two trainees accepted into the training programme again this year (announcements were made in May 2017). This is an achievement for the service as well as the individuals, and indicates that registrars are receiving a high standard of experience and training in this department.

PROGRAMME RISKS

Risk	Status	Comment
Inadequate RMO resource to provide services		Significant progress has been made in recruiting registrars, particularly senior registrars. By September 2017 there will be a full complement of registrars. An Advanced Trainee is also to be appointed as an AGES fellow (advanced laparoscopy) which will bring the total number of advanced trainees to three.
Inadequate SMO resource to provide services	 *Improved*	While there is not yet a full contingency of SMOs, recruitment has been positive with a new appointment due to start in July and another later in 2017.
Inadequate Midwifery resource to safely provide services		The rate of recruiting midwives has significantly increased with just under 6.0FTE increase across June and July.
Failure to provide safe and effective *acute* services		As more experienced registrars are employed, there is less need for additional cover from the SMOs. Work is progressing to reduce the need for SMOs to cover registrar shifts after hours.
Failure to provide adequate *elective* services and meet KPIs (incl ESPI targets)		Elective services continue to be outsourced as required and locums are still being used while we transition to the new team structure.
Resistance to change		There is a strong interest in change and improvement, particularly when compared with the resistance early in 2016. A much more positive climate and culture is apparent.
Potential adverse employment relations		While there is no obvious risk at present, there is the possibility of some adverse employment relations given the proposal for change document which if implemented, may cause dissatisfaction from affected staff. This will be well mitigated by ensuring robust HR processes are followed.
RANZCOG accreditation not afforded in time for 2017 core trainees	 *Improved*	The appointment of the Clinical Unit Leader, who is well respected by RANZCOG, is a significant step for the service. Whilst the service is unlikely to be allocated trainees for the December 2017 registrar run, we are confident that we will regain accreditation for training this year.
Status key:		
 **= Urgent attention required**  **= Some concerns exist**  **= Risk is well mitigated**		

NEXT STEPS

The focus for the Commissioner and Transformation change team over the next couple of months is as follows:

1. Preparation for RANZCOG review with all Women's Health informants
2. Full implementation of the team structure and new clinical schedules
3. Completion of a business case for a new Maternity Model of Care (including the separation of the gynaecology and antenatal ward, and improvements of Induction of Labour management
4. Completion of the consultation, decision and implementation of a new management structure.

A report summarising the progress on the full transformation programme will be provided with the next HSC report.

Recommendation

THAT

The Committee notes the content of the report.

TANYA MALONEY
COMMISSIONER, WOMEN'S HEALTH TRANSFORMATION

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
14 JUNE 2017

AGENDA ITEM 9.6

ELECTIVE SERVICES IMPROVEMENT COMMISSIONER PROGRESS REPORT

Purpose	1) For information

Introduction
This report provides an update on the work undertaken in the area of elective services improvement since the last report at the end of March. It is based around the five key areas of work, identified both in the initial report into elective services issues and in the Action Plan agreed for the commissioner role.

Key Focus Areas

Wait list management and ESPI Compliance
The services are still finding it difficult to manage the ebbs and flows in both the wait list numbers and the number of patients treated. April was a particularly low delivery month with public and school holidays impacting on volumes. Acute volumes and bed constraints have led to significant elective cancellations in May, compounding the existing issue of insufficient anaesthetic resource. Outsourcing (both full outsourcing and facility lists) has been used as much as possible to counteract those effects

ESPI results to end March (the most recent available from the Ministry of Health) are at Appendix 1. Final results for April and preliminary internal results for May will be available for the meeting on 14 June.

ESPI 2 (Outpatients waiting more than four months for assessment)
We achieved the required compliance (in line with our dispensation requirements) in March and were fully compliant in April. This means we have avoided any financial penalties at this point in time. At time of writing the result for May is unknown, but it is possible we will be compliant. Again, results will be available for the 14 June meeting.

ESPI 5 (Inpatients waiting more than four months for treatment)
As predicted, we achieved compliance in March, again thereby avoiding financial penalties. Internal reporting suggests this is not the case for April or May. Work is underway to assess June and July – however subspecialty issues remain within orthopaedics.

Delivery of elective volumes
We continue to deliver the Health Target volumes, which include procedures such as skin lesion removal and intra-ocular injections. However, this remains a volume

target only and funding is based on the delivery of elective caseweights through the Electives Initiative. As can be seen in Appendix 2, we are behind on our anticipated year to date caseweights in several specialties. Internal reporting for April (May is not available at time of writing) shows the outsourcing programme (particularly in orthopaedics) has brought our total caseweight delivery to over 95% of the target (a key target for the Ministry in assessing performance). In spite of this extra activity, we will still not deliver our full orthopaedic volumes and as previously noted, a relatively small amount of budgeted revenue will not be earned. This has been reflected in financial forecasts.

Electives funding is able to be spread across the Electives Initiative (as above) and the Ambulatory initiative, which funds additional outpatient assessments and procedures. For 2017/18, it is the DHB's intention to ensure that funding is allocated across all electives components to ensure the risk of under delivery is minimised.

In respect of outsourcing volumes, we have received responses to our Request for Quotes and we are now working towards confirming both outsourced and facility lists for 2017/18. We have agreed a panel of suppliers who we can use over the next three years across a range of specialties.

Systems and Processes
Work has focused on some specific areas recently. These are:

- Transitioning urology wait list data to DHB systems and seeking to ensure the service is ESPI compliant and remains so;
- Input into reporting from the Pre-Hospital Preparedness project, to measure time from assessment to wait list;
- Input into the production planning process and links to funder decisions (reflecting Ministry purchasing intentions);
- Input into the review of surgical services (including theatre) currently underway;
- Reviewing processes for structural heart patients and the relationship between cardiology and cardiac surgery.

Clinical decisions
No specific work has been focused on clinical prioritisation or other clinical decisions, except as incidental to other work.

Project governance and operational oversight
These groups continue to meet on a regular basis.

Recommendation
THAT
The Committee notes the report.

Brenda Wills
Elective Services Improvement Commissioner

Please note that I am on leave during June, so the Executive Director Waikato Hospital will be presenting this report on my behalf. I will attend the next meeting in August.

Appendix 1

MoH Elective Services Online

Summary of Patient Flow Indicator (ESPI) results for each DHB

DHB Name: Waikato

	2016 Apr			2016 May			2016 Jun			2016 Jul			2016 Aug			2016 Sep			2016 Oct			2016 Nov			2016 Dec			2017 Jan			2017 Feb			2017 Mar		
	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.
1. DHB services that appropriately acknowledge and process patient referrals within required timeframe.	20 of 26	76.9%	6	24 of 26	92.3%	2	25 of 26	96.2%	1	22 of 26	84.6%	4	21 of 26	80.8%	5	18 of 26	69.2%	8	18 of 26	69.2%	8	3 of 26	11.5%	23	6 of 26	23.1%	20	20 of 26	76.9%	6	14 of 26	53.8%	12	6 of 26	23.1%	20
2. Patients waiting longer than the required timeframe for their first specialist assessment (FSA).	168	1.8%	-168	24	0.3%	-24	262	2.7%	-262	585	6.4%	-585	464	4.5%	-464	30	0.3%	-30	140	1.4%	-140	393	3.7%	-393	406	4.0%	-406	342	3.4%	-342	189	2.0%	-189	122	1.3%	-122
3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT).	9	0.1%	-9	41	0.3%	-41	93	0.6%	-93	82	0.5%	-82	61	0.4%	-61	44	0.3%	-44	42	0.3%	-42	15	0.1%	-15	10	0.1%	-10	11	0.1%	-11	14	0.1%	-14	14	0.1%	-14
5.Patients given a commitment to treatment but not treated within the required timeframe.	255	5.9%	-255	201	4.8%	-201	38	1.0%	-38	46	1.3%	-46	43	1.2%	-43	45	1.3%	-45	27	0.7%	-27	34	0.8%	-34	63	1.4%	-63	181	3.9%	-181	99	2.2%	-99	42	0.9%	-42
6. Patients in active review who have not received a clinical assessment within the last six months.	2	12.5%	-2	4	8.5%	-4	4	4.0%	-4	4	4.5%	-4	1	1.5%	-1	4	8.5%	-4	20	45.5%	-20	4	25.0%	-4	2	10.5%	-2	2	8.7%	-2	2	11.8%	-2	0	0.0%	0
8. The proportion of patients who were prioritised using approved nationally recognised processes or tools.	1075	100.0%	0	1143	99.7%	3	1118	99.8%	2	916	93.2%	67	1183	93.4%	83	1081	93.8%	72	932	90.0%	103	1363	93.9%	89	916	90.1%	101	921	94.8%	51	1159	94.8%	64	1565	92.7%	123

Data Warehouse Refresh Date: 28/Apr/2017

Report Run Date: 01/May/2017

Appendix 2

Actuals as at : 30/04/2017

Waikato - 2016/17 Electives Initiative
YTD Discharge Summary and Full Year Plan

IDF outflow as at:26/04/2017

Purchase Unit Group	Purchase Unit Code and Name	YTD Base Planned Discharges	YTD Additional Planned Discharges	YTD Total Planned Discharges	Actual Discharge Delivery	Base to Actual Discharge Variance	Total to Actual Discharge Variance	% YTD Discharge Delivery	2016/17 Base Planned Discharges	2016/17 Additional Planned Discharges	2016/17 Total Planned Discharges
Other	D01.01 Inpatient Dental	505	208	713	862	357	149	120.9%	617	252	869
	M10.01 Cardiology	375	156	531	716	341	185	134.8%	457	191	648
Other	**Other PUCs Total:**	**880**	**364**	**1,244**	**1,578**	**698**	**334**	**126.8%**	**1,074**	**443**	**1,517**
Surgical	S00.01 General Surgery	1,325	392	1,717	1,872	547	155	109.0%	1,615	478	2,093
	- Less additional General Surgery				-252						
	S00.01 General Surgery Less additonal volumes recorded against additional below	1,325	392	1,717	1,620	295	(97)	94.4%	1,615	478	2,093
	S05.01 Anaesthesia	68	24	92	126	58	34	137.0%	81	28	109
	S15.01 Cardiothoracic	93	51	144	127	34	(17)	88.2%	114	64	178
	S25.01 ENT	1,407	0	1,407	1,304	-103	(103)	92.7%	1,715	0	1,715
	S30.01 Gynaecology	943	250	1,193	1,019	76	(174)	85.4%	1,148	305	1,453
	S35.01 Neurosurgery	80	54	134	143	63	9	106.7%	98	65	163
	S40.01 Ophthalmology	1,335	130	1,465	1,293	-42	(172)	88.3%	1,627	160	1,787
	S40007 Intraocular injections	0	657	657	2,122	2,122	1,465	323.0%	0	800	800
	S45.01 Orthopaedics	757	748	1,505	1,184	427	(321)	78.7%	924	912	1,836
	S55.01 Paed Surgical	340	164	504	430	90	(74)	85.3%	412	199	611
	S60.01 Plastics	1,048	422	1,470	1,611	563	141	109.6%	1,277	516	1,793
	S70.01 Urology	596	0	596	446	-150	(150)	74.8%	728	0	728
	S75.01 Vascular	299	176	475	536	237	61	112.8%	364	215	579
Surgical	**Surgical PUCs Total:**	**8,291**	**3,068**	**11,359**	**11,961**	**3,670**	**602**	**105.3%**	**10,103**	**3,742**	**13,845**
	MS02016 Skin Lesion Removal	608	373	981	1,624	1,016	643	165.5%	741	453	1,194
	PUCs Total:	**608**	**373**	**981**	**1,624**	**1,016**	**643**		**741**	**453**	**1,194**
	Total Discharges:	**9,779**	**3,805**	**13,584**	**15,163**	**5,384**	**1,579**	**111.6%**	**11,918**	**4,638**	**16,556**

as at 30/04/2017

Waikato - 2016/17 Electives Initiative

Purchase Unit Group	Purchase Unit Code and Name	YTD Base Planned CWD Volume	YTD Additional Planned CWD Volume	YTD Total Planned CWD Volume	Actual CWD Delivery	Base Plan to Actual Variance	Total to Actual CWD Variance	% YTD CWD Volume Delivery	2016/17 Base Planned CWD Volume	2016/17 Additional Planned CWD Volume	2016/17 Total Planned CWD Volume
Other	D01.01 Inpatient Dental	215.7	103.7	319.4	413.2	197.51	93.81	129.4%	262.9	126.4	389
	M10.01 Cardiology	378.1	255.5	633.6	1,088.0	709.91	454.44	171.7%	460.9	311.4	772
Other	**Other PUCs Total:**	**593.8**	**359.2**	**953.0**	**1,501.2**	**907.41**	**548.25**	**157.5%**	**723.8**	**437.8**	**1,162**
Surgical	S00.01 General Surgery	1,918.0	569.9	2,488.0	2,736.0	817.92	248.00	110.0%	2,337.9	694.7	3,033
	S05.01 Anaesthesia	17.1	5.7	22.8	38.2	21.11	15.36	167.3%	20.8	7.0	28
	S15.01 Cardiothoracic	621.2	350.3	971.5	821.0	199.87	(150.46)	84.5%	757.1	427.0	1,184
	S25.01 ENT	1,008.4	0.0	1,008.4	900.2	(108.19)	(108.19)	89.3%	1,229.1	0.0	1,229
	S30.01 Gynaecology	924.6	243.5	1,168.1	1,011.3	86.65	(156.84)	86.6%	1,127.1	296.8	1,424
	S35.01 Neurosurgery	284.0	187.3	471.2	503.5	219.50	32.21	106.8%	346.1	228.3	574
	S40.01 Ophthalmology	806.5	79.2	885.7	757.2	(49.30)	(128.47)	85.5%	983.0	96.5	1,080
	S40007 Intraocular injections	0.0	38.8	38.8	104.0	104.04	65.20	267.9%	0.0	47.3	47
	S45.01 Orthopaedics	2,033.4	1,959.0	3,992.4	3,090.3	1,056.97	(902.07)	77.4%	2,478.5	2,387.9	4,866
	S55.01 Paed Surgical	258.6	123.5	382.1	345.8	87.18	(36.30)	90.5%	315.2	150.5	466
	S60.01 Plastics	813.4	328.5	1,141.9	1,135.0	321.64	(6.86)	99.4%	991.5	400.4	1,392
	S70.01 Urology	800.5	0.0	800.5	575.5	(225.03)	(225.03)	71.9%	975.8	0.0	976
	S75.01 Vascular	508.0	296.7	804.7	800.8	292.80	(3.91)	99.5%	619.2	361.7	981
Surgical	**Surgical PUCs Total:**	**9,993.6**	**4,182.5**	**14,176.2**	**12,818.8**	**2,825.16**	**(1,357.37)**	**90.4%**	**12,181.3**	**5,098.1**	**17,279**
	MS02016 Skin Lesion Removal	145.9	89.6	235.5	393.8	247.92	158.35	167.2%	177.8	109.2	287
	PUCs Total:	**145.9**	**89.6**	**235.5**	**393.8**	**247.92**	**158.35**	**167.2%**	**177.8**	**109.2**	**287**
	Total CWD Volume:	**10,733.3**	**4,631.3**	**15,364.6**	**14,713.8**	**3,980.49**	**(650.77)**	**95.8%**	**13,082.9**	**5,645.1**	**18,728**

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
14 JUNE 2017

AGENDA ITEM 9.7

PATIENT FLOW PROGRAMME

Purpose	1) For information

Background
Waikato DHB, particularly Waikato Hospital, is challenged daily with sub-optimal patient flow. This occurs for a number of reasons and results in bed block, delayed assessment and processing through ED, delayed patient care, delayed treatment and ultimately delayed discharge from hospital.

This often translates into a poor patient experience, increased clinical risk, increased stress and staff frustration and inequitable workload for staff and ultimately in financial pressure on the wider organisation. The latter occurs as a result of unnecessary consumption of bed days and potential penalties associated with an inability to meet Ministry of Health (MoH) targets, namely the Shorter Stays in ED (6hr) target and the Elective Services Performance Indicator (ESPI) targets.

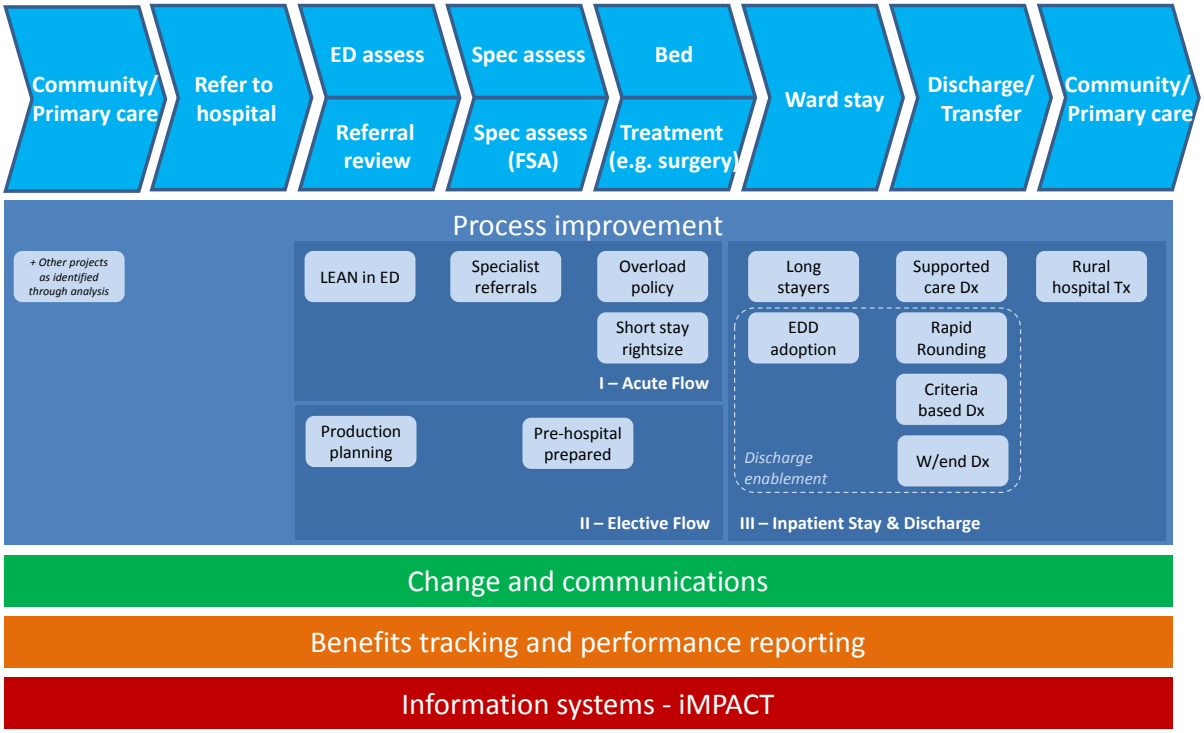
The goal of the Patient Flow Programme of work is to provide timely, efficient patient care to enable better flow through our hospital system, reduce non-value added time in hospital and reduce non-value added staff activity. This will enable the organisation to more effectively meet MoH targets and deliver a reduced average length of stay, which in turn frees up bed capacity.

Programme objectives
The objectives of the Patient Flow Programme are to:

- improve patient flow from presentation at ED through to discharge.
- improve the patient journey by providing the appropriate continuum of care i.e. the right care in the right place at the right time.
- support the organisation to meet patient service timeliness MoH targets.

Programme approach
The approach for the performance improvement programme has seen the establishment of a number of individual projects to address patient flow problems identified. The initial set of projects was formed by pulling together several existing initiatives and localised problems. Project teams were formed for each of these and assistance from the change team was secured in October 2016 and projects were then managed under the Waikato Way programme management methodology. It was however recognized that the level of familiarity of this team with performance improvement methods (LEAN, six sigma, co-design) was limited. Some changes were made to embed key principles from improvement science into the project methodology, such as problem statement, key measure and control measurement.

The diagram below shows the process improvement initiatives, as well as the supporting workstreams of Change and communications, Benefits tracking and performance reporting and Information systems. Further detail and current status for each of these projects is covered in the next two sections.



Achievements and completed initiatives since programme start
Since the inception of the Programme in October 2016, several changes have been implemented:

Initiative	Deliverables	Benefits
Operationalised full capacity procedures *(Overload policy)*	• Bed spaces created • Procedure / process developed • Bed management policy amended • Trigger tool created • Quarterly reporting to BOCG established	FCP triggered 16 times between 1 Feb and 8 May Effective in reducing ED risk Limited effect on acute flow target.
Launched acute flow performance dashboards *(Part of the benefits tracking and performance reporting workstream)*	• Daily / Weekly / Monthly reports created (appendix 1) • Acute flow measured in	Reports used daily in ED, weekly at Demand and Capacity meeting and routinely within specialities to review and

Initiative	Deliverables	Benefits
	3 accountability phases: 3/2/1 • Communication and training of CULs and Directors completed	improve 2 hour speciality assessment performance.
Established weekly DHB wide demand and capacity meeting ***(Part of the benefits tracking and performance reporting workstream)***	• Terms of reference and membership (appendix 2) • Key measures agreed and tracked • Communication processes established	Issues identified and addressed in forum. Improved communication between Waikato Hospital and rurals, community care, radiology.
Implemented speciality referral guidelines and escalation ***(Specialist referrals)***	• Guidelines confirmed and validated. • Escalation processes agreed.	Increased clarity and improved ability to escalate to clinical directors.

Current projects and project status

Key projects that are currently underway in the programme are listed below, with recent progress updates.

Patient Flow – Current Projects	Progress Updates
Acute Flow - Lean in ED **Short stay right size, Waikato Hospital** The aim is to enhance the patient flow through ED by increasing capacity in an SSU observation area. This will ensure that low acuity ambulatory patients are located in seats rather than beds, thus freeing bed space in the main department and also reducing overcrowding and waiting times in the waiting room.	• Business case completed • Building plans drafted • Goal is to complete by July 2017
Acute Flow - Lean in ED **Streaming, Waikato Hospital** The aim is to improve the flow of patients through the ED department, working with staff to identify opportunities for removal of waste in staff time and the patient's	• Initial streaming workshops have now been completed with key ED staff • Work on ideas for areas of focus and priorities (as suggested by staff) is

Patient Flow – Current Projects	Progress Updates
journey.	underway • Standardise patient pathways • Review activities and actions at the start of the patient's visit to ED to look at how to support standardised pathways • Ensure that roles and functions support agreed pathways, reduce waste or duplication • Review current patient redirection approach
Elective Flow – Production Planning Design and establishment phase 1 The project is to address long standing issues associated with the planning and co-ordination of discharges from the Waikato DHB inpatient services. This lack of planning and co-ordination contributes to increased patient wait times for elective treatment, and in unforeseen capacity constraints causing budget deficits or patient flow delays.	• FY18 Delivery planning nearly complete • Bed capacity planning and theatre capacity planning completed • 2017/18 production planning design phase using the learnings to design the future production planning capability (process, team, tools).
Elective Flow – Pre Hospital Preparedness Optimising the elective patient journey by implementing a protocol driven framework that shifts the preparation aspects to the beginning of the patient's journey. By doing so this ensures patients are prepared and ready for their procedure and cancellation is much less likely.	• Implement with Vascular surgery, Obstetrics and Specialist Paediatrics by July 2017 • Project closure due 31st July 2017.
Inpatient Stay and Discharge **Phase 1: Discharge enablement for routine discharges: SAFER policy roll out** SAFER is an evidence based model drawn from the UK that operates as a standardised set of activities/rules applied in the clinical setting to ensure all patients are allocated an estimated date of discharge (EDD) within 24hrs of admission	• Currently planning to implement Phase 1, SAFER framework – discharge enablement, rapid rounding, criteria based discharge, w/end discharges (appendix 5) • Target implementation in July 2017

Patient Flow – Current Projects	Progress Updates
and that patients are reviewed daily in a structured way.	
Inpatient Stay and Discharge **Phase 2: Complex discharges** ***(supported care discharges)***	• Not started, will follow implementation of Phase 1.
Inpatient Stay and Discharge **Rural Transfers** Patients from rural areas are spending longer than they need and/or want in Waikato Hospital, causing unnecessary travel and accommodation costs for relatives, isolation from friends and family. This also results in unnecessary stress on Waikato Hospital and under-utilisation of patient beds in rural hospitals.	• Workshop held with all key stakeholders • Patient stories collected for co-design work • Admission criteria developed for all rural facilities and district nursing (appendix 3) • Reporting developed to aid patient transfers (appendix 4)
Long stayers Patients with a long length of stay are at times in the hospital unnecessarily, and due to services outside the hospital not being in place or other (non-medical) factors. Regular comprehensive review of these patients, their wishes, and their options outside the hospital can identify and address the reason for their extended stay.	• Not a formal project • Weekly reporting improved, changes to reason codes • Weekly review included in SAFER bundle
Information Systems - Patient Flow Tool iMPACT We cannot currently provide staff with real-time visibility of patients' journeys and where the patient is at, resulting in: a) Patients experiencing multiple delays in getting the right treatment in the right place at the right time. b) Delays in the patient journey leading to poor patient experiences and increase in the likelihood of poor patient outcomes. c) Delays in discharge leading to longer stays and sub-optimal use of beds. d) Waikato DHB struggles to consistently meet Ministry of Health mandated targets.	• Organisation-wide tool deployment, all hospitals, Mental Health and community care. • Objective is to provide accurate information to enable timely, efficient patient care (right care, right place, right time) and facilitate better flow of patients through Waikato DHB. • Business case currently awaiting sign off with the Ministry of Health.

Patient Flow – Current Projects	Progress Updates
Benefits tracking and Performance reporting	• Programme benefits dashboard being developed for the Patient Flow Programme • Key measures defined: o Bed days saved and DRG level LOS reporting o Increase in patients meeting 6hr acute flow performance

Assessment and next steps

The programme governance group has recognized that whilst significant work is underway and several changes have been implemented, the impact of these changes has not had the desired effect so far. Limitations to key staff availability and limits to the amount of change the organisation can manage to absorb at any given time, have meant that progress has not been as quickly as anticipated. Going forward, the governance group of the Patient Flow Programme will look to re-focus effort to where it is expected to have the greatest effect.

In addition, the programme will strengthen the alignment and integration with other improvement work that is underway via Acute Patient Governance Group, Demand Management Advisory Group and the new group to make improvements on our System Level Measure "Acute Bed Days". Broader and more transformational solutions to improve patient value will be considered as part of end-to-end system-wide service and patient pathway redesign. This is likely going to be a service by service undertaking and should inform Clinical Service Planning obligations.

Recommendation

THAT:

The Committee receives and notes the progress and next steps for the programme

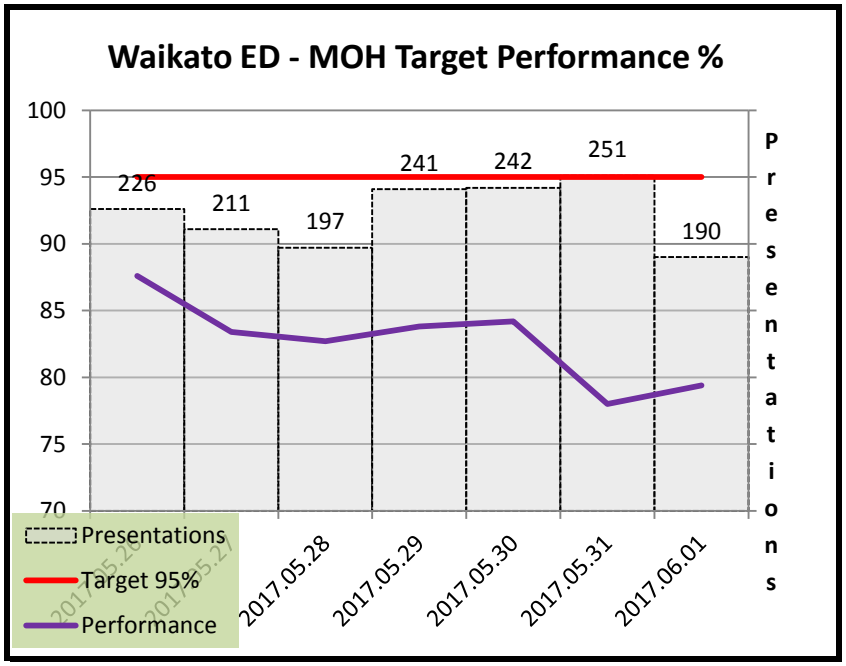
MARC TER BEEK
EXECUTIVE DIRECTOR OPERATIONS & PERFORMANCE

Appendices:

1. **Acute Flow Dashboard (daily, weekly, monthly)**
2. **Weekly meeting Terms of Reference**
3. **Rural Transfers admission criteria**
4. **Rural patients report**
5. **SAFER bundle overview**

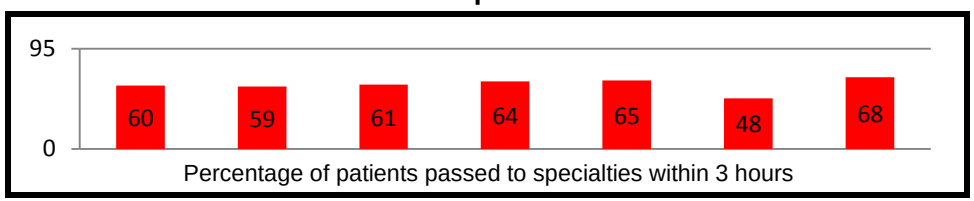
Waikato Acute Flow Dashboard - Last 7 Days

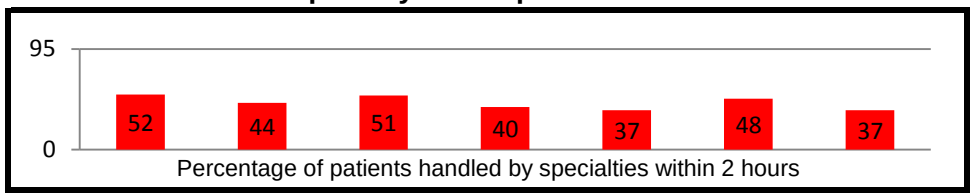
Quarter to Date Performance	83.3%

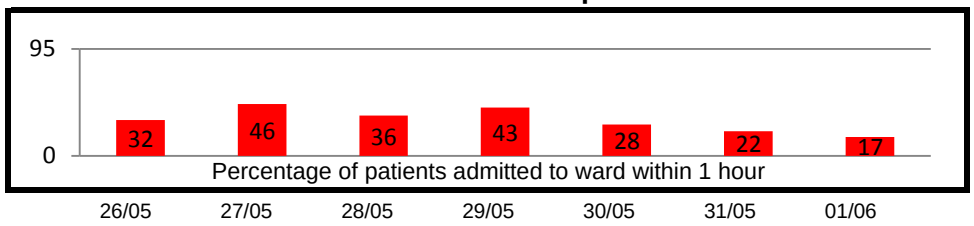


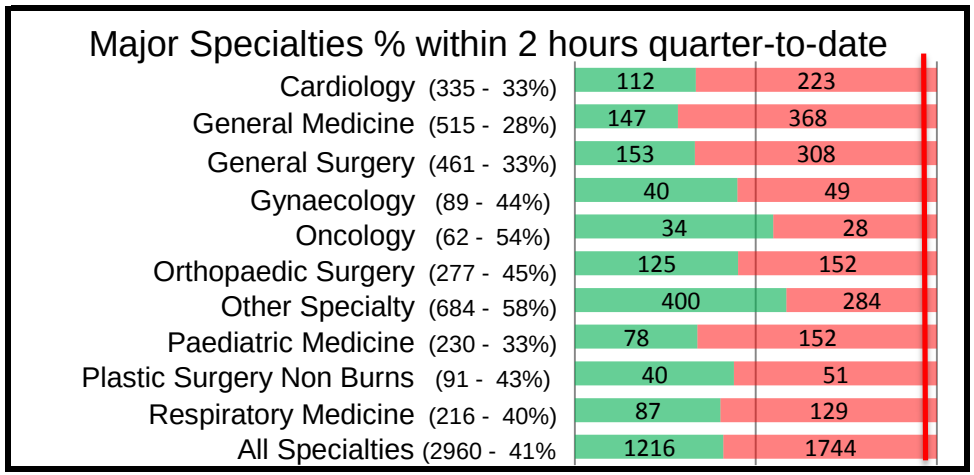
Yesterday: Thursday, Jun 1, 2017

	Admitted	Not Admitted	Total
Totals	**80**	**110**	**190**
Breaches	**29**	**10**	**39**
Met Target	**64%**	**91%**	**79%**





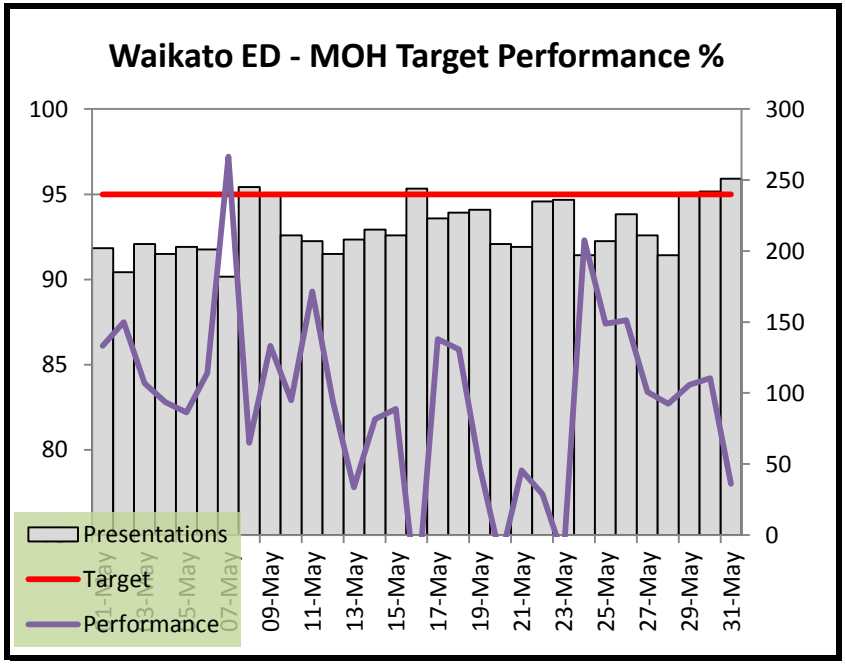




Please note: only MOH target included numbers appear in this data

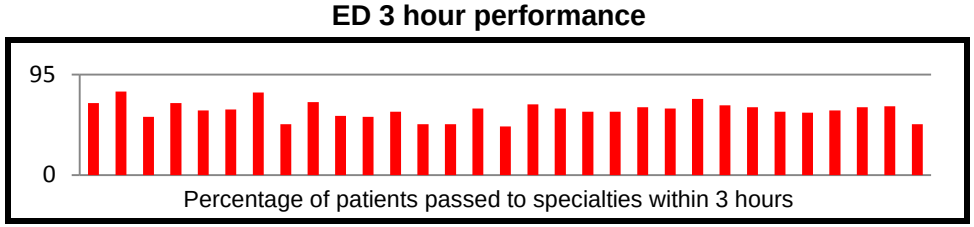
Waikato Acute Flow Dashboard - Monthly

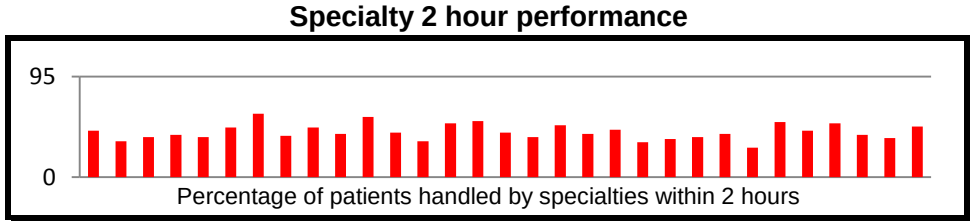
Month Performance	82.84%

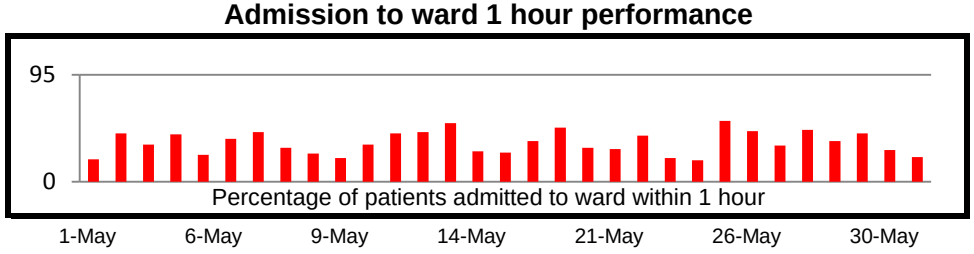


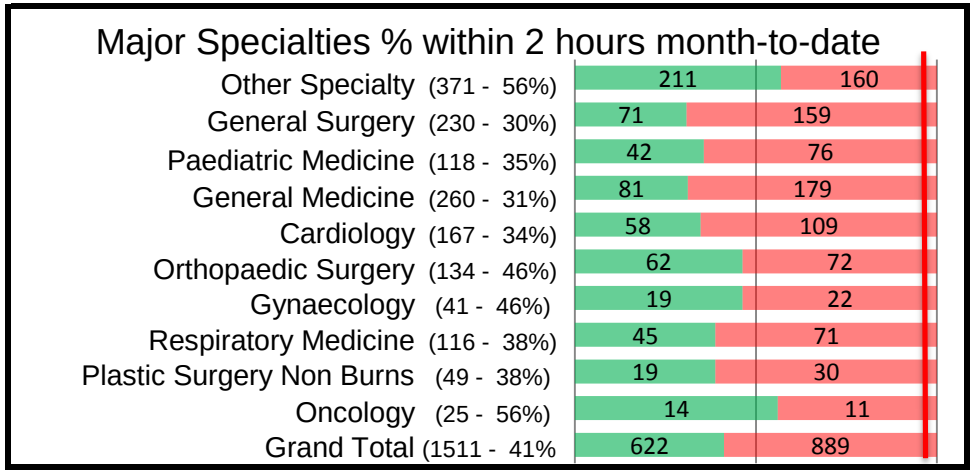
Month: May 2017

	Admitted	Not Admitted	Total
Totals	**2561**	**4123**	**6684**
Breaches	**789**	**358**	**1147**
Met Target	**69%**	**91%**	**82.84%**





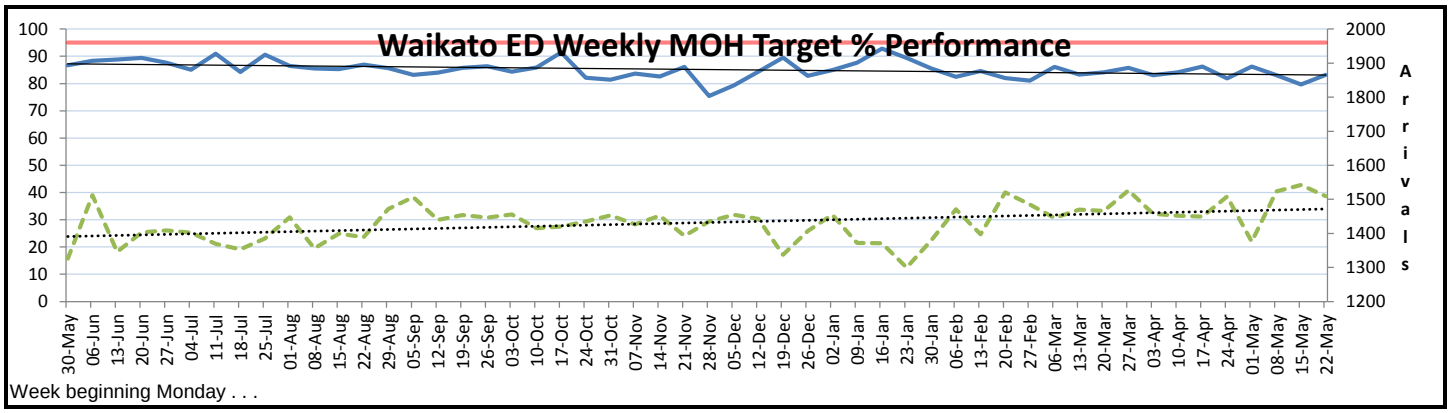


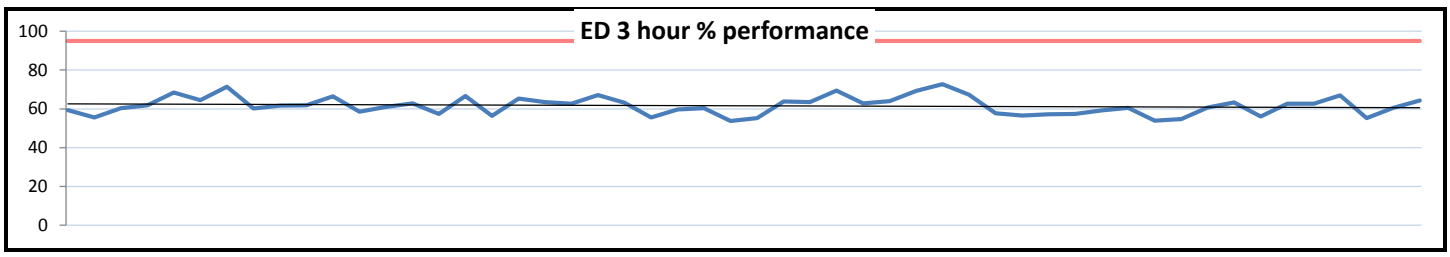


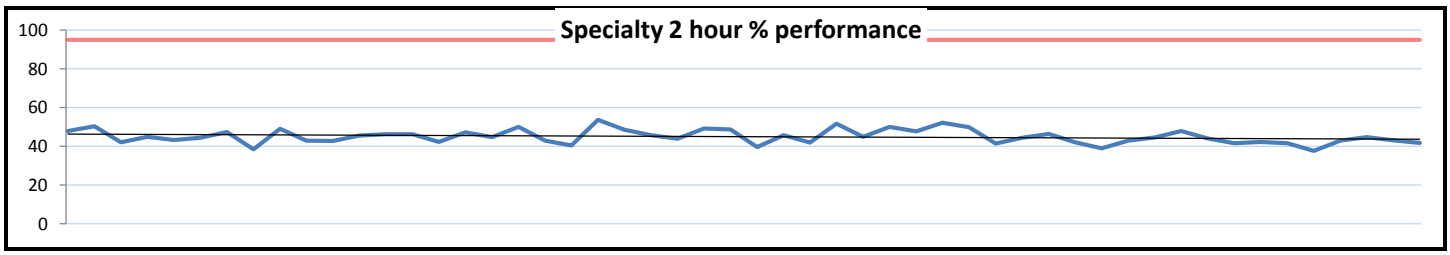
Please note: only MOH target included numbers appear in this data

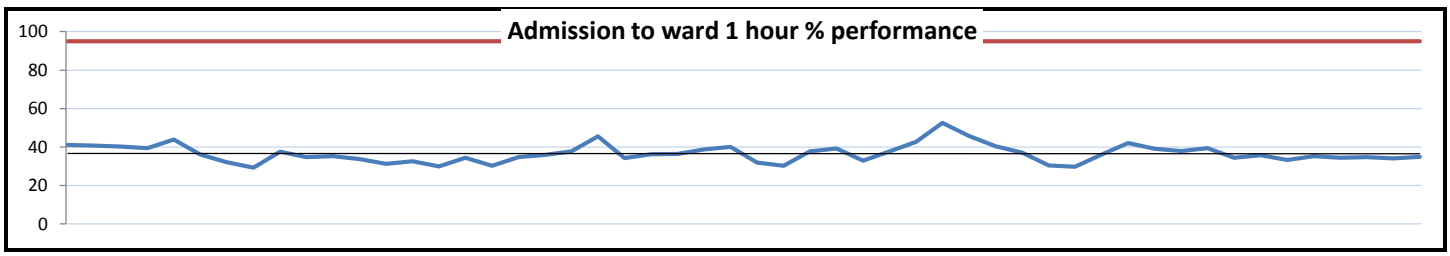
Last 52 Weeks Percentage Achievement of Acute Flow Performance Targets

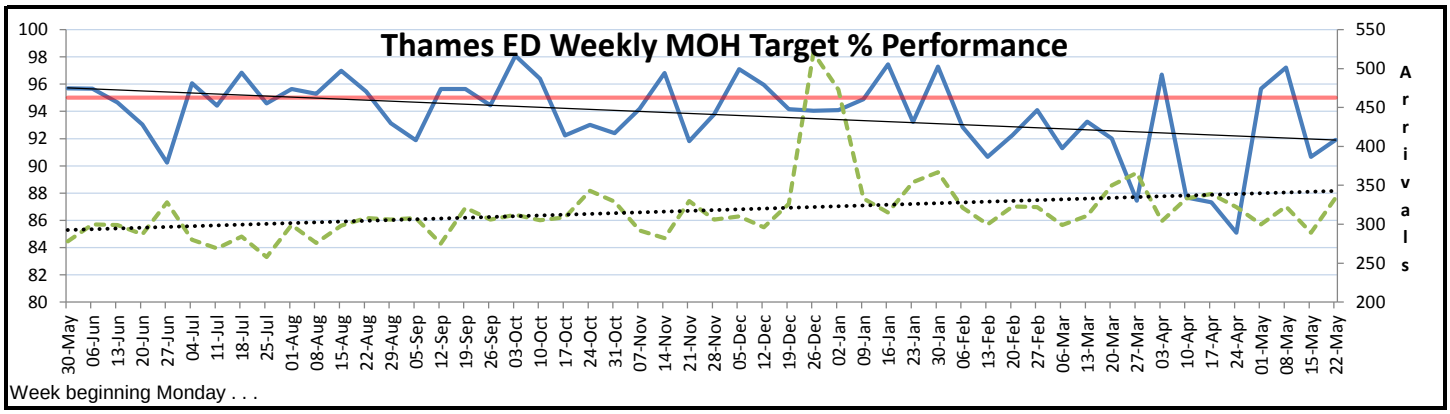
Waikato | Thames











Meeting Name: Demand and Capacity Weekly Forum

<table>
<tr><th colspan="5">Meeting Description</th></tr>
<tr><td>Purpose</td><td colspan="4">To provide whole of DHB view of bed status, occupancy and flow.
To review performance in last week and identify learnings and positives.
To identify key risks and issues that could have an impact on clinical safety and patient flow in the next week.</td></tr>
<tr><td>Attendees</td><td colspan="4">IOC manager, Bed capacity manager, Responsible person for each cluster (Cluster Director, CUL, Nurse manager), CUL Surgery, CD Cardiology, Mental Health rep, Allied Health rep, Facilities rep, DSL rep, Rural hospitals reps, Infection control rep, Community services, Laboratory rep, Radiology rep, Pharmacy rep, RMO coordinator, Comms team rep, ED Operations & Performance</td></tr>
<tr><td>Frequency
Date/Time</td><td colspan="4">Weekly
Tuesday from 12.15 to 12.45 (30 minutes)</td></tr>
<tr><td>Location</td><td colspan="4">#MR Acute Services, L3 – Meeting Room 1 & 2 – standing meeting</td></tr>
<tr><th colspan="5">Meeting Process Definition</th></tr>
<tr><td>Inputs & Suppliers</td><td colspan="4">Key performance targets updated on wall, with trend charts – Target owners or delegate
1. Acute Flow 6 hr and 3-2-1 performance (all hospitals)
2. % discharges by 11 AM
3. Long stayers (# of patients with LOS > 10 days; >20 days)
4. Acute theatre access <48 hours
5. LOS (inc. for top-5 DRG)

Issues impacting on patient safety or flow in next week - Representatives

Weekly performance report - Bed Capacity Manager
• Occupancy (YOY compare and vs projection):
○ Ins vs Outs by day, site
• Demand:
○ ED presentations (daily) and conversion
○ Theatre minutes
○ Watches
○ Acuity level
• Capacity:
○ Sick leave
○ Roster gaps
○ Transit lounge utilization
○ OPR/DSL status</td></tr>
<tr><td>Process (Agenda)</td><td>What</td><td>Lead</td><td>Time</td><td>Expected Outcome(s)</td></tr>
<tr><td></td><td>Week that was
(SAC, exceptions, variances)</td><td>BCM</td><td>10</td><td>• Shared understanding of facts and past performance, learnings, positives</td></tr>
<tr><td></td><td>Targets
(review and actions)</td><td>ED OP</td><td>5</td><td>• Performance against improvement targets understood
• Agreed owners for improvement actions</td></tr>
<tr><td></td><td>Projections
(by facility, cluster, key areas, volumes and staffing)</td><td>IOC</td><td>10</td><td>• Shared understanding of likely pressure points in next week
• Agreed owners for identified concerns and actions</td></tr>
<tr><td></td><td>Other impacts on flow
(attendees report key impacts on operational capacity/ demand)</td><td>All</td><td>5</td><td>• Shared understanding of future impacts on patient flow
• Agreed owners for identified concerns and actions</td></tr>
<tr><td>Outputs & Customers</td><td colspan="4">Performance targets on wall updated and actions logged
Business As Usual risks/issues/positives/events documented
Escalation plans initiated as required
Intranet updated
Representatives communicate outcomes to own unit</td></tr>
</table>

Meeting Scope

Meeting Name: Demand and Capacity Weekly Forum

IS	Information sharing forum Risks/issues identification – including action holders	
IS NOT	Problem solving forum Issue resolution forum	
Meeting Roles		
Chair	IOC Manager	2nd Nurse manager on call
Minutes	Assistant to IOC manager	2nd TL Reception
Time Keeper	Bed Capacity Manager	2nd
Process Champion	ED Operations & Performance	2nd

Southern Rural Hospitals
Taumarunui, Te Kuiti, Tokoroa

PATIENT TRANSFER ADMISSION CRITERIA

Note: All patients transferring from Waikato Hospital to a Southern Rural Hospital, require a doctor to doctor handover, followed by nursing handover and allied health to allied health handover.

Section 1: CRITERIA FOR ACCEPTANCE	
Patients that can be managed locally with virtual support by Waikato consultants	ACCEPTED
Medically stable non complex patients who do not require specialist level input or investigations that are only available at Waikato Hospital	
Patients who need START but are too young (under 65 years)	
Stable elective orthopaedic patients postoperatively	
Patients with non-operative fractures who require a period of rest and recovery before discharge to home	
Patients who require recuperation time and assistance with facilitating transition home (e.g. equipment provision arranged by Waikato, carer/ family training) prior to going home	
Current resthome patients, who require allied health planned care to return to their resthome	
Patients who require further support for non-injury related reasons e.g. pain, medication management	
Stroke patients in their recovery phase, on a stable pathway post their acute Waikato Hospital inpatient stay, who also require allied health input prior to going home	
Locally domiciled palliative patients	
Section 2: NEGOTIATED ACCEPTANCE TO ENSURE REQUIREMENTS ARE IN PLACE	
Paediatric patients 15 years and under.	NEGOTIATED
Patients with complex wounds - e.g. NPWT - CNS involvement	
Patients with drains, e.g. under water seal drains	
Patients who require safety partners or have security issues	
Section 3: EXCLUSIONS	
Acute stroke patients (must be admitted to an acute stroke unit)	EXCLUSIONS
Traumatic brain injury and spinal injury patients, in the acute phase	
Patients requiring ongoing specialised diagnostic investigations/treatments at Waikato, which are not available in the rural hospital	
Patients who will require a journey back to Waikato for further investigations/treatments within the next 48 hours	
Patients who require intensive Speech Language Therapy input	

Thames Hospital
Medical Inpatient Unit

PATIENT TRANSFER ADMISSION CRITERIA

Note[1]: For all Medical patients transferring from Waikato Hospital to Thames Hospital a consultant or registrar (Waikato) must have a discussion with SMO (Thames) regarding the referral

Note[2]: Allied Health to Allied Health handover required

Note[3]: Transfer during business hours (8am-4pm) i.e. reach Thames by 1600 hrs. (outside of these hours are to be negotiated with CNM and/or SMO)

Section 1: CRITERIA FOR ACCEPTANCE	
Patients that can be managed at Thames with virtual support by Waikato consultants	ACCEPTED
Patients requiring complex discharge planning	
Patients in the recovery phase of medical illness, including those who require telemetry monitoring	
Palliative care patients living in the Thames / Coromandel region	
Ongoing medical issues that do not require multiple procedures / investigations or speciality service input	
Section 2: NEGOTIATED ACCEPTANCE TO ENSURE REQUIREMENTS ARE IN PLACE	
Patient requiring cross over services (i.e. surgical patient in Waikato to medical ward Thames)	NEGOTIATED
Patient requiring medical bed when Thames rehabilitation beds at capacity	
Patient needing to stay in hospital until impending investigation or surgery	
Transfer will be after hours (junior doctor cover not available daily)	
Patient awaiting mental health review	
Active delirium	
Patients who have required a safety partner in the past 24hrs	
Section 3: EXCLUSIONS	
Hemodynamically unstable or requiring HDU level care	EXCLUSIONS
Requiring ventilation support	
Patients requiring ongoing procedures or imaging with speciality service input not available at Thames Hospital	
Patients requiring constant 24hr safety partner (no access to agency staff to manage this)	

Thames Hospital
Surgical Inpatient Unit

PATIENT TRANSFER ADMISSION CRITERIA

Note[1]: SMO's at Waikato may outlie surgical patients to Thames with virtual support, while maintaining clinical responsibility.

Note[2]: An SMO (delegable) discusses with RMO or SMO (Thames) regarding transfer. A plan for follow-up should already be made.

Note[3]: Allied Health to Allied Health handover required

Note[4]: Patients for transfer are to be on the 1230 PTS from the Transit Lounge, Waiora campus.

Section 1: CRITERIA FOR ACCEPTANCE	
Patients with vacuum assisted dressings, or other surgical wounds, drains etc. preventing admission to a rehabilitation bed	ACCEPTED
Patients for convalescence before discharge (consider rehabilitation)	
Patients for discharge planning including ostomy patients needing education	
Any patients for primary nursing care or complex discharge planning	
Section 2: NEGOTIATED ACCEPTANCE TO ENSURE REQUIREMENTS ARE IN PLACE	
Patient transfer on Friday	NEGOTIATED
Patients with high stoma output for fluid management	
Section 3: EXCLUSIONS	
Patients at high risk of deteriorating	EXCLUSIONS
Patients requiring registrar or SMO input over a weekend	
Patients with continuing significant complications e.g. ileus, sepsis	

Community and Southern Rural Health Services
District Nursing Service

PATIENT REFERRAL CRITERIA

Referrals must be at Community Referral Centre by *3pm* each day for next day visits. Referrals must have enough detail for continuation of care (see the back of the referral form for more supporting information.)

Section 1: ACCEPTED REFERRALS	
Wound Management, Negative Pressure Wound Therapy discharge date to be negotiated	ACCEPTED
All ACC wound referrals	
IV cellulitis protocol **(excluding where primary options available)**	
IV therapy daily doses	
Advanced IV Access Management (Central Venous Access devices) - PICC / Porta Cath	
Continence assessment / Catheter management	
Support for new ostomy patients	
Palliative/End of Life Care *(Patient's in Hamilton, Cambridge, Ngaruawahia, care provided by Hospice Waikato)*	
Acute Home Support Services	
Differential diagnosis for leg ulceration / Doppler assessments	
Management of long term home oxygen, following respiratory physician referral	
Rheumatic Fever management	
Aged residential facilities - ACC, Central Venous Access Device, IV otherwise negotiate	
Section 2: NEGOTIATED	
IV Therapy, more than once a day doses	NEGOTIATED
Clexane administration (only in exceptional circumstances)	
Short term IM medication	
Residents in aged care facilities / supported living environments that require assistance with treatment planning	
Section 3: EXCLUSIONS	
Venepuncture / re-cannulation	EXCLUSIONS
Simple acute non ACC surgical wound care / routine suture removal	
Long term intramuscular and sub cutaneous medication administration	
Hypertension / blood glucose / weight checks	
Eye drops / applying creams	
Routine staple, Suture removal	
Medication oversight	

Rural domiciled Inpatients at Waikato hosp

Data Qualifications:

Hospital: Waikato

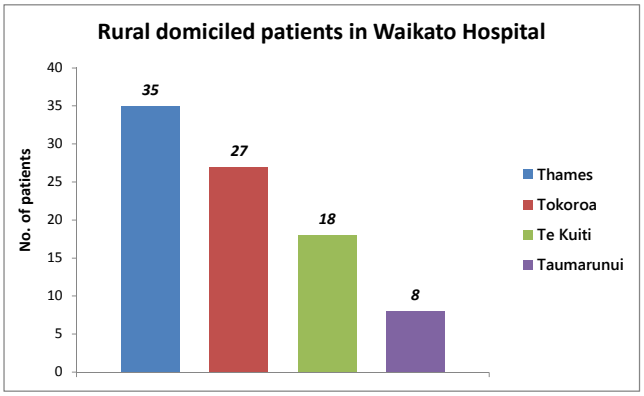
Excludes: ED & Paeds wards

Rural regions: 'Thames-Coromandel', 'Hauraki', 'Waitomo', 'Otorohanga', 'South Waikato', 'Ruapehu'

Report refresh date: 05/05/17

1) CLICK HERE TO UPDATE DATA

2) Refresh the pivot table below



No. of patients Ward name	Domicile area Thames	Tokoroa	Te Kuiti	Taumarunui	Total
WK Day of Surgery Admission	3	3	2	1	9
WK Womens Assessment Unit		2	2	2	6
WK M16 Orthopaedics	3		2	1	6
WK E08 Medihotel	2	4			6
WK M17 Ear, Nose, Throat and Eyes	1	2	2		5
WK M12 General Surgery	2	1	1	1	5
WK M07 Burns, Plastics, Maxillofacial and Urology	2	1	1	1	5
WK Ward A2	1	1	2		4
WK M02 General Surgery	1	2	1		4
WK M14 Cardiac, Thoracic and Vascular Surgery	2	2			4
WK High Dependency Unit Short Stay Unit	2	1	1		4
WK M06 Orthopaedics	4				4
WK Cardiac Care Three	1	1	1		3
WK OPR3 Orthopaedic Rehabilitation	1	1	1		3
WK Ward AMU Short Stay	1	1	1		3
WK Ward A3	1		1		2
WK E01 Womens Health	1	1			2
WK Ward A4	1	1			2
WK OPR2 General Assessment, Treatment and Rehabilitat	1			1	2
WK M05 Haematology and Oncology	2				2
WK (W50) Mothercraft	2				2
WK Intensive Care Unit		1			1
WK Cardiac Care Two		1			1
WK M03 Renal				1	1
WK M08 Neurosurgery		1			1
WK Cardiac Care One	1				1
Total	**35**	**27**	**18**	**8**	**88**

Filter by Health spec

- Cardiology
- Cardiothoracic Surgery
- D01 Geri Active Rehab
- D41 PD Active Rehab
- Dental Surgery
- Emergency Medicine
- Endocrinology
- Gastroenterology

SAFER Actions

Waikato District Health Board

S SENIOR REVIEW

- RMO round, discussion with SMO, and care plan updated daily
- Consultant round at least twice weekly

A ALL PATIENTS HAVE AN EDD

- Recorded on iPM and patient whiteboard within 24 hours of admission (NB: EDD can be amended if patient condition changes)

F FLOW OF PATIENTS

- “Pull” first patient from assessment units and referring wards before 10am

E EARLY DISCHARGE

- All discharge paperwork readied the day before discharge, so patient can be discharged as soon as medically ready
- Criteria-based discharge checklists prepared for nurse-led discharges (if appropriate)

R REVIEW LONG LOS PATIENTS

- Regular MDT review of long length of stay patients

SAFER Actions

Waikato District Health Board

S - Senior review

- **RMO review daily for all patients before midday and Consultant review at least twice weekly**
- RMO to update the plan of care daily
- Patients should be seen in a specific order:
  i. Sick unstable patients
  ii. Potential discharges
  iii. The remaining patients

A - All patients have an Expected Date of Discharge (EDD)

- **EDD recorded in iPM within 24 hours of admission**
- Agreed by MDT
- Recorded on patient whiteboard and updated regularly
- Recorded on handover sheet and clinical whiteboard for 100% of patients

F - Flow of patients

- "Pull" first patient from assessment units and referring wards before 10am

E – Early discharge

- Discharge information given to patient upon admission
- **Focus on discharging patients when they are medically ready, with an even number throughout the day**
- Patients sent to transit lounge if medically ready for discharge but awaiting transport
- Any medication to take home, for planned discharges, should be prescribed and collection should be planned with the patient the day before discharge
- A "Discharge Planning" board, with all patients being discharged in the next 2-5 days and the tasks required for discharge, to be completed by the day before discharge (e.g. transportation arranged, prescriptions arranged, family/facility notified, equipment needed)
- **Criteria-based discharge checklists allow doctors to collaborate with nursing staff, allowing patients to be discharged once certain criteria are met, rather than waiting for an available doctor to complete the paperwork**

R – Review long LOS patients (>10 days for acute and >20 days for OPR)

- Senior medical clinician led, MDT review to identify the issues and ensure actions required to facilitate discharge will be completed
- Clear management plan written in medical record
- Follow up any procedures or tests for which the patient is waiting

** The SAFER bundle is a set of simple rules. There may be a need for local teams to adapt it slightly. This is ok as long as the rules are broadly followed each day every day.*

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
14 JUNE 2017

AGENDA ITEM 9.8

QUALITY ACCOUNT

Purpose	For discussion and feedback.

Quality accounts are designed to give prominence to the reporting of quality of care, alongside the traditional reporting of financial performance. The Health Quality and Safety Commission (HQSC) recommend the structure and content of the account.

The 2016/17 priority areas are aligned with the strategic imperatives. Progress is slower than expected but there is good engagement by the clinical teams particularly with the advance care planning and sepsis management work streams.

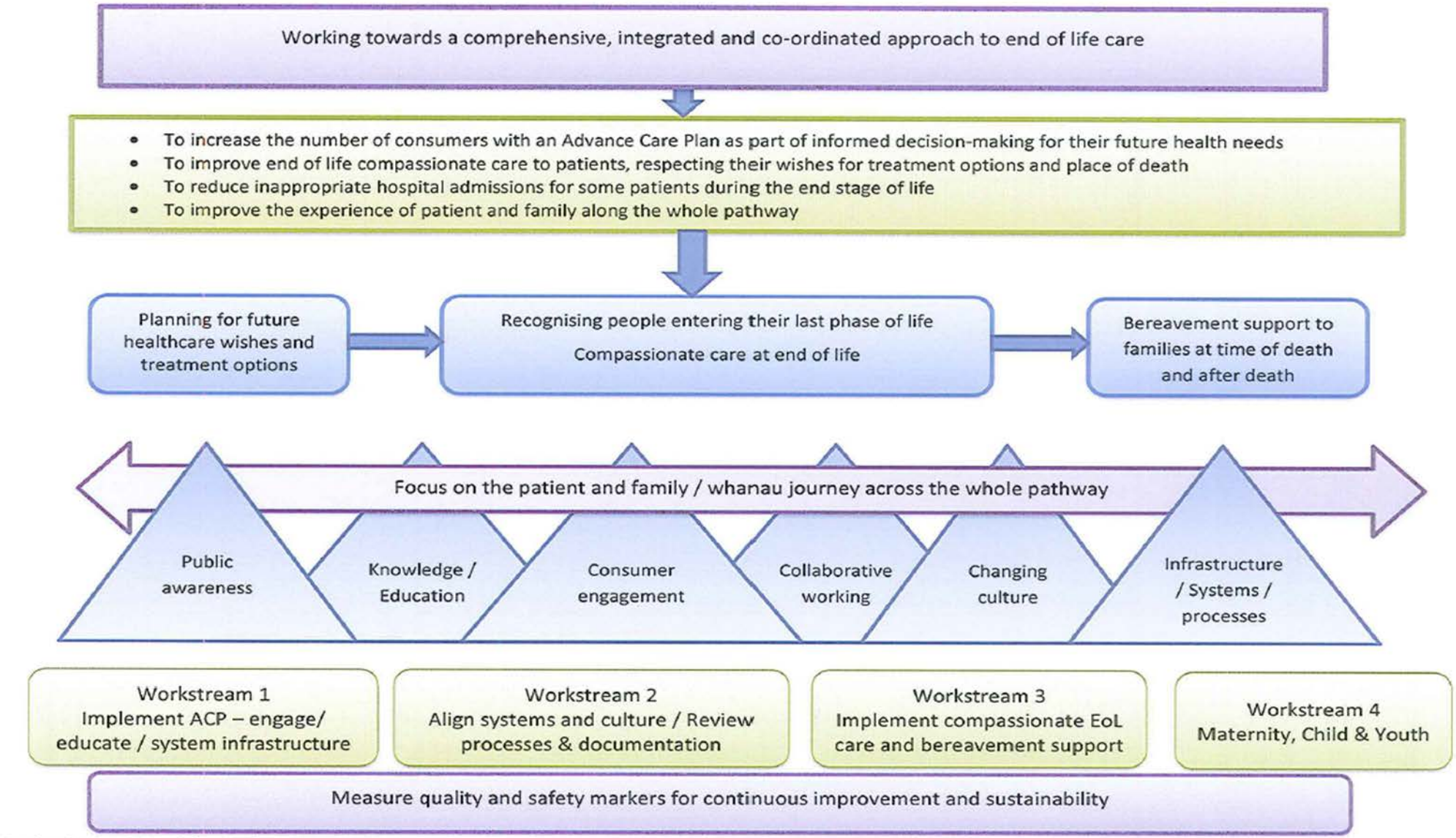
The next quality account is due with the Ministry of Health in November 2017, but the plan internally is to align it with the annual report and so development will begin shortly. Proposed priority areas will be discussed with the executive group and Board

Recommendation
THAT
The report be received.

Mo Neville
DIRECTOR QUALITY AND PATIENT SAFETY

Quality Accounts Summary

Patient Safety Priority areas 16/17	Q1	Q2	Q3	Commentary
Reduce severe harm events – falls	Green	Amber	Green	Reduction in harm in last quarter
Reduce severe harm events – medication safety programme	Red	Amber	Amber	Funding and programme approved
Improve hand hygiene	Green	Green	Green	But note number of areas not achieving 85% compliance has increased over last quarter.
Improve care around deteriorating patients – sepsis and family escalation	Amber	Amber	Amber	Baseline measures completed. Plan is to adopt the Australian program for sepsis reduction. Links being made with region and HQSC
Patient Outcome Priority areas 16/17				
Advise and support patients, pregnant woman and general population to quit smoking	Green	Green	Green	Co-design project in place
Continue to increase the uptake of immunisation especially for infants up to 8 months of age	Amber	Amber	Amber	
Continue heart and diabetes checks in community	Green	Green	Green	
Patient Experience Priority areas 16/17				
Develop an end of life care framework to be used across the organisation and in ongoing care facilities	Amber	Amber	Amber	Proposed work streams and governance structure identified.
Roll out the Advance Care Planning (ACP) process	Red	Amber	Green	National approach to training is expensive and not flexible to our needs
Establish the Consumer Council	Amber	Amber	Green	Proposed membership and process presented to Board in May – on target for year end



Heather Burden, Patient Safety Facilitator
October 2016

Priority two – Improve end of life care for patients and their family / whanau

The End of Life Programme has executive support with an oversight programme board is proposed to ensure whole of system membership and engagement. There are 4 underpinning work streams:

- Planning for future care: Advance Care Planning (ACP)
- Identifying people in the last phase of life
- Bereavement care and support
- End of Life care – Child & Youth and Maternity services

Progress to date

1) Planning for future care: Advance Care Planning (ACP)

- Advance Care Planning is progressing to the work plan.
- Engagement: Primary care, community groups, ARCs and secondary care engagement in progress.
- Education: 90% of allocated training places have been filled for L1a and L2 courses and 200 staff have undertaken the e-learning modules at L1. Post training support in place.
- IT system: Gaps in IT Systems between primary and secondary care exist but work is progressing to resolve these.

2) Identifying people at risk in the last phase of life

- Working Group identified but have not yet met
- Te Ara Whakapiri document (Ministry of Health publication) and AMBER care tools (a tool developed in the NHS and adopted in Australia and NZ) identified for potential use. The recent end of life health round table (HRT) workshop has identified a number of areas that could be adopted here. Both HRT end of life reports and emergency department reports will be used for baseline measures
- There is a co-design project for urgent transfer to home as preferred place of death progressing

3) Bereavement care and support

- Other DHBs being contacted to benchmark bereavement care services.
- Work is underway within suicide prevention around bereavement support including counselling for bereaved families and self-help groups such as WAVES

Challenges:

- Funding for the ACP Co-operative ends June 2017 although there is support from this DHB to extend the national contract by six months, pending the development of a local sustainable work and education program that would support a wider 'difficult communication' skills approach

- PHO approaches for rollout of ACP ranges from high priority (Hauraki PHO) to low priority (Midland Health Network PHO). One small PHO (National Hauora Coalition PHO) is still to be engaged.

Priority five – Improving care around deteriorating patients

1) Sepsis management

Sepsis is a medical emergency where early recognition and prompt treatment is essential to improve survival. The aim of the sepsis management working group is to implement a programme of work across the organisation to improve early recognition and management of sepsis. The majority of patients with sepsis present via emergency departments, though sepsis can occur at any time during the patient's hospital journey. Common infections can lead to sepsis and in adults this includes amongst others, lung infections, urinary tract infections, gut and skin infections.

Sepsis disproportionately affects Maori and Pacific Island populations in the Waikato District Health Board catchment. 63% of patients are over 65, 17% are admitted to ICU, 20% have multi-organ failure and mortality at one year is approximately twice that at hospital discharge.

The Clinical Excellence Commission in Australia has developed the Sepsis Kills programme which has been successfully implemented in a number of hospitals. We have permission to use this programme which includes an implementation plan, treatment pathways, education requirements and data collection tools. These would need to be adapted to be appropriate to our environment and local requirements. A proposal is underway to send a group to one of the Sydney hospitals to better understand the challenges, pitfalls, reality and resources involved in implementation.

Challenges:

- Engaging lead consultants / clinicians in every service to promote and support the programme
- Having sufficient resource to implement and monitor the programme
- Having an agreed pathway across the organisation that is responded to appropriately where ever the patient is and what ever time of day rather than multiple different approaches according to clinician preference.
- Recognition of deterioration and sepsis will often involve the bedside nurses and junior clinicians. Recognition must be followed up by appropriate response which, as above, must be agreed and adhered to.

2) Patient and Family Activated Escalation

This process enables the patient, family or care givers to trigger an escalation of care when they have concerns that the patient is deteriorating and need a response to their concerns. Many of our complaints or adverse events contain an element of family recognising patient deterioration but not being listened to by clinical staff. This process is increasingly being implemented in other organisations and known by such names as Ryan's Rule, REACH (recognise, engage, act, call, help) of CARE (call and respond early).

The process starts by encouraging the concerned relative to speak to the patient's nurse, if not satisfied, then the nurse in charge or doctor, if still not satisfied, to call a phone number which will trigger a response and a clinical review.

Two meetings have been held with clinicians to discuss the process and feasibility of implementation. The idea is wholly endorsed and supported though there is strong resistance to implementing the process until the appropriate infrastructure is in place. The PAR team are currently most suited as responders but the service is not a 24 hour a day service. We do not have a Medical Emergency Team (MET), and hospitals where this has been successfully implemented have a MET team in place. The responder needs to be independent of the patient clinical team at the point of the phone call escalation.

As this process would be widely publicised to the patient, family and carers, it is vital that we are able to respond accordingly and meet expectations of time frames and clinical review. To implement this without the appropriate team in place risks adverse publicity and lack of trust in the process.

Challenges:

- To ensure availability of suitable personnel to process and respond to escalation calls such as an extended MET team which includes PAR team members who would most often be first responders to calls for concern.
- Up to date and reliable vital sign recording is also seen as key. A number of DHB's have introduced or a planning to introduce an e-vital signs system. The steering group are currently reviewing the available systems.

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE

14 JUNE 2017

AGENDA ITEM 9.9

UPDATE ON WAIKATO MEDICAL SCHOOL

Purpose	For information and noting.

In October 2016 the University of Waikato and Waikato DHB put in a proposal to the Tertiary Education Commission (TEC) for the development of a community engaged graduate entry medical programme to be based at Waikato Hospital. The outline of this proposal has previously been presented to the Waikato DHB board.

In April 2017, we received a letter from the Minister of Tertiary Education and the Minister of Health in response to the proposal asking for clarification on a number of key points including:

1) Greater detail on the question of the level of funding sought and the sources of the funds.
2) The long-term affordability for both the University and the DHB of the proposal including the current financial performance and assets of each institution.
3) A stronger management plan with the critical pathway from conception to implementation clearly presented.
4) An understanding of the engagement that has occurred with relevant stakeholders.
5) Information on the specific strategies to be employed with regards the management of the increased numbers of medical placements envisaged including the impact on the existing medical schools. This information to also include rural and community based learning centres and opportunities for interprofessional learning.
6) Further detail on the evidence that the proposed medical school will produce graduates who are willing to serve communities outside the main centres.

Following receipt of this letter from the Ministers, a meeting was arranged on 8 May 2017 with TEC, Treasury and staff from the Ministry of Health to further clarify the points raised and the expected response. Additional meetings with key stakeholders have also been held including with the Ministry of Health, Health Workforce New Zealand, the NZ Nurses Organisation, the Medical Council of New Zealand, local and regional government, PHOs, Royal NZ College of GPs, and with executives and clinical teaching staff from the Bay of Plenty, Lakes, Tairawhiti and Taranaki DHBs. We have also been approached by Wairoa District Council from Hawkes Bay who are very interested in partnering with the Medical School.

The original business case has been updated and was re-submitted to the Tertiary Education Commission on 31 May 2017 for further consideration.

The updated business case included:

- Explicit detail on the question of the amount of funding being sought including the capital funding. This includes requests for funding for additional laboratory facilities at the University of Waikato, funding to support the development of a multi-purpose education building on the Waikato Hospital Campus and funding for the 15 community learning centres which now include plans to accommodate not only medical students but also nursing and allied health students and junior doctors such as PGY 1 and 2 doctors and GP registrars. The funding request noted the already achieved and planned philanthropic support from the community. The request for funding was supported by evidence of the expected regional economic benefit of the government investment.
- The management case has been updated including an updated critical pathway from conception through to the production of graduate doctors. This included an updated request for funding for the set up for the programme including the hiring of key leadership staff, the purchase of a curriculum, the costs of the MCNZ/Australian Medical Council accreditation requirements and the planning costs for new buildings.
- An outline of the key meetings that have occurred with key stakeholders
- An update on the impact on the medical workforce and our strategy for increasing the number of PGY1 and 2 places and our reduction in the requirement to import so many junior doctors each year from overseas to fill shortages.
- A literature review of the evidence that a community engaged programme can influence the career choices of graduates from the programme. The review highlights the importance of the selection process, the need for development of an appropriate curriculum, the benefit of community based longitudinal placements and relevant postgraduate training opportunities in helping to produce a more diverse and appropriate medical workforce for the future

The updated business case is being considered by the Tertiary Education Commission and a response is expected shortly.

A formal presentation will be given at the next Health Strategy Committee meeting.

Recommendation
THAT
The Committee receives the report.

DR NIGEL MURRAY
CHIEF EXECUTIVE

PROF ROSS LAWRENSON
CLINICAL DIRECTOR, STRATEGY & FUNDING

Waikato District Health Board

Item within
Public Excluded

Primary and Integrated Care

Damian Tomic
Clinical Director
Primary and Integrated Care

Why we need integration

Better, Sooner, More Convenient – 2009 health policy implementation

There have been a number of changes over the last few decades in relation to the development of primary health organisations and Health alliances which have in the main been intended to:

- Enhance integration of services
- Improve access to services and reduce health inequities
- Explore new ways of service delivery
- Maori have a 22% higher crude ASH rate for 00-04yr olds than Other Ethnicities and for 45-64s it is 240% higher!
- Emergency Department presentations and acute hospital bed days are growing faster than the population

The Primary and Integrated Care team

- Clinical Director Primary and Integrated Care.
- 5 GP Liaisons who work across the health sector to agree clinical pathways to support timely and appropriate access to care for our population.
- Director, Integrated Care – new position. Commenced May 2017

Our PHOs- who are they

PHO	Enrolments	% of DHB Population
Midlands Health Network - Waikato	243,661	59.7%
National Hauora Coalition	5,852	1.4%
Hauraki PHO	134,803	33.1%
Not Enrolled (or enrolled in other DHB)	23,544	5.8%
Total	407,860	100.0%

Primary care plan/strategy

- We have an agreed process in place to develop a Primary care plan with our community NGOs.
- Workshop with DHB Board in place June 2017
- Workshop July 7 with our community partners.
- Linked to Waikato DHB Strategy 2016, PPPs and strategic service plans.
- This is a work in process. Initial conversations and formal workshops are required to move this forward

Integration enabling tools: Map of Medicine /ereferral

- To lead regional implementation of standardised evidence-based clinical pathways of care using Map of Medicine as the tool across primary and secondary care. Improves quality and reduces variation.
- Revising the ereferral content to reflect the updated clinical pathway including agreed referral criteria is a critical component to the implementation of standardised care

MURIAL

Midland United Regional Integration Alliance Leadership (MURIAL) Team

- The MURIAL Team was established by the Partners. The MURIAL Team's primary objective is to develop and lead a regional strategic "whole of system" approach that will contribute to the delivery of better health outcomes through more integrated health and social services. Specific work streams will be defined through an agreed annual work programme.

MoM supports the creation of new integrated services

- Suspected Bowel cancer pathway and ereferral direct to colonoscopy avoiding FSA
- Teledermatology pilot for suspected melanoma
- Heart failure management including direct access to echocardiography for GPs.
- Community post menopausal bleeding clinic
- Raising health kids pathway tools and reources for GPs

Primary Secondary Expert Advisory Groups

- Mental Health Integration
- Demand Management Advisory Group
- Waikato Child and Youth Health Network
- Diabetes collaborative
- Community Falls and Fracture prevention

Mental health

- Transitioning patients with severe and enduring mental health (but stable) issues back to primary care (supported packages of care)
- Physical needs of some secondary mental health patients being addressed by primary care.
- Education/Support – self-harm/suicide
- New psychiatry liaison position

Demand Management Advisory Group

- COPD
- IV adenosine
- Primary Options
- Unenrolled population

Waikato child and Youth Health Network

- Work around meeting the raising healthy kids national health target (going well)
- The development of a “clinical pathway” around weight management in children. Includes tools and resources for primary care to manage the majority and defines who to refer to secondary/allied services

Highlights - Diabetes collaborative

- Implemented T2D management back to Primary Care 2016 with support from specialist services as necessary

Community Falls and Fracture Prevention

A plan is in development to ensure we have a robust integrated Waikato plan in place to reduce falls and fragility fractures;

- Primary care
- Community Strength and balance services
- Secondary and allied (in home strength and balance)
- Fracture liaison service

Emergency Department

- Reviewing the changes in GP acute referrals to ED.
  - Establishing an audit procedure, contacting GPs where ED feels the referral is inadequate.
- Overall the new process is working well with very few complaints.
- Clinical pathways from GP to ED to Services in development

System level measures Framework

- SLM framework drives integration
- 6 System Level Measures reported nationally and agreed local contributory measures and activities across primary and secondary care
- We submit a Waikato DHB improvement plan (six primary secondary working groups submitting recommendations)
- Six system level measures are:
  - ASH 0-4
  - Youth access
  - Smoke free infants
  - Amenable mortality
  - Acute bed days
  - Patient experience of care

Why SmartHealth?

Patient benefits

- Access to health information
- Ask questions
- Virtual consults
- Free online doctor evenings and weekends

Clinician Benefits

- Offer virtual consults
- Less travel
- Peer review
- CME
- Clinical networks

Highlights - SmartHealth

- Hauraki PHO contract
- National Hauora Coalition
- ARRC/BUPA
- Waikato Hospice
- Out of hours
- Healthline
- Outpatients

Challenges

- Our pace of change/integration is too slow.
- Resistance to change is vibrant and difficult to overcome with no clear mandate

Waikato District Health Board

Priority Programme Plans

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE

14 JUNE 2017

AGENDA ITEM XXX

PRIORITY PROGRAMME PLAN 1.4: ENABLE A WORKFORCE TO DELIVER CULTURALLY APPROPRIATE SERVICES

Purpose	1) For approval

Introduction

Attached is the second priority programme plan prepared to operationalise the Waikato DHB's Strategy. This plan was developed using the PPP templated approach (see HSC meeting minutes April 2017) and the committee is asked to provide comment and approval for the Plan to progress to the implementation phase.

One of the difficulties this process presents is that on the one hand we do not wish to cramp original thinking by prosaic concerns around funding and capacity to deliver, while on the other we do not want to generate a whole host of ideas that have no hope of being delivered.

The approach that has been adopted is to allow the process to generate original ideas while at the same time recognising that the ability to launch them needs to take account of:

1) Funding
2) What other work emerges from the strategy and from other sources
3) A realistic assessment of organisational capacity to deliver
4) Organisational culture, discipline culture, and team culture within the Waikato DHB's workforce

The recommendations that follow recognise this tension.

At this stage, the following priority programme plan is concerned with enabling a workforce to deliver culturally appropriate services within the Waikato DHB. It is arguable that we should be doing the same within the agencies we fund. However, it is our present view that enabling a workforce to deliver culturally appropriate services within the Waikato DHB will flow into the way we deal with other providers while trying to make others culturally appropriate when we still have areas to improve upon, has little chance of success.

Recommendation
THAT

1) The Committee approves the PPP to “enable a workforce to deliver culturally appropriate services”.
2) The Committee notes that because PPPs are being developed progressively there will be ongoing reviews as implementation happens to manage overlaps and effects on/from other PPPs as they are identified.
3) The Committee notes further that because implementation of PPPs is subject to budget it will be necessary to stagger implementation to align with the funding available.
4) At the conclusion of the work to develop PPPs and on an annual basis thereafter the Committee is presented with a consolidated view of the recommended timing for all projects and progress on them.
5) Projects arising from the PPPs are approved for commencement under the general delegation framework of the Waikato DHB.

Presenting on behalf of Sue Hayward (Chief Nursing & Midwifery Officer Waikato DHB)

DARRIN HACKETT
EXECUTIVE DIRECTOR, VIRTUAL CARE AND INNOVATION

Supported by
Millie Berryman and the PPP Project team

14 June 2017

2017

Priority Programme Plan - 1.4: Enable a workforce to deliver culturally appropriate services

Strategic Imperative:
Health equity for high need populations
Oranga

Sue Hayward and team
Waikato DHB

The information in this document was compiled to plan for the delivery of the Waikato DHB's priority 1.4: Enable a workforce to deliver culturally appropriate services, one of four priorities to be delivered in order to meet the strategic imperative "Health equity for high need populations". For more information on this priority or the Waikato DHBs Strategy please go to:
http://www.waikatodhb.health.nz/about-us/our-vision-and-strategy/

The information in this document has been summarised through a template designed to capture key information to inform this plan. For detail on this priority, use the following paths:
Executive Director for the priority: Sue Hayward
Website location: xxx
Intranet location: xxx

Table of Contents

Introduction

The Waikato DHB employs around 6,000 staff across the district, from diverse backgrounds and across a wide range of disciplines. All these people are working toward better health for the people of Waikato and beyond and their efforts need to be culturally appropriate. This means doing things in a different way for different people.

The majority of Waikato DHB staff interact with patients, their family/whanau, other health providers, social and health agencies, or Waikato communities. We need to ensure that as a workforce, we are providing services in a way that meets the needs of those we interact with. By this means we will improve access and satisfaction.

The Waikato DHB staff/workforce will reflect the population it serves. A one-size fits all approach will not work. The Waikato DHB is a large complex organisation with a wide variety of activities and areas of work an each area will need to ensure that their service delivery caters to the particular community being served.

Enabling a workforce to deliver culturally appropriate services is about equiping those who partner in health care now and in the future with skills and knowledge to provide care and services that meet the diverse values, beliefs, and cultural needs of our people.

In order for Waikato DHB to achieve its vision of healthy people, excellent care, the population requires wellness to be at the forefront of staff activity. Compassion and kindness are key requirements to create a culture where staff are enabled to be the workforce that will deliver culturally appropriate services.

Why we need to enable a workforce to deliver culturally appropriate services:

- Our population is diverse yet our workforce does not culturally represent our population
- Our population is aging faster than we can provide funding or clinical staff to care for them
- Our population health needs are becoming more complex with many lifelong chronic expensive illnesses
- Our patients are customers with greater information, equal say and accountability for their care
- Our current health care model is no longer sustainable and the New Zealand health service will fail if we continue delivering health care in 2020 as we do today
- Our current environment does not take full advantage of our patients and communities, our people and partners, and the technology and opportunities available to push our healthcare further

What we need to do to enable a workforce to deliver culturally appropriate services:

- We need to have a holistic view of the diverse needs of our population
- We must understand our accountabilities, power position, responsibility and authority so we can ensure culturally appropriate interactions, services, and care
- We must have a healthy relationship with diversity

- To get an empowered population we need to change: including attitudes; behaviours and approach
- We need our organisational culture to move from outputs to outcomes
- We must support each other to ensure cultural safety
- Focusing on relationships we must adhere to the 3 Principles of Te Tiriti o Waitangi (Partnership, Participation, Protection)
- HOW not what we do – it's the how not the what
- We need a workforce that reflects the diversity of our population
- We must accept not knowing so we can learn, grow, develop, and engage
- We want an empowered population – they need to feel empowered before and after they are using our services

Where we need to be once we have enabled a workforce to deliver culturally appropriate services:

- We will have health equity for our high-need populations
- We will have service users who understand and are as comfortable as they can be with the health and care services they receive
- We will have a workforce who practice cultural humility
- We will have a workforce who are self-aware and practice critical reflection in order to deliver culturally appropriate services
- We will have an organisation where the next generations of health workforce want to train and work at the Waikato DHB

To deliver on this priority a thematic analysis determined that performance and activities needed to be aligned with the following:

Enablers	**People**	**Process**	**Environment**
Themes for a successful priority	• Give and earn respect - Accept differences and diversity • Give and earn respect - Own what you do • Give and earn respect - Put yourself in the shoes of others • Give and earn respect - Value everyone's contribution	• Growing the good - Provide experiences to maximise potential • Stronger together - Foster a supportive safe work place • Listen to me; talk to me - Listen to and hear others • Fair play - Clear and transparent processes	• Fair play - Create opportunities for inclusive decision-making • Listen to me; talk to me - Open and safe sharing • Stronger together - Collaborate to achieve known outcomes

If we want a workforce to deliver culturally appropriate services we (Waikato DHB) need to change the way we do things and set the scene and environment so the workforce are successful.
This plan identifies at a very high level what we propose to do, when, what success looks like, and how we will monitor to ensure sustainability and succession for the priority to become 'just how we work'.

Existing Activities/Projects

Activities/ Projects	Activity assessment (1-8)- A score of 4 or higher is a positive correlation	Objectives of activity	Timelines	Ownership and project reference code
Quest for new Medical School	7	Allows approaches to curriculum and type of doctors and clinicians needed for our diverse population	TBD	Nigel Murray
Health Integrity Line	8	A free anonymous 24/7 phone line to report fraud or any other activities relating to the health industry. This includes but Is not limited to: • Dishonesty or inappropriate use of public money • Inappropriate use of technology • Workplace bullying • Theft • Drug use • Harassment All calls are passed onto the appropriate team or agency to follow up.		
Rural Health	6	A comprehensive review and redesign of rural health service capacity, capability, service delivery and human, facility and technological infrastructure.	On Hold	Mark Spittal
Patient flow improvements	5	Performance improvement programme of work, covering a series of process improvement projects, change support, benefits measurement and technology enablement (iMPACT), Electronic whiteboard, information particularly what a patient is waiting on will become visible.	Feb 2017	Marc ter Beek
eSPACE	5	Accessiblility to information and approaches to clinical management	2019	Maureen Chrystal
Cultural Safety work plan	8	Positive creation of a workforce culture	2017	Committee
Priority Programme Plan Process	8	Create the framework to: •Reduce duplication •Organise work currently occurring and scheduled to be carried out •Identify gaps and plan activities to fill gaps in the short and long term •Work more proactively where possible •Strengthen processes to identify and respond to priority areas •Work more collaboratively and stop silos •Develop a clear and sustainable process that will achieve the priorities •Clearer accountabilities and responsibilities •Clearer communication and transparency of activities	February – December 2017	Neville Hablous
Production planning	4	Establishment of robust production planning routines, planning tools, meeting forums to take more pro-active production decisions in the long, medium and short term horizon. Enhancement of annual planning process, new monthly service plan reviews and weekly waitlist and theatre	TBC	Marc ter Beek

		capacity reviews.		
Women's Health Model of Care	4	Review of Model of Service Delivery for: · Elective Caesareans · E1 Gynaecology and Antenatal ward · Scope of Women's Assessment Unit Outpatient clinics and patient pathway, including the use of Virtual Health	TBC	Tanya Malony
Mental Health & Addictions Models of Care	8	The current models of care for the delivery of mental health & addictions services in New Zealand are not sustainable into the future. Will not meet growing demand not be affordable in its current format	Dec 2017	Derek Wright
CBD Offices and Facilities Consolidation	4	Acquisition and fit out of a single CBD facility (12,000sqm) providing consolidated accommodation for: Mental Health, Diabetes, Population Health, Payroll, IT, Healthshare, Strategy & Funding, Accounts P&R	June 2018	Chris Cardwell
Sterile Services Unit (Project Alloy)	**6**	The project will create a standardised operating model with scalable repeatable processes, work practices, and flow within and between the three departments. The operating model then becomes a solid foundation for continuous improvement to achieve best practice in a clinically critical high volume operational area. The programme of work has a number of facets which incorporate the full spectrum of people, process and technology and is expected to run over a minimum of a three year period		
National Patient Flow (NPF)	**4**	The National Patient Flow programme is a multi-year programme of work aimed at measuring the patient journey through secondary care services. It is primarily focussed on a Ministry of Health (MoH) mandated data collection but requires both system development and ongoing large scale process review and changes in order for Waikato DHB to meet the MoH requirements.	Aug 2017	Marc ter Beek
Maternity Quality and Safety Programme: Primary Care and Maternity Services Alliancing	**8**	Primary Care and Maternity Services Alliancing - working across the sector to improve maternity services in primary care - GP practices, pharmacy and LMC practice. Improve quality and access to maternity services in the community for primary health needs of pregnant women	Ongoing	BAU
Maternity Quality and Safety Programme: Increasing Consumer Engagement	**8**	Key aspect of MQSP is to enable consumers to monitor and be part of improvements in the maternity sector alongside health professionals.	Ongoing	BAU

Maternity Quality and Safety Programme: Primary Birthing facilities	**7**	Balance birthing and postnatal bed footprint across the maternity sector, strengthening clinical governance in Waikato Primary Birthing services to continue the confidence of health professionals and women in these services.	Ongoing	BAU
Maternity Quality and Safety Programme: Priority Women	**8**	Improving outcomes for priority women: • Improve service and outcomes for Maori and Pacific Island women, rural isolated women, women living in low socio economic areas and families experiencing pregnancy loss and neonatal loss • Increase early registration with a midwife for groups were the access rate is much later in pregnancy – this will increase early screening to pick up problems early ensure health care through pregnancy • Access to pregnancy and parenting education improve woman's knowledge about caring for herself and her baby • Reducing maternal smoking – Waikato has a high rate, decreased rates of smoking will show improvements in poor outcomes for women and infants • Promoting safe sleep – reduce the SUDI rate in Waikato • Increasing breastfeeding – consistently lower rates for Maori babies • Improving bereavement services.	Ongoing	BAU
Maternity Quality and Safety Programme: Secondary / Tertiary Services	**4**	Focus on national maternity clinical indicators and areas including monitoring Neonatal Encephalopathy rates, implementing the national guideline on gestational diabetes. Investigate and where necessary make improvement changes to where Waikato is an outlier against the national clinical indicators: Instrumental delivery, Perineal care, induction of labour, GA caesarean section.	Ongoing	BAU
Primary / Secondary Interface Integrated Care Pathways (map of medicine)	**8**	Integration of primary/ secondary and community services in a manner that moves services closer to home where appropriate. Defining the scope of primary care and secondary care and how the interfaces are managed. Embedding standardised best practice integrated care pathways across the Midlands region	Ongoing	Damian Tomic
Discharge Enablement Project	**8**	SAFER Patient Flow Bundle (from NHS) Camplex and long stay discharges work Criteria based discharges Weekend discharges	Sept 2017	Barb Garbutt
Workforce credentialling to work in Virtual Health environment	**8**	Create professional standards to deliver virtual care ensuring consistency of practice	TBC	Darrin Hackett

Nursing Documentation Project	**8**	4 year improvement project that has dramatically reduced the number of forms nurses use for assessing patients, and instead refocuses them on patient care and what really matters to each patient. The most intangible result is the breakdown of nursing 'silos' and changes in nursing practice. Implementation is due in mid-May 2017.	TBC	Sue Hayward

Potential Activities or Projects

The following list of ideas has not been prioritised or filtered and simply represents feedback that has been presented by the PPP 1.4 working group and the Executive Group on possible activities or projects for further exploration.

Activities/ Projects	Objectives of project/action plans	Timelines (commencing)	Proposed Ownership & project reference code
Customer service training for all staff, not just frontline	Waikato Host Training (Kiwi Host): The Waikato Way We have internal and external 'customers'		
Cultural Competency training to be part of orientation	• E Learning • Working through Scenarios		
Comms plan to deliver the priorities message	• For staff • For hospital visitors/patients e.g. foyer design: "your whanau/family are cared for here" Future employees		
Cultural arrest team	I need help with a cultural critical incident with another staff member /patient /stakeholder		
Physical spaces that reflects our bi-culture	• Bilingual signage • Area in front of ED (Waikato hospital) can show who we are • Enquiries desk at ED is made more welcoming Our physical spaces needs to reflect who we are, who our population are, and the needs they have of our facilities		
Population demographic hiring	We are explicit in hiring staff whose culture is reflective of our population. We are explicit in DHB expectations and values when recruiting.		
Celebrations	• What does your team do to celebrate diversity • What does your team do to celebrate each other • What does your team do to celebrate you • Patient stories • Staff stories		
Staff WOF	Performance reviews that do a warrant of fitness for cultural competency and safety.		
Service and Team WOF	Stocktake cultural state of services and assess need for culture change. Modifying or implementing recommended changes to service delivery.		
Values workshops	Mandatory – if not already For EG For Board		
Staff journey of self-development and discovery	Sharing stories of staff's reflection on situations, learnings		

	etc. TED Talk style?		

Delivery requirements and detail

Processes and functions

Please note: the following has not been confirmed, this list is proposed

Phase	Timeframe	Outcomes
One	To be confirmed following approval from Health Strategy Committee	1. Establish PPP governance group* (below) 2. Gap and objective assessment to be completed with governance group 3. Finalise Programme Plan outlining proposed approach 4. Feasibility review of potential activities 5. Appropriate scopes or project plans for proposed activity finalised for BRRG 6. A comms plan developed for communicating priority to staff 7. Risk plan developed 8. 9. At least one new proposed activity in progress
Two	To be confirmed following approval from Health Strategy Committee	1. Budget for priority delivery finalised 2. Resource list finalised 3. Addendum to evidence base 4. Sustainability plan developed 5. At least one new proposed activity completed 6. Governance review for performance update
Three	To be confirmed following approval from Health Strategy Committee	1. All activities on-track or complete (as required) 2. Sustainability plan implemented

*Governance: The governance group proposed is made up of members from the working group, some other staff, and a Board member. Please note: the following people have not been confirmed, this list is proposed.

Priority Lead	Sue Hayward
Priority lead 2ic	Millie Berryman
Subject matter oversight	Chris Baker (Prof.Dev.Unit.Workforce)
Financial oversight	Rory O'Donnell
Cultural oversight	Hemi Curtis, Nikki Haereroa (Training)
Quality oversight	
Change oversight	
Strategic oversight	
Business Analyst oversight	Alfredo Bernal
Communication oversight	Amy Mackay
Clinical oversight: Nursing	Melody Mitchell (Nurse Manager) Debra Larsen (Nurse Manager) Lin Marriott (Nurse Manager)
Clinical oversight: Allied Health	
Board member	
Others	Mary-Anne Spence (Nurse Manager Clinical Education)

Meetings: Recommended frequency of once a month during implementation phase 1 and once every two months for phase 2, twice a year for phase 3

Monitoring and Evaluation

The purpose of this section is to show how and when monitoring will occur and what will be measured.

Please note the Monitoring and Evaluation page will be completed following finalisation of delivery requirements and detail.

Monitoring form	Measure	Dates
Staff feedback	TBC - Survey	TBC
Governance Group	TBC	TBC
Executive Group	TBC	TBC
Evaluation checkpoint (plus 3 months)	TBC	TBC
Evaluation checkpoint (plus 6 months)	TBC	TBC
Evaluation checkpoint (plus 12 months)	TBC	TBC
Evaluation checkpoint (annual)	TBC	TBC
Performance measure result	TBC – Annual Plan and Board quarterly report Dashboard (intranet)	TBC

Methodology and Apendicies

This Priority Programme Plan was developed using the PPP template which is designed to:

1. Provide a consistent, yet flexible approach to developing 24 Priority Programme Plans
2. Contribute to the wider projects objectives:
    - Identification of projects and activities at a National, Regional, and Local level (with the aim to reduce duplication)
    - Organise work currently being carried out and scheduled to be carried out by the Waikato DHB
    - Identify gaps and plan activities to fill the gaps in the long and short term
    - Identify ways to work more proactively where possible
    - Strengthen processes to identify and respond to priority areas
    - Work more collaboratively with each other / stop silos (where possible and/or required)
    - Ensure accountability and responsibility is clear
    - Ensure robust information for decision making is available
    - Develop a process that responds to the diversity of the organisation's business and activities
3. Provide the opportunity for ideas to achieve the priority from people actively working in the area of the priority and beyond

The following activities have occurred with outputs provided in detail in the appendicies.
Programme Plan template overview:

Stage	Phase	Overview of the phase	Appendix
Discovery and Research	Resource planning – Who is involved at a Priority Programme Plan level?	This will show: • Who is involved in the development of the Priority Programme Plan • Some key dates	Appendix A: Working group TOR – page 16 to 25
	Definition & Alignment - What does this priority mean and what other priorities are you aligned to?	This will show: • The definition and explanation of the priority • That the priority programme plans are not individual stand-alone developments and how they link with other priority programmes.	Appendix B: Definition – page 26 to 29 Appendix C: Alignment – page 30 to 31
	Evidence Base – What information do you need so you can understand the environment that the Priority is in?	This will show: • Activity relevant to this priority that is currently underway and planned for at a national, regional, local level • Information to help understand the status of the priority and contributing factors • What others have done to succeed in this priority or lessons learnt from unsuccessful activity • What the priority requires in order to ensure activity is equitable	Appendix D: Evidence Base – page 32 to 109
	Analysis - What activity is needed for the priority to be successful?	This will show: • What other activities will impact on this priority (for better or worse) and what activities will be impacted by this priority (for better or worse)	Appendix D: Current Activity – page 110 to 115 Appendix E: A Successful Priority – page 116

		• What a successful priority would look like • The gaps between the current state of the priority and the priority being successful • Measureable activity to show progress and performance of the priority	Appendix F: Activity Gap Assessment – page 117 to 118 Appendix G: Objectives – page 119 to 121
Planning	Programme Plan - What do you need to focus on for the next few years?	This will show: • A high-level outline of the specific activity and actions that will contribute to the achievement of the priority	No Appendix as this is delivered as the front section of this document – page 1 to 15

Appendix A: Working group Terms of Reference

Priority Programme Plan

1.4: Enable a workforce to deliver culturally appropriate services

Working Group Terms of Reference

Author:	Nicola Parker / Esmae McKenzie-Norton
Last Updated:	15 March 2017
Document Name:	Priority Programme Plan 1.4 - Working Group Terms of Reference
Version:	1.2

Revision history

Date	Author	Summary of Changes	Version
07/02/2017	Naomi Arnet	Draft inclusion for PPP 1.4	1.0
15/03/2017	Esmae McKenzie-Norton	Update following distribution to working group	1.2

Distribution

Name	Title	Issue Date	Version
Sue Hayward	Chief Nursing & Midwifery Officer	07/02/2017	1.0
Working group	PPP 1.4 Working group	02/03/2017	1.1

Purpose

The Priority Programme Plan (PPP) working group are responsible for coordinating, communicating, championing and providing expert input to ensure the success of the Priority Programme Plan (PPP).

The PPP will provide an overview and outline of the key aspects of the Priority that need to be captured, documented and detailed.

Background

When the Waikato DHB Strategy Refresh Project Brief was presented to Board in September 2015 the need for a strategy implementation mechanism was highlighted and the priority programme plan concept was born. *A programme plan in this context is defined as: a set of related projects and activities to deliver outcomes and benefits that contribute towards achieving our strategic imperatives.*

Without a structured implementation process a strategy becomes a document that resides unopened on a bookshelf or at the bottom of a draw somewhere.

The spirit of “Enable a workforce to deliver culturally appropriate services” from the strategy is about:

Strategy… What do we mean:	The Waikato DHB employs around 6,000 staff across the district, from diverse backgrounds and across a wide range of disciplines. All these people are working toward better health for the people of Waikato and beyond and their efforts need to be culturally appropriate. This means doing things in a different way for different people.
Strategy… Why does this matter:	The majority of Waikato DHB staff interact with patients, their family/whānau, other health providers, social and health agencies, or Waikato communities. We need to ensure that as a workforce, we are providing services in a way that meets the needs of those we interact with. By this means we will improve access and satisfaction.
Strategy… What will this look like:	The Waikato DHB staff/workforce will reflect the population it serves. A one-size fits all approach will not work. The Waikato DHB is a large complex organisation with a wide variety of activities and areas of work and each area will need to ensure that their service delivery caters to the particular community being served.

Objectives

In addition to delivering on the Priority Programme Plan and its objectives the Working Group is tasked with delivering a focussed approach to:

- Reduce duplication of reporting and work within Waikato DHB

- Organise work currently being carried out (and scheduled to be carried out)
- Work more proactively where possible
- Strengthen processes to identify and respond to priority areas
- Work more collaboratively with each other / stop silos (where possible and/or required)
- Develop a process that responds to the diversity of the organisation's business and activities

Mandate

It is acknowledged that while Priorities should be co-operating (not competing) some conflict between Priorities, and between operational aspects of the business, may occur. The authority, accountability and mandate for key leadership roles is outlined below to provide clarity around expectations, and of escalation processes. Please refer to appendix A for specific role descriptions.

Alpha leader

Accountability: the Alpha leader will be accountable for meeting the objectives, metrics and timing that the Working Group have developed to determine successful delivery of the Priority

Authority (financial): The Alpha leader will have the required Delegated Level of Authority to deliver the Priority Programme Plan. Projects identified to deliver on the objectives determined for this Priority will follow normal Waikato DHB consultative and delegation processes.

Authority (change): The Alpha leader will have the authority to access resources for completing the Priority Programme Plan. This will require close collaboration where the Alpha leader is not the head of a functional area from which information and resource is required and is subject to normal Waikato DHB consultative and delegation processes.

The Alpha Leader will establish the members of the Working Group – with support from the Bravo Leader. Key leadership roles for the Priority are listed below, these roles include: the Priority Working Group; Alpha role; Bravo role; Subject Matter Experts; Executive Stakeholder Group. The Terms of Reference for the Working group provides an overview of expectations for all roles that do not have an individual description.

Additional expectations may be added in by each Priority dependent on requirements.

Resource Planning:	
Allocated Priority:	Enable a workforce to deliver culturally appropriate services
Programme Sponsor (Alpha role):	Sue Hayward (Acting Alpha 18.05.2017-26.06.2017 is Darrin Hackett)
Programme Sponsor 2ic (Bravo role):	Millie Berryman
Programme Working Group: *Who is involved at a Priority Programme Plan level?*	
Alpha leader	Sue Hayward
Bravo leader	Millie Berryman
Appropriate Subject Matter Experts	Chris Baker Ikimoke Tamaki-Takarei
The appropriate analyst or financial advisor	Rory O'Donnell
A Programme Administrator	Naomi Arnet
A Cultural Advisor	Hemi Curtis

A Quality role	Forum Representative
A Change role	Nicola Parker
A Clinical role	Melody Mitchell (Nurse Manager) Debra Larson (Nurse Manager)
A Business Analyst	Alfredo Bernal
A Comms advisor	Lydia Aydon (to advise)
Any other appropriate role that will contribute to the success of the Priority	Dr John Barnard (Chair Cultural Safety Group) Mary-Anne Spence (Nurse Manager Clinical Education) Esmae McKenzie-Norton (Strategic oversight)

Scope

- Achievement of this Priority
- Understanding and integrating with other dependent activity that is not owned by this Priority
- Ensuring that reporting is maintained and kept up to date as required by Waikato DHB Strategy team
- Sharing and communicating all relevant information with Waikato DHB
- Providing active and visible support for this Priority
- Collaborating with other Priorities and activities to contribute to the overall success of the Strategy and Waikato DHB as a whole

Constraints/Risks

Risks are to be identified, assessed against the Waikato DHB matrix, and registered in Datix.

The following constraints and risks are acknowledged for the PPPs as an entire group of work

- Conflict and availability of resource requirements for this and other Priorities
- It is stepping outside what is usually done – which will means challenges to how we usually do things

- Large workload up front (although it is expected there will be less work in the long run)
- The costs of making changes may impact time for delivery
- Time and resource constraints on staff's ability deliver on objectives and continue to meet BAU

Reporting

Initial reporting will be to Executive Group in line with the dates agreed on the Resource sheet of the Priority Programme Plan
Ongoing reporting is expected to be monthly and will be directed by the Strategic reporting framework that is under development
Project reporting is expected to be in line with Waikato Way standards using Project Server.

Methodology

Complete the templated process outlined for all Priority Programme Plans providing refinement and additional information as is appropriate for this Priority

Internal quality control will be managed and guided by the Quality representative on the Working Group and overseen by the overarching Priority Programme Plan Project team and sponsor.

Key Milestones

Minimum specific deliverables for the priority include:

Deliverable:	Working Group to Complete by:
Understanding of the alignment and integration of other Priorities	31.03.2017
Identify New Zealand Health Strategy integration points for this Priority	31.03.2017
Development of specific objectives for this Priority	05.04.2017
Development of a objectives and metrics set to measure progress towards this Priority	05.04.2017
An assessment of how this Priority may be affected by the current environment (with consideration of the impact of any foreseeable environment changes)	05.04.2017
An assessment of how the current Waikato DHB and wider activity contributes to this Priority	31.03.2017
An assessment of any gaps in activity towards achieving this Priority (and how they can be filled)	31.03.2017
Capture and identification of key data and information that can be used to report on this Priority and hence the strategy	31.03.2017

Assumptions

The Chief Executive Officer expects staff to be responsive to the strategy as part of Waikato DHBs approach to delivering services and therefore staff should cooperate and assist in preparing Priority Programme Plans.

Costs

It is important to keep track of the significant contribution being made by individual staff and the Executive release of them to carry out this work. While it is not expected that costs associated with the development of the Priority Programme Plans will be transferred it is still important to keep track of the time spent to develop Priority Programme Plans. Templates will be developed to assist with this record.

Priority Name				
Estimated Hourly Rate				
Activity	**Actual Time**		**Inkind Time**	
	Time	**$**	**Time**	**$**
		-		-
		-		-

		-		-
		-		-
		-		-
		-		-
		-		-
		-		-
		-		-

TOR Appendix A

Programme Priority Plans – Working Group and Leadership Roles

Key leadership roles for the Priority are described below, these roles include: the Priority Working Group; Alpha role; Bravo role; Subject Matter Experts; Executive Stakeholder Group. The Terms of Reference for the Working group provides an overview of expectations for all roles that do not have an individual description.

Additional expectations may be added in by each Priority dependent on requirements.

Priority Working Group

The programme working group is expected to consider:

- Alpha Leader
- Bravo leader
- A cultural advisor
- The appropriate financial manager
- Appropriate Subject Matter Experts
- A programme manager
- A Quality role
- A Consumer representative
- A Change role
- A Clinical role
- A business analyst
- Any other appropriate role that will contribute to the success of the Priority

At least two leadership roles will be put in place for each Priority. An allocation matrix was developed in consultation with Executive Group in August 2016, sign off occurred in September 2016. High level overviews of the role purpose, objectives and expectations are below.

ALPHA role

Purpose:

To own and be accountable for the organisational objectives and metrics for the Priority

To be accountable for and drive delivery of the outcomes for the allocated Priority

Ultimate decision making responsibility

Active and visible sponsorship of the Priority

Direct communication with employees regarding the Priority

Create a coalition of sponsorship that creates buy-in from other leaders and solicits and listens to feedback from managers

Resolve issues outside the control of the Priority Working Group

Lead a collaborative approach to delivering the Priority

Responsible for identifying the business needs, problems or opportunities relating to the Priority
Ensuring the project remains a viable proposition that realises benefits

To identify risks, assess them using the Waikato DHB matrix, and register them in Datix

NOTE: Where multiple Alpha's are allocated a lead Alpha will need to be determined – the lead Alpha will have primary accountability for delivery of the Priority but a group or combined Alpha responsibility will also exist.

Objectives:

Relevance: Ensure that any work that falls within the Priority remains aligned with both the changing external environment and relevant Waikato DHB strategic priorities.

Breaking down siloes: Remove organisational and political obstacles that are preventing or hindering progress towards the Priority

Communication: To update Board, Executive Group and all interested stakeholders on progress to achieve the Priority

Expectations:

The role is expected to:

- Model and reflect the values of Waikato DHB as outlined in the refreshed strategy
- Assume ultimate responsibility for achieving delivery of the Priority
- Sign off on all objectives and measurements
- Sign off on all approvals to proceed to the next stage
- Sign off on monthly Priority reporting
- Champion the priority at Executive level and across the business
- Provide the Priority with business direction, ensuring ongoing alignment with the organisations strategic Priorities
- Support the Priorities deliverables through all operational areas
- Sign off on reporting to inform EG and the wider organisation
- To provide coordination and cohesiveness with other Priorities
- Establish a working group that governs, manages and facilitates the programme of all pieces of work within the Priority
- Review and approve strategies to resolve project risk

<u>BRAVO role</u>

Purpose:

Ownership of objectives and metrics for the Bravo's operational area/scope

To provide a pilot environment to operationalise Priority initiatives

To support and drive delivery for the allocated Priority while providing an integrated perspective that adds values and increases robustness of work within the priority

Active and visible sponsorship of the Priority

Create a coalition of sponsorship that creates buy-in from other leaders and solicits and listens to feedback from managers

Objectives:

Relevance: Ensure that any work that falls within the Priority remains aligned with both the changing external environment and relevant Waikato DHB strategic priorities.

Breaking down siloes: Remove organisational and political obstacles that are preventing or hindering progress towards the Priority

The role is expected to work closely with the Alpha role to:

- Model and reflect the values of Waikato DHB as outlined in the refreshed strategy
- Support the Alpha role and provide back up
- Increase the experience and knowledge mix being to applied to the Priority
- Champion the priority at Executive level and across the business
- Provide the Priority with business direction, ensuring ongoing alignment with the organisations strategic Priorities
- Support the Priorities deliverables through all operational areas
- To provide coordination and cohesiveness with other Priorities
- Support the working group to govern, manage and facilitate the programme of all pieces of work within the Priority

<u>WORKING GROUP ROLE</u>

Purpose:

Provide specific expertise (Quality Assurance, Risk Management, Technical input, specialist knowledge etc) to ensure the success of the Priority Programme Plan development.

To provide additional knowledge, context, perspective and challenge that will support positive outcomes for the Priority

Membership may require key stakeholders, both internal and external to Waikato DHB, who have the ability to provide new and challenging perspectives that will contribute to the robustness and quality of the Priority Programme Plan

Objectives:

Relevance: Ensure that any work that falls within the Priority remains aligned with both the changing external environment and relevant Waikato DHB strategic priorities.

Breaking down siloes: Remove organisational and political obstacles that are preventing or hindering progress towards the Priority

Reduce Duplication: provide timely specialist input that creates increased standardisation and focuses work to address and deliver on work objectives

Quality: technical assurance

Knowledge sharing

The role is expected to:

- Model and reflect the values of Waikato DHB as outlined in the refreshed strategy
- Attend initial 2 hour workshop
- Attend work group meetings
- Assume responsibility for ensuring the most appropriate specialist information is taken into consideration
- Create consistency of specialist input where it is required for more than one Priority (where the member is involved in development of more than one Priority Programme Plan)
- Actively Participate in the Priority Programme Plan deliverables
- Communicate, promote and champion (where appropriate) the Priority Programme Plan
- Provide challenge and expertise to ensure quality of Priority Programme Plan delivery

<u>SUPER ALPHA role</u>

Waikato DHB Priority Programme Oversight

The Chief of Staff has responsibility and accountability for the overall programme of work that constitutes the completion of Priority Programme Plans. Where a conflict occurs between Priorities or between a Priority and Operational activity the Chief of Staff is able to make a final decision on the best approach, based on knowledge of all Priority Programmes and operational awareness. The Chief of Staff may choose to raise the matter for debate in the Executive Group Meeting forum.

Appendix B: Definition

Defining Priority Programme Plan Priority 1.4: Enable a workforce to deliver culturally appropriate services

Word	Source Definitions	Workshop and Alpha Bravo Definitions	Proposed Definition
Enable	"give (someone) the authority or means to do something; make it possible for". Oxford Dictionary, 2016	• Inclusion - the act of allowing others to be involved in the process or being part of something. • The opposite of disable. • Confidence - an individual needs to be confident, in a safe environment to be enabled. • In Māori terms - it's the supporting of, allowing someone into your process, how we behave, a type of behaviour, Manaakitanga. • It is kind of about what I mean to you. I might mean something to you. • The ability to deliver anything is much easier, it comes from a base of confidence. • Cultural humility. • Working with – acknowledgement • Inherent individual self-awareness is key to enable	• Support the workforce to learn and understand the importance of providing care/service that is regardful of the diverse needs of the population • To provide skills/knowledge, authority and support to staff to confidently perform their required tasks. This would also mean minimising/eliminating barriers to service delivery (e.g. language) • Policies and exec behaviour reflects the support to enable staff • Actively and intentionally promote and facilitate across all levels of the organisation, whole of system, directorates, management and individual staff.
Workforce	"The people engaged in or available for work, either in a country or area or in a particular firm or industry." Oxford Dictionary, 2017	• Waikato DHB has multiple workforces, clinical, non-clinical, contractors, providers. • In the Waikato DHB context workforce is anyone that is there to provide a health service to the population of Waikato. • A workforce is clinical and non-clinical people employed to deliver	• Workforce includes clinical and non-clinical staff involved in providing health services, including those allocating funding and resources to meet needs of the population • All DHB staff

		a health service within Waikato boundaries • How diverse are we in our teams and groups?	• Those people who contribute to the delivery of health care now and in the future • I think it is also about anyone who might be here in the future too – how do we encourage people to choose a career as a health professional
Deliver	"Bring and hand over (a letter, parcel, or goods) to the proper recipient or address" "Provide (something promised or expected)" Oxford Dictionary, 2017	• The act of delivery. • What practices are used by the workforce to deliver the service? • Operationalise the values to provide ways of working and supporting the workforce. • Deliver is like a task, we want it to be a sense of being. • Everyone needs to be open to who they are and their beings. • Behaviours and attitudes can be part of that word culture. • 'How can I work with you?' • Normalise the question: "how can I work with you to…" • Deliver implies sense of tasks, should be 'a way of being'	• Deliver means to provide health care that focuses on the needs of health consumers • Any connection with individuals or communities that impact on health care. E.g 1:1, physical environment, system interventions, eg outpatient letter, buildings etc
Culture	"The beliefs, customs, arts, etc. of a particular society, group, place, or time; A particular society that has its own beliefs, ways of life, art, etc.; A way of thinking, behaving, or working that exists in a place or organisation(such as a business)". Waikato DHB Strategy,	• Big C = a culture eg Maoridom, Indian • Small c = organisation, nurses etc • All cultural but with bi culture partnership. • Culture is a small c. There are some basic principles, teach the workforce to work with a wide variety of people • When the care is being delivered there needs to be a touch point where the patient is asked "is this OK with you". Care is delivered in a manner that is acceptable to that person with compassion. • My values and beliefs might be very different from yours and our	• Wepa's (2005, p.31) definition reflects the complexity of culture and situates culture within a social context: "Broadly speaking, culture includes our activities, ideas, our belongings, and relationships, what we do, say, think, are. Culture is central to the manner in which all people develop and grow and how they view themselves and others.

	2016, p.8	own biases. People should be able to work in this organisation in a safe way with no judgement. It is a place to work with others, not judge others. • Waikato Hospital is in the heart of the Kingitangi, there is an expectation that the people would expect Kia ora to be the greeting. • Everyone likes the word diverse • Culturally – this brings up a lot of other things. The individuals need to be aware of who they are, self-awareness. • The treaty has two parties • Behaviour, attitudes, values, awareness-self then others	It is the outcome of the influences and principles of people's ancestors, ideology, philosophies of life and geographical situation. Culture is never completely static and all cultures are affected and modified by the proximity and influences of other cultures". • As per strategy definition • The values and beliefs that are important to the individual or group.
Culturally appropriate	None	• Culture humility – article available • Diversity - People to be open to understand or explore diversity. • Sometimes someone may be not be comfortable with a situation but will be OK to explore further with some help • We hold multiple cultural lenses. Nursing has pioneered the way forward - how do we interact with our people, our services, how can I work with you e.g. female Muslim might not be comfortable with a male doctor. How can I work with you? • This priority is higher than ethnicity. • We could use culturally humility. How can I work with you to get these outcomes, acknowledgement and being open to others. • Been regardful of their set of values • Regardful (clinical and non-clinical) • Respectful behaviour to all – engagement across the cultural spectrum • How anybody in this organisation interacts with the diverse values of others • Cultural humility	• The health consumer determines that the care / service provided has been regardful of their cultural values, beliefs and preferences. • Being self-aware (includes one's culture, biases, stereotype, others) • Recognises and respectfully accepts differences (on aspects that impacts on health care delivery) • Addresses the power balance • Non-threatening • Appropriate is that which is founded on a partnership with the individual or group and takes into consideration what is important to them, , appropriate is determined by the person or group that we are connecting with.
Appropriate	"Suitable or proper in the circumstances" Oxford Dictionary, 2017	• Not discussed as a stand-alone concept, it was discussed as either culturally appropriate or appropriate services	• The health consumer and service provider work together to determine best course of action to meet health consumer needs

Appropriate services	none	• Those that we are delivering care to, those that we are working with. • Defined by the 3Ps • Partnering with Clinical or non-clinical • Interaction makes all the different to the patient • Their (people we deliver services to) views on how we've done	• Service that recognizes the culture of both the provider and the recipient without moving away from the DHB policy/procedures/ guidelines and evidence-based practice.
Services	"Health services include all services dealing with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health. They include personal and non-personal health services… Service provision refers to the way inputs such as money, staff, equipment and drugs are combined to allow the delivery of health interventions." World Health Organization, 2016	• Everything that we do, across the board • Put it into the sense of customer services, everyone will deliver that service • Services - combines patient and non-patient. Would encumber everyone even [redacted] when he is doing finance • Services to patients and non-patients	• I quite like the WHO definition • Everything that we do, Environment, Communication etc
Strategy… What do we mean:	The Waikato DHB employs around 6,000 staff across the district, from diverse backgrounds and across a wide range of disciplines. All these people are working toward better health for the people of Waikato and beyond and their efforts need to be culturally appropriate. This means doing things in a different way for different people.		
Strategy… Why does this matter:	The majority of Waikato DHB staff interact with patients, their family/whānau, other health providers, social and health agencies, or Waikato communities. We need to ensure that as a workforce, we are providing services in a way that meets the needs of those we interact with. By this means we will improve access and satisfaction.		
Strategy… What will this look like:	The Waikato DHB staff/workforce will reflect the population it serves. A one-size fits all approach will not work. The Waikato DHB is a large complex organisation with a wide variety of activities and areas of work and each area will need to ensure that their service delivery caters to the particular community being served.		
Definition sentence	We will equip those who partner in health care now and in the future with skills and knowledge to provide care and services that meet the diverse values, beliefs, and cultural needs of our People.		

Appendix C: Alignment

ALIGNMENT OF RELATED PRIORITIES

Purpose
To acknowledge key points of overlap, integration and knowledge sharing that will need to be managed to ensure a collaborative approach that delivers standardised, streamlined consistent outcomes for Waikato DHB - and the overarching strategy as a whole.

Significant: High level of integration and collaboration required to ensure mutual success for Priorities. Priorities are both critical to each other's success

Medium: Coordination and communication are required to optimise success. One of the priorities is critical to the success of the other

Low: The priorities have little or no impact on the success or each other

	Priority relationship being assessed	**Sig**	**Med**	**Low**	**Notes**
Health equity for high need populations					
1.1	Radical Improvement in Māori health outcomes by eliminating health inequities for Māori	√			
1.2	Eliminate health inequities for people in rural communities	√			
1.3	Remove barriers for people experiencing disabilities	√			
1.4	Enable a workforce to deliver culturally appropriate services				
Safe, quality health services for all					
2.1	Deliver timely, high quality, safe care based on a culture of accountability, responsibility, continuous improvement and innovation	√			
2.2	Prioritise fit-for-purpose care environments	√			
2.3	Early intervention for services in need			√	
2.4	Ensure appropriate services are delivered to meet the needs of our populations at all stages of their lives			√	

People centred services					
3.1	Utilise the expertise of communities, providers, agencies, and specialists in the design of health and care services	√			
3.2	Provide care and services that are respectful and responsive to individual and whānau needs and values	√			
3.3	Enable a culture of professional cooperation to deliver services	√			
3.4	Promote health services and information to our diverse population to increase health literacy	√			
Effective and efficient care and services					
4.1	Live within our means			√	
4.2	Achieve and maintain a sustainable workforce	√			
4.3	Redesign services to be effective and efficient without compromising the care delivered		√		
4.4	Enable a culture of innovation to achieve excellence in health and care services	√			
A centre of excellence in learning, training, research and innovation					
5.1	Build close and enduring relationships with local, national, and international education providers	√			
5.2	Attract doctors, nurses, and allied health staff to the Waikato through high quality training and research		√		
5.3	Cultivate a culture of innovation, research, learning, and training across the organisation		√		
5.4	Foster a research environment that is responsive to the needs of our population		√		
Productive partnerships					
6.1	Incorporate te Tiriti o Waitangi in everything we do	√			
6.2	Authentic collaboration with partner agencies			√	
6.3	Focus on effective community interventions using community development and prevention strategies		√		
6.4	Work towards integration between health and social care services		√		

Appendix D: Evidence Base

Priority Programme Plan 1.4

January 1

Effective and Efficient

Table of Contents

Introduction to Evidence Base

District Health Boards

DHBs, as defined by the New Zealand Public Health and Disability Act 2000, were established as vehicles for the public funding and provision of personal health services, public health services and disability support services for a geographically defined population.

The DHB is required to improve, promote and protect the health of people and communities; promote the integration of health services, especially primary and secondary care services; seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs; promote effective care or support of those in need of personal health services or disability support.

Each DHB is required to plan and deliver services regionally, as well as in their own geographic areas. They are also required to promote the inclusion and participation in society and the independence of people with disabilities; reduce health disparities by improving health outcomes for Māori and other population groups and reduce – with a view toward elimination – health outcome disparities between various population groups.

DHBs, as publicly owned and funded agencies, are expected to show a sense of social responsibility, to foster community participation in health improvement, and to uphold the ethical and quality standards commonly expected of providers of services and public sector organisations.

Nationally, DHBs are facing a number of pressures including demographic changes and smaller annual funding increases. DHBs need to consider how improved planning, systems and processes and models of service delivery will enable them to live within their means, while continuing to improve the quality of health services for their populations. (Waikato DHB, 2014)

Waikato DHB Strategy

During 2015/16 Waikato DHB undertook a Strategic Refresh Project. This project was driven by our Board and focussed on ensuring the organisation is heading in the right direction, focusing its resources and making the most of future opportunities. It is recognised that there are some fundamental challenges we must face along the way if we want to continue improving the health status of our population and our work to eliminate health inequities.

The first pre-requisite to the success of our strategy will be strong and unambiguous leadership. In order to respond to the challenges we face we must become more innovative

and we must get comfortable with change. Turning this strategy into action will mean making changes; some changes will see more investment in some areas and some changes will mean disinvestment. Whatever the changes, they will be done by using robust decision-making and in partnership with others to ensure we are delivering excellent health services and care.

Priorities:

To connect strategy with day-to-day activity, priority plans are being developed (all 24 priority programme plans are due to be developed by November 2017). These plans will detail the transformative innovation needed to create the health system that works best for the Waikato. The plans will identify specific activity and actions that will contribute to the achievement of our strategic imperatives and vision. A priority programme plan is created to:

Coordinate, direct and oversee implementation of a set of related projects and activities in order to deliver outcomes and benefits related to Waikato DHB's strategic imperatives.

- Radical improvement in Māori health outcomes by eliminating health inequities for Māori
- Eliminate health inequities for people in rural communities
- Remove barriers for people experiencing disabilities
- Enable a workforce to deliver culturally appropriate services

- Deliver timely, high quality, safe care based on a culture of accountability, responsibility, continuous improvement, and innovation
- Prioritise fit-for-purpose care environments
- Early intervention for services in need
- Ensure appropriate services are delivered to meet the needs of our populations at all stages of their lives

- Utilise the expertise of communities, providers, agencies, and specialists in the design of health and care services
- Provide care and services that are respectful and responsive to individual and whānau needs and values
- Enable a culture of professional cooperation to deliver services
- Promote health services and information to our diverse population to increase health literacy

- Live within our means
- Achieve and maintain a sustainable workforce
- Redesign services to be effective and efficient without compromising the care delivered
- Enable a culture of innovation to achieve excellence in health and care services

- Build close and enduring relationships with local, national, and international education providers
- Attract doctors, nurses, and allied health staff to the Waikato through high quality training and research
- Cultivate a culture of innovation, research, learning, and training across the organisation
- Foster a research environment that is responsive to the needs of our population

- Incorporate te Tiriti o Waitangi in everything we do
- Authentic collaboration with partner agencies and communities
- Focus on effective community interventions using community development and prevention strategies
- Work towards integration between health and social care services

Priority 1.4: Enable a workforce to deliver culturally appropriate services

The Waikato DHB employs around 6,000 staff across the district, from diverse backgrounds and across a wide range of disciplines. All these people are working toward better health for the people of Waikato and beyond and their efforts need to be culturally appropriate. This means doing things in a different way for different people.

The majority of Waikato DHB staff interact with patients, their family/whanau, other health providers, social and health agencies, or Waikato communities. We need to ensure that as a workforce, we are providing services in a way that meets the needs of those we interact with. By this means we will improve access and satisfaction.

The Waikato DHB staff/workforce will reflect the population it serves. A one-size fits all approach will not work. The Waikato DHB is a large complex organisation with a wide variety of activities and areas of work an each area will need to ensure that their service delivery caters to the particular community being served.

In order for Waikato DHB to achieve its vision of healthy people, excellent care, the population requires wellness to be at the forefront of staff activity. Compassion and kindness are key requirements to create a culture where staff are enabled to be the workforce that will deliver culturally appropriate services.

Why we need to enable a workforce to deliver culturally appropriate services:

- Our population is diverse yet our workforce does not culturally represent our population
- Our population is aging faster than we can provide funding or clinical staff to care for them
- Our population health needs are becoming more complex with many lifelong chronic expensive illnesses
- Our patients are customers with greater information, equal say and accountability for their care
- Our current health care model is no longer sustainable and the New Zealand health service will fail if we continue delivering health care in 2020 as we do today
- Our current environment does not take full advantage of our patients and communities, our people and partners, and the technology and opportunities available to push our healthcare further

What we need to do to enable a workforce to deliver culturally appropriate services:

- We need to have a holistic view of the diverse needs of our population
- We must understand our accountabilities, power position, responsibility and authority so we can ensure culturally appropriate interactions, services, and care
- We must have a healthy relationship with diversity

- To get an empowered population we need to change: including attitudes; behaviours and approach
- We need our organisational culture to move from outputs to outcomes
- We must support each other to ensure cultural safety
- Focusing on relationships we must adhere to the 3 Principles of Te Tiriti o Waitangi (Partnership, Participation, Protection)
- HOW not what we do – it's the how not the what
- We need a workforce that reflects the diversity of our population
- We must accept not knowing so we can learn, grow, develop, and engage
- We want an empowered population – they need to feel empowered before and after they are using our services

Where we need to be once we have enabled a workforce to deliver culturally appropriate services:

- We will have health equity for our high-need populations
- We will have service users who understand and are as comfortable as they can be with the health and care services they receive
- We will have a workforce who practice cultural humility
- We will have a workforce who are self-aware and practice critical reflection in order to deliver culturally appropriate services
- We will have an organisation where the next generations of health workforce want to train and work at the Waikato DHB

Definition

We will equip those who partner in health care now and in the future with skills and knowledge to provide care and services that meet the diverse values, beliefs and cultural needs of our people.

Methodology

Qualitative methods were used to collect the information in this document. Using a variety of qualitative methods allows for triangulation of findings, which helps to determine themes for a thematic analysis. This document includes information from document analysis, literature review, workshops, and staff feedback.
The following provides a brief overview of the methods used.

Related Activity

Related activity is any current activity, projects, or business at a national, regional, local level relevant to the priority. This should include the New Zealand Health Strategy, Ministry of Health's measures and other relevant national activity. Also, activity in the Regional Services Plan or activity occurring across sectors in the Midland Region. At the local level, activity in the various plans for the organisation, such as the Annual Plan for the DHB and for other organisations in the Waikato where relevant

PESTLE

PESTLE is a mnemonic, which in its expanded form denotes P for Political, E for Economic, S for Social, T for Technological, L for Legal and E for Environmental. It gives a bird's eye view of the whole environment from many different angles that one wants to check and keep a track of while contemplating on a certain idea/plan.

All the aspects of this technique are crucial for any industry a business might be in. More than just understanding the market, this framework represents one of the vertebras of the backbone of strategic management that not only defines what a company should do, but also accounts for an organisation's goals and the strategies stringed to them.

It may be that the importance of each of the factors are different to different kinds of industries (or priorities), but it is imperative to any strategy a company wants to develop that they conduct the PESTLE analysis as it forms a much more comprehensive understanding of wider environment to assist when developing the SWOT analysis.

SWOT

A SWOT analysis is a widely used framework that assists with identification and understanding of the Strengths, Weaknesses, Opportunities and Threats for an organisation.

Strengths – internal attributes and resources that support success

Weaknesses – internal attributes and resources that work against success

Opportunities – external attributes and resources that support success

Threats – external attributes and resources that work against success

For the purposes of the Priority Programme Plans a SWOT analysis will be used to understand the current state of Waikato DHB with regard to each Strategic Priority, and to form a foundational base that can be used to plan and manage from

Literature Review

A literature review is an objective, thorough summary and critical analysis of the relevant available research and non- research literature on the topic being studied (Hart, 1998).

Its goal is to bring the reader up-to-date with current literature on a topic and form the basis for another goal, such as the justification for future research in the area (Cronin, Ryan, Coughlan, 2008). As recommended for a good literature review this document has gathered information about a particular subject from many sources and written with few (if any) personal biases.

HEAT

HEAT aims to promote equity in health in New Zealand. It consists of a set of 10 questions that enable assessment of policy, programme or service interventions for their current or future impact on health inequalities. The questions cover four stages of policy, programme or service development.

1. Understanding health inequalities.
2. Designing interventions to reduce inequalities.
3. Reviewing and refining interventions.
4. Evaluating the impacts and outcomes of interventions.

HEAT enables health initiatives to be assessed for their current or future impact on health equity. The questions challenge users to think broadly about equity issues.

The Health Equity Assessment Tool: A User's Guide, Ministry of Health 2008

Related Activity

Project/activity
Quest for new Medical School
eSPACE Programme
Priority Programme Plan process
Cultural Safety work plan
Health Integrity Line
Rural Health
Patient flow improvements
Production planning
Women's Health Model of Care
Mental Health & Addictions Models of Care
CBD Offices and Facilities Consolidation
Sterile Services Unit (Project Alloy)
National Patient Flow (NPF)
Maternity Quality and Safety Programme: Primary Care and Maternity Services Alliancing
Maternity Quality and Safety Programme: Increasing Consumer Engagement
Maternity Quality and Safety Programme: Primary Birthing facilities
Maternity Quality and Safety Programme: Priority Women
Maternity Quality and Safety Programme: Secondary / Tertiary Services
Primary / Secondary Interface Integrated Care Pathways (map of medicine)
Discharge Enablement Project
Workforce credentialling to work in Virtual Health environment
Nursing Documentation Project

PESTLE ANALYSIS – EXTERNAL

Political

<table>
<tr><td colspan="2">National</td></tr>
<tr><td>Cons</td><td>Pros</td></tr>
<tr><td>• Cut in Government funding to health sector will have a negative effect on the DHB's budget for the year

• Election campaigning can impact Ministry of health activities and priorities

• Government must be responsive to health professionals union representation

• Immigration rules

• Student Loan adjustments, for example no longer interest free which may alter the number of students and graduates entering the sector.</td><td>• Elections can result in new government membership, which can result in fresh perspectives

• In New Zealand, the level of stakeholder engagement in developing regulations is 2.5 (on a scale between 0 and 4); slightly higher than the OECD average of 2.4 See: http://www.oecdbetterlifeindex.org/topics/civic-engagement/

• In New Zealand we have a Ministry of Business, innovation, and employment (see: http://www.mbie.govt.nz/info-services/science-innovation)

• There is a clear drive for standardisation nationally.

• Development of a new health workforce model</td></tr>
<tr><td colspan="2">Local (Waikato)</td></tr>
<tr><td>Cons</td><td>Pros</td></tr>
<tr><td>• Recent change in board members may have impact on strategy decision making within the DHB (Lampp, 2016)

• Pressure from central government on government agencies located locally has resulted in some negative outcomes. Example: removing physical offices from rural areas

• If there is a political push for changes in health targets staff may revert back to biases</td><td>• New membership to the Waikato DHB Board and local government Councils can provide new perspectives and experiences for talking existing and new issues

• Improving collaboration and coordination of Government, Regional, and Local policy. Example: The Waikato Plan [http://www.waikatoplan.co.nz/]

• Te Tiriti o Waitangi is embedded into our constitution</td></tr>
<tr><td colspan="2">Key resources for further reading:</td></tr>
</table>

For international and national information: http://www.oecdbetterlifeindex.org/#/11111111111

Environmental

National	
Cons	Pros
• Effects of climate change – the projected effects of climate change may see changes in the countries climate, which could impact on various community's ability to provide for their wellbeing. In addition the effects of climate change could exacerbate existing environmental challenges such as natural hazards and loss of biodiversity. **See:** http://www.mfe.govt.nz/climate-change/overview-climate-change/about-climate-change • "The effects of society on the ecological system have been managed with little national regulation… While guidance, tools, and monitoring systems have been provided, it has largely been left to others to interpret, apply, and measure policy implementation." **(Ministry for the environment, 2016. P. 8)**	• Freshwater – in global terms New Zealand has generally a good and steady supply of freshwater • The importance of ensuring a healthy environment is a part of the common narrative when exploring issues we as a nation are facing
Local (Waikato)	
Cons	Pros
• Declining health of fresh water bodies particularly in terms of nutrient concentrations and health for aquatic organisms • Loss of biodiversity – the Waikato has seen considerable biodiversity loss and although the rate of loss has slowed biodiversity is still in decline. • Availability of water - Competition for water will be a future issue. A significant proportion of Waikato's surface water resources are fully allocated meaning that there is little available for additional users. • Health of rural soils – Although the soils of the Waikato are generally of good quality, they are declining in quality • Contamination of rural soils – in some parts of Waikato cadmium is accumulating in rural soils. This has the potential to limit future uses of these soils.	• Good quality soils – the soils of the Waikato are generally versatile and some of the best quality nationally • Climate – the Waikato has a mild climate that supports the high levels of primary production within the area • Renewable electricity resources – the Waikato is rich in renewable electricity resources including hydro-generation and geothermal generation • An extensive and varied coastal environment Improving collaboration amongst relevant agencies to improve our knowledge of resources including the coastal and marine areas, natural hazards and biodiversity

Key resources for further reading:
http://www.mfe.govt.nz/publications/about-us/four-year-plan-2016-2020 http://www.mfe.govt.nz/publications/rma/way-forward-national-direction-2016 http://www.mfe.govt.nz/publications/about-us/hitting-mark-our-strategic-plan-2045

Social

National	
Cons	Pros
• Inequities are prevalent in a number of areas: • Māori and Pacific peoples are performing less well across a number of social wellbeing. • Females continue to fall behind males in some domains such as Economic Standard of Living, while they are ahead of males in others such as Health. • Having a low income and low material wellbeing and living in an area of high deprivation result in relatively poor social wellbeing outcomes across most domains. Source for above: social wellbeing at a glance section in http://socialreport.msd.govt.nz/social-wellbeing-at-a-glance.html • Health and General Literacy issues	• The importance of measuring social indicators results in a variety of reports that provide organisations some understanding around areas requiring attention. Example: http://socialreport.msd.govt.nz/index.html • In 2014, the majority of New Zealanders rated their overall life satisfaction highly and felt that the things they did in their lives were worthwhile. • The rise of social media and population expectation. • Increased visibility of diversity and changing needs of the population. • Introduction of Bachelor of Health Sciences Māori (Nursing)

Local (Waikato)	
Cons	Pros
• Healthy Housing is a significant issue for many in our District. Example: 55% of Waikato's housing is pre 1980s (See p.52 http://www.waikatoplan.co.nz/PageFiles/300/6_%20c)%20Social%20Wellbeing%20Report%20-%20December%202013.pdf) • There is still a tendency to apply 'solutions' using a one size fits all model, resulting in inequities amongst demographic groups. • Waikato, and the Midland region, is geographically spread creating extra cost with provision of care – and challenges to	• "In 2013, the Government introduced the Housing Accords and Special Housing Areas Act. Its purpose is to enhance housing affordability by facilitating an increase in land and housing supply in certain regions or districts identified as having housing supply and affordability issues. As of 2014, Hamilton has been included in the Appendix to this Accord which would allow special housing areas to be identified within Hamilton. However, no special housing areas have yet been identified (as of May 2015)." (See p.4 of the following report: http://www.waikatoplan.co.nz/PageFiles/300/6_%20b)%20Social%20Wellbeing%2

placing specialist staff in positions • Maintain cultural values and delivery through industry changes • Power dynamics within relationships are changing, our population wishes to be treated on an equal footing. • The Waikato DHB workforce diversity does not reflect the Waikato DHB population. • The population of Rural communities are not provided with medical professionals at this point.	0Addendum%20-%20May%202015.pdf) • There is a slow move towards understanding social capital as an outcome of social wellbeing and the benefits for government spend when investment is put into raising peoples social capital (such as reduced costs for the ministries of health and social development) • Proposed Waikato Medical School - Waikato DHB understands and is committed to the concept of rurality and the need to develop a workforce to meet population needs.

Māori Health inequity summary

- Inequalities in health tend to be highest for people living in areas identified as quintile four and five and these people are likely to experience lower life expectancy and higher rates of chronic conditions
- High numbers of the Māori population in our district live in areas identified as quintile four and five
- In 2012–2014, life expectancy at birth for Māori in the Waikato Region was 76.5 years for females (7.5 years lower than for non-Māori females) and 72.2 years for males (8.1 years lower than for non-Māori);
- The all-cause mortality rate for Waikato Māori was twice as high as the non-Māori rate during 2008–2012;
- Injury mortality was 85 percent higher for Māori than for non-Māori in Waikato. Males had higher rates of death from injury than females;
- Potentially avoidable mortality and mortality amenable to health care were 2.6 times and 2.7 times as high for Māori as for non-Māori in Waikato during 2007–2011;
- The all-cause rate of hospital admissions was 16 percent higher for Māori than for non-Māori during 2011–2013;
- Almost 5,200 Māori hospital admissions per year were potentially avoidable, with the rate 38 percent higher for Māori than for non-Māori. The ambulatory sensitive hospitalisation rate was 75 percent higher;
- The rate of hospitalisation due to injury was 19 percent higher for Māori than for non-Māori. Males had higher rates of admission than females
- The most common causes of injury resulting in hospitalisations among Māori were falls, exposure to mechanical forces, complications of medical and surgical care, transport

accidents, and assault;

- Rates of hospital admission for injury caused by assault were over 5 times as high for Māori females as for non-Māori females and 2.4 times as high for Māori males as for non-Māori males. Males had higher rates than females;
- Compared to non-Māori, cancer incidence was almost 50 percent higher for Māori females while cancer mortality was close to twice as high. For Māori males, cancer incidence was similar to that of non-Māori, while cancer mortality was two-thirds higher;
- Breast screening coverage of Māori women aged 45–69 years was 55 percent compared to 68 percent of non-Māori women at the end of 2014;
- Cervical screening coverage of Māori women aged 25–69 years was 60 percent over 3 years and 75 percent over five years (compared to 78 percent and 91 percent of non-Māori respectively);
- The rate of lung cancer was 4 times the rate for non-Māori, as was the mortality rate. Breast cancer incidence and mortality rates were both two-thirds higher for Māori than for non-Māori;
- During 2011–2013 Māori with diabetes were nearly 4 times as likely as non-Māori to have a lower limb amputated;
- Māori adults aged 25 years were 82 percent more likely than non-Māori to be hospitalised for circulatory system diseases (including heart disease and stroke) in 2011–2013;
- Waikato Māori were 28 percent more likely than non-Māori to be admitted with acute coronary syndrome, 43 percent more likely to have angiography.
- Heart failure admission rates were 5 times as high for Māori as for non-Māori.
- Stroke admission rates were twice as high for Māori as for non-Māori, as were rates of admission for hypertensive disease;
- Chronic rheumatic heart disease admissions were almost 6 times as common for Māori as for non-Māori, while heart valve replacement rates were just over twice as high;
- By September 2014, 66 percent of Māori girls aged 17 years and 64 percent of those aged 14 years had completed all three doses of the human papilloma virus (HPV) immunisation. Coverage was higher for Māori than for non-Māori;
- Rates of hospitalisation for serious injury from self-harm were similar for Māori and non-Māori among those aged 15–24 years during 2011–2013 but over a third higher for Māori than for non-Māori at ages 25–44 years;
- Māori aged 45 years and over were 3.8 times as likely as non-Māori to be admitted to hospital for chronic obstructive pulmonary disease.
- Asthma hospitalisation rates were 2 to 3 times as high for Māori than for non-Māori in each age group
- On average, 2,180 Māori infants were born per year during 2009–2013, 40 percent of all live

births in the DHB. Seven percent of Māori and six percent of non-Māori babies had low birth weight

- In 2013, two-thirds of Waikato Māori children aged 5 years and one-third of non-Māori children had caries
- At Year 8 of school, almost three in five Māori children and just over two in five non-Māori children had dental caries
- Māori children under 15 years were two-fifths more likely than non-Māori to be hospitalised for tooth and gum disease
- Māori were four-fifths more likely as non-Māori to be admitted to hospital for a mental disorder during 2011–2013. Schizophrenia type disorders were the most common disorders, followed by mood disorders.

Key resources for further reading:

- Vital signs report, community snapshot of Waikato District, Matamata-Piako, Hamilton

https://static1.squarespace.com/static/556f46bce4b02b07d0842cc7/t/5800196fb8a79b850d84e805/1476401672824/Waikato_Vital_Signs_Report_2016_lowres.pdf

- Over the next 20 years, the health needs of the Northland population will increase as a result of population growth and ageing. - http://www.northlanddhb.org.nz/Portals/0/NHSP_2012-2017_Full_Version.pdf
- Social capital is about the value of social networks, bonding similar people and bridging between diverse people, with norms of reciprocity (Dekker and Uslaner 2001; Uslaner 2001): http://www.socialcapitalresearch.com/literature/definition.html

Technological

National	
Cons	Pros
• "The National Infrastructure Plan notes that future demand for current communications infrastructure. This is due in part to the fact that New Zealand's copper network cannot be upgraded to provide the speed and capacity consumers expect in the medium term, and investment in wireless cannot provide a complete alternative in the short-term" (Windle, 2014) • Lengthy cycle between concept and acceptance or prevalence of innovations in the health environment	• IT advances mean New Zealanders will be able to receive treatment closer to home – using the services that are available in their community. For example, videoconferencing is already allowing some doctors to carry out 'virtual' ward rounds, which then means people can go home from hospital sooner because they can be supported by a virtual care team or monitored by a specialist via a videoconference. (Ministry of Health, 2013) • Sixteen DHBs are now using eReferrals, and the other four are introducing them. By 2014, all DHBs will have an eReferrals system. More than 40,000 eReferrrals are being sent around New Zealand each month. (Ministry of Health, 2013) • High level of acceptance amongst many groups of technology for example high proportion of smart phone users • Introduction of free UFB connections for all NZ residential properties
Local (Waikato)	
Cons	Pros
• "There is a significant gap between broadband availability, services, speed and quality in urban and rural areas within the Waikato." (Waikato Regional Economic Profile, 2012. p. 70) • There is exponential growth and an education gap for some staff who need to now master technology as well as health changes.	• "Throughout the Waikato Region (and nationally), fibre optic cables are increasingly being installed while new mobile phone networks and extensions to broadband networks are underway. In addition, telecommunication and information transfer infrastructure are undergoing major technological change and regulatory reform." (Windle, 2014) • Growing network of technology innovators based in the district • Increased interconnectivity. • Addition of Smart Health to the Waikato DHB Portfolio.
Key resources for further reading:	
➢ Tech threatening privacy: http://web.simmons.edu/~chen/nit/NIT'96/96-025-Britz.html (good reference list)	

- Nanopore sequencing: https://nanoporetech.com/applications/dna-nanopore-sequencing
- http://www.mbie.govt.nz/info-services/science-innovation/digital-economy
- See section 6.4 Telecommunications: http://www.waikatoplan.co.nz/PageFiles/300/7c%20%20Infrastructure%20Inventory%20-%20December%202013.pdf

Economic

National	
Cons	Pros
• Risks of depopulation of our rural communities. **Ref:** http://www.salvationarmy.org.nz/sites/default/files/uploads/20150904SA_Mixed_Fortunes_Booklet_Web_v2.pdf • Health has become a bit of a marketplace. What will be the affordability in the future of investment into health, will the same interventions be available. • An increase in student loan interest may deter people from studying. • An aging population affecting the future tax base • The rise in cost for private health insurance making it unaffordable for many increasing the load on the public service.	• When funding availabilities change, organisations can take the opportunity to work differently for solutions rather than spending money on solutions. **Example:** 2007 Global Financial Crisis, some organisations moved all staff to a short work week so no redundancies had to be made

Local (Waikato)	
Cons	Pros
• The National context impacting on the local. **Example:** House prices rising in Auckland area, bubble shifting to Hamilton and greater Waikato area, may have impact on mean household income and population numbers. • Waikato DHB diverse geographies can create challenges when delivering health and care services that will be effective and efficient. Following sourced from Economic wellbeing report: Economic inequalities across the region. • Encouraging greater innovation and value-added in key industries. • Difficulty projecting positive image nationally and internationally. • Relatively weak performance on measures of visitor attraction, which is also important for attracting and	• Sizeable contribution to national economy. • National strength in a number of industries, such as dairy, meat and horticulture, forestry and wood products, related manufacturing and services, electricity generation and minerals. • Relatively high industrial diversity and value chains across the region. • A broad range of organisations and infrastructure to support innovation. • Significant natural amenities and economic benefits from natural resources. • A good quality road and rail transport network. • A nationally significant juncture for freight and transport, and has good connections to large and growing populations in Auckland and Tauranga. Above points all sourced from Economic wellbeing

retaining skills and business. • Weak linkages between research and education organisations and industry. • A range of skills constraints. • Managing water and soil demands and the environmental impacts of natural resource use. • The population of Rural communities are not provided with medical professionals at this point adding additional cost.	report: http://www.waikatoplan.co.nz/PageFiles/300/4_%20c)%20Economic%20Wellbeing%20Report%20-%20December%202013.pdf
Key resources for further reading:	
Waikato Economic: http://www.waikatoplan.co.nz/PageFiles/300/4_%20c)%20Economic%20Wellbeing%20Report%20-%20December%202013.pdf	

Legal

There are a number of laws that relate to the priority, however it was determined that these are not as simple as a positive or negative. The team decided to look at thoughts and questions, and include a list of resources for further reading.

National	
Cons	Pros
• Increased focus on privacy within the industry • Increased focus on compliance within the industry.	• In Aotearoa / New Zealand such legislative changes are epitomised in the Health Practitioners Competency Assurance (HPCA) Act (2003). As the name infers the intention of this legislation is to ensure public safety by requiring the life-long competence of a wide range of health practitioners (pg. 41) (Duke, Conner & McEldowney, 2009)

Thoughts and Questions

- Probity, privacy, procurement laws can hinder innovation as well as protect innovation
- Legal compliance creates a trust environment, which can allow for innovation to be encouraged
- Are there local or regional council plans or bylaws that hinder innovation in health and care services
- Political/Legal – to allocate (Anderson, Scrimshaw, Fullilove, Fielding & Normand, 2003)

National Standards for Culturally and Linguistically Appropriate Services in Health Care

In March 2001, the Department of Health and Human Services' Office of Minority Health published national standards for culturally and linguistically appropriate services (CLAS) in health care. The CLAS standards (Table 2) were developed to provide a common understanding and consistent definition of culturally and linguistically appropriate healthcare services. Additionally, they were proposed as one means to correct inequities in the provision of health services and to make healthcare systems more responsive to the needs of all clients. Ultimately, the standards aim to eliminate racial and ethnic disparities in health status and improve the health of the entire population. The healthcare interventions selected for this review by the Task Force on Community Preventive Services (the Task Force) complement the recommended CLAS standards for linguistic and cultural competency by assessing the extent to which meeting some of these standards results in improved processes and outcomes of care.

Key resources for further reading:

- Check this article https://www.technologyreview.com/s/526401/laws-and-ethics-cant-

keep-pace-with-technology/

- Clinical ethics and law https://depts.washington.edu/bioethx/topics/law.html
- TECHNOLOGY AS A THREAT TO PRIVACY: Ethical Challenges to the Information Profession http://web.simmons.edu/~chen/nit/NIT'96/96-025-Britz.html
- Legal, Ethical, and Financial Dilemmas in Electronic Health Record Adoption and Use: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3065078/
- Overview of Legal and Ethical Issues in Health Care: http://www.merckmanuals.com/en-ca/home/fundamentals/legal-and-ethical-issues/overview-of-legal-and-ethical-issues-in-health-care
- Ethical and Legal Issues in Interactive Health Communications: A Call for International Cooperation: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1761840/
- New England journal of health articles (lots of articles): http://www.nejm.org/medical-articles/health-law-ethics-and-human-rights

SWOT ANALYSIS – WAIKATO DHB

STRENGTHS

Waikato DHB

- Provides both secondary and tertiary services (such as highly complex surgery) to the Midland region, giving people in the region easier access to more advanced healthcare and giving the DHB access to a wider market. (Waikato DHB, 2014)
- Provides funding to a huge range of health services and establishments (such as Thames hospital, Waikato hospital. (Waikato DHB, 2014)
- Staff opinionated? (certain staff are opinion makers/influential to other staff members)\
- Infrastructure is in place to support geography of the Waikato DHB catchment
- Existing relationships with Midland DHBs to facilitate IDFs and treatment
- Existing relationships with Midland DHBs to facilitate opportunities for standardisation, shared approaches and new initiatives
- Existence of siloes or “guilds” in professional areas that create a sense of belonging, pride and achievement
- Knowledge and expertise of staff
- Passion to improve patient outcomes
- Desire to, where appropriate, utilise co-design methodologies to optimise healthcare outcomes
- Level of consultation required to design, develop and implement change
- Increased focus and move towards person centric services
- New Waikato DHB strategy provides clarity of strategic direction
- Commitment by Governance and Management to implement strategy
- Adjustments to professional training to provide improved care of individual needs

PPP 1.4 - Enable a workforce to deliver culturally appropriate services

- Commitment from the wider organisation to values and beliefs, accountability and responsibility are being described and built into things such as job descriptions and orientation
- We have a strong base with professional values.

- There is an understanding from education providers that culturally appropriate services are built into training.
- We have a cultural competency framework in place (TPO).
- Recognition of the need for changes to the way we provide services, to all of our population (external and internal).
- Need for radical change has been identified and prioritised within the strategy
- Pockets of cultural support for staff currently exist
- Funding has been made available for Maori and Pacific opportunities
- Value workshops are available throughout the organisation including the executive level
- Waikato Hospital is the heart of the Kingitanga
- Staff are adaptable to supporting patient needs in a culturally appropriate way.

WEAKNESSES

Waikato DHB

- Around 60% of the 394,000 people that live in the Waikato DHB area live rurally, making it difficult to give everyone consistent and appropriate healthcare. (Waikato DHB, 2016)
- Change in board disrupts process of having strategy implemented
- Certain staff are opinion makers/influential to other staff members
- Existence of siloes or "guilds" in professional areas that create a sense of belonging, pride and achievement
- Responsiveness to cultural diversity of patients
- Ability to meet and optimise healthcare outcomes in line with cultural considerations and norms
- Ability to balance the tension of long term gain and goals with short term "survival" and "functionality"
- Cynicism and change fatigue - in places
- Mismanagement of previous changes/inability for change to be implemented and sustained.
- Technology infrastructure operates at a "less than current" level
- Level of consultation required to design, develop and implement change
- Shortage of some professional resources and limited ability to recruit in a competitive market
- Fundamental differences between existing and modern/proposed management and organisational practices (eg strategy as an active and agile tool that is constantly reviewed, traditional professional cultures and norms that do not dovetail with evolving and current models of organisational behaviour)
- Professional and generational ingrained cultural traits that are not aligned with desired or required cultural traits (eg bullying, flexibility of work arrangements, move to provide more agile services (nurse-led clinics etc))
- Limited ability to carry out cost benefit decision making
- Limited ability to measure and quantify non-financial benefits
- Acknowledgement of cost cutting proposals and the impacts and flow on effects on the level and standard of service delivery
- Some staff are adept at working around rules and processes that they want to avoid
- Staff have a lack of awareness of what we do poorly

- Innovation is not currently embedded in performance management, job descriptions etc
- Limited celebration and recognition of innovative approaches
- Hospital centric, and Waikato hospital in particular
- Waikato centric – when working with Midland DHBs
- Lack of communication/understanding on the shop floor of changes
- Staff are marginalised and made to feel bad if they do not hold mainstream health beliefs, for example vaccinations, fluoride

PPP 1.4 - Enable a workforce to deliver culturally appropriate services

- We are not enabling our staff to attend cultural training. Service will always have priority over education.
- It is part of our current culture that our own belief sets are allowed to be exposed.
- There are no consequences for poor behaviour
- Whilst there is cultural competency framework in place it is not practiced
- There is no equal status given to cultural and clinical competency
- We do not understand how the treaty underpins the work we do. We lack confidence to say we don't understand and worry we will insult others.
- We lack confidence to be vulnerable and concerned
- Orientation is not consistent across the organisation, there are many different versions making it difficult to demonstrate organisation values to new employees
- Our organisation is focused on output rather than outcome.
- Our organisation does not currently understand accountability, responsibility or professional cooperation.
- It is difficult to change innate behaviour
- Patients lack trust in our organisation.
- We have a blame culture within the organisation, even when we feel we are doing the right thing.
- There can be restriction placed on staff members to advocate for diversity.

OPPORTUNITIES

Waikato DHB

- Large advancements in technology give opportunity to the DHB to harness new tech and adapt it for more streamline, efficient and cheaper healthcare (DNA toothbrush) (Oxford Nanopore Technologies, 2016)

- https://www.waikatodhb.health.nz/assets/about-us/Engaging-with-our-communities/Youth-AoD/Waikato-Youth-AOD-youth-recommendation.pdf

- IT advances mean New Zealanders will be able to receive treatment closer to home – using the services that are available in their community. For example, videoconferencing is already allowing some doctors to carry out 'virtual' ward rounds, which then means people can go home from hospital sooner because they can be supported by a virtual care team or monitored by a specialist via a videoconference. (Ministry of Health, 2013)

- Improvement of relationships with partner organisations and strategic alliances (PHOs, NGOs, Providers, Ministry, Social Agencies etc)

- Increasing patient desire and engagement to manage their own health information and healthcare

- Desire to, where appropriate, utilise co-design methodologies to optimise healthcare outcomes

- Ability to learn from other organisational successes and failures – particularly the ability to share and collaborate within the public sector

PPP 1.4 - Enable a workforce to deliver culturally appropriate services

- New Zealand has an increasing diverse community with many different cultures.

- Culturally appropriate services will serve the population of Waikato more effectivily by positively influencing engagement with health services.

- Nursing has pioneered the way forward previously

- Application of learnt skills (doing)

- There are opportunities available to engage in cultural training.

- We need to provide staff with cultural protection when working outside of the organisation in cultural settings

- Staff don't know what they don't know, change the DHB profile for diversity.

- Enabling staff to advocate for diversity.

- Power dynamics are changing, making sure that cultural needs are in place.

- Supporting staff in clinical areas in a gentle and considerate way if they do not hold

mainstream health beliefs, for example vaccinations, fluoride.

THREATS

Waikato DHB

- 65+ age group is expected to increase by 52% between 2011/12 and 2025/26, meaning the DHB will need to adapt its strategies and health care system in order to combat the drastic change in patient age demographic. (Waikato DHB, 2016)

- Both locally, nationally and internationally life expectancy is increasing but health expectancy is not, meaning that we are living longer with poor health (chronic conditions)

- Outdated laws surrounding privacy and information services may hinder the process of harnessing new technology, as it may cross over with certain laws (ability of National legislation and compliance requirements to keep pace with exponential growth of technology and medicine impinging Waikato DHB ability to change/innovate).

- Inability to balance the tension of long term gain and goals with short term "survival" and "functionality"

- The need to balance needs of individuals against the greater good of populations and communities

- Current quality of relationships to drive innovation and implement change with partner organisations and strategic alliances (PHOs, NGOs, Providers, Ministry, Social Agencies etc)

- High need populations (cultural, age and decile) are generally less able to respond to and engage with healthcare service delivery changes; especially technology related

- Complexity of health issues is increasing

- Corresponding shift between transactional and creative responses that provide preventative and responsive solutions

- Increase in males that are selecting nursing as a career. The older population (over 85) are not supportive of male nurses.

PPP 1.4 - Enable a workforce to deliver culturally appropriate services

- There is prioritisation of service delivery over learning and development

- A lot of the learning and development is online and expectation that it will be done in own time.

- There is nervousness about cultural competency, driven by a lack of clarity.

- Learning is not valued.

- Cultural training is not valued and viewed as an "add on"

- Staff that are not taking up technology improvements and are not engaged with the

changing environment are getting left behind

- Lack of understanding and clarity from populations/communities and stakeholders due to complexity of environment, diversity of stakeholder groups and inability to reach/communicate with these groups
- Organisational tendency to be egocentric (inward looking not outward looking)
- Maori staff have to battle for correct cultural interaction bringing them into conflict with their colleagues and sometimes it is detrimental of their careers.
- Cultural differences relating to care and who is providing the care.

LITERATURE REVIEW – WAIKATO DHB

New Zealand - Staff Development

Māori Nursing Workforce Development – (Chris Baker, Nurse Co-ordinator Cultural Support, Waikato DHB, July 2016)

The Nursing Workforce Programme Governance Group (2015) identified Māori workforce as one of the key messages and set 2028 as the date for the Māori nursing workforce to match the percentage of Māori in the population. The group identified that this will require new and sustained efforts to grow the Māori nursing workforce and consider partnership and engagement opportunities with iwi, education providers and employers.
Over the past two decades, significant efforts have been made to grow the Māori nursing workforce. The table below shows the gains made in Māori participation in the nursing workforce since nursing ethnicity was first recorded in 1994. Over the last 21 years the annual rate of growth in Māori nurses was 16 percent compared with 4 percent for all nurses. This equates to an average increase of 127 Māori nurses per annum.

Growth of the Māori nursing workforce 1994–2015[1]

	1994	1998	2010	2013	2015
Māori nurses	780	955	2,858	3,279	3,448
Total nurses	28,122	31,869	45,526	47,751	52,729
% of Māori nurses	1.1%	1.9%	6.3%	6.9%	6.5%

However there is still a significant gap between the proportion of Māori in the nursing workforce and the proportion of Māori in the population. An extra 4252 Māori nurses are needed now to match the current proportion of Māori in the population, i.e. 16 per cent.
Māori nurses can help to reduce barriers for Māori patients and whanau and address cultural issues that may arise. Māori are our most vulnerable population and when cared for by Māori have higher expectations than they do of non-Māori health professionals providing health care. There is increasing evidence that highlights how Māori nurses bridge two worlds, practice differently and go beyond what non-Māori nurses would do (Wilson & Baker, 2012). By bridging two worlds Māori nurses advocate for Māori and may be put in positions where they have to defend Māori customary practices to colleagues, they interpret the movement between the two worlds for patients and families and their personal and professional cultural identities may be at odds with each other causing tension. By going beyond, Māori nurses extend their practice beyond that expected of other RNs, their cultural identity is source of commitment to improving Māori health outcomes and enables them to connect and relate to Māori patients and whanau in a way that other nurses cannot. Māori nurses practice differently by blending the world of Māori with the world of nursing, feel obligated to ensure cultural practices occur and support whanau cultural identity and collective responsibility.
Māori health and nursing practice frameworks support how Māori nurses integrate Māori practices into their practice to engage and connect with Māori patients and whanau in a culturally appropriate manner by sharing whakapapa and through whanaungatanga (Barton

[1] In 1994 nurses were asked to identify which ethnicity they most closely identified with. This may have had the effect of underestimating the number of Māori nurses. In 1996 the question was revised in line with census data collection were able to identify up to three ethnicities they identify with.

& Wilson, 2008; Durie, 1998; Lyford & Cook, 2005; Maloney-Moni, 2004; Simon, 2006). It is important to support and equip Māori nurses to meet the demands of Māori patients and whānau and avoid the risk of burnout due to extra expectations placed on them (Nursing Review, 2016)

Nurse Managers: Creating healthy workplaces - (Kia Tiaki Nursing, 2016)

The NZNO Nurse Managers New Zealand annual conference drew 110 delegates from across the country. Speakers included psychologist Nigel Latta on leading "difficult" people, and emergency medicine professor Mike Ardagh on how nurses run hospitals while doctors "mess them up". Held in Tauranga in November, the conference was organised by Tauranga hospital duty managers, led by Lynne Hansen, with the theme What's the Plan?

New Zealand - Health Care Customer

Building 'Super Diversity' - (Longmore, 2016)

Becoming a culturally competent health practitioner – (Duke, Conner, & McEldowney, 2009)

"Cultural competence is the term used for the development of skill needed in health discipline practitioners, for example nursing, medicine, social work, clinical psychology, occupational therapy, pharmacy, osteopathy, for working with clientele who come from cultures that differ from that of the practitioner. Cultural safety, a term developed in Aotearoa/New Zealand and currently used internationally, focuses on culturally safe care as a health outcome"

The beginnings of cultural safety in Aotearoa/New Zealand arose from concern about the health outcomes for the indigenous Maori population. In the United States and Australia, because of the drive to improve the health outcomes of marginal groups, specific agencies operate to assist organisations to develop policy and programmes for cultural competence.

"Cultural competence and cultural safety is also relevant to other groupings, for example, older people, people with specific gender or sexual orientation, religious beliefs, and disabilities. These groups all experience inequalities in health systems that tend to have a national mainstream orientation."

Although cultural safety includes the concepts of awareness and sensitivity like other international models of cultural competence, these have a different emphasis because of the underlying theoretical perspective. Cultural awareness includes difference in many contextual components - historical, economic, political, social and particular human factors. Sensitivity focuses on the student/practitioner learning to identify the assumptions and prejudices of their own culture, and learning to acknowledge, and become regardful of difference in other cultures.

Table 1. Summary of generic competencies which form a platform for the development of cultural competence Generic competency, outlined in Duke, Conner, & McEldowney (2009).

General Competency	Comment
The health professional, within reflexive practice, evolves:	
technical skills and empirical knowledge that keep the clientele physically safe.	The greater or lesser need for technical skills varies according to the nature of each health discipline.
own whole person development.	Understanding of their own personalities is important: personalities is important: how to nurture their strengths and use these in their professional encounters to enhance the therapeutic effect of their work.
understanding of self within their own cultural context and of others within their cultural contexts.	This includes knowledge of their cultural characteristics and those of the people they work with and how these are situated within power balances and imbalances. Moreover,it involves the need to appreciate the discursive and contestable nature of what informs reflexive practice. Critical appraisal and analysis with the outcome of 'learning to learn' is the essence of such a process.
emotional intelligence or metafeeling.	Within self awareness is the acknowledgement of emotions/feelings and how they are part of the negotiation process within a dialogue.
trusting relationships within a partnership with clientele and in the learning/teaching environment .	Central within these relationships is honouring the personal expertise of the clientele bought to the when a practitioner is seeking to understand the construction of their health situation. Such a process needs to be modelled in the teaching learning situation. This understanding begins a dialogue with the practitioner seeking out the expert-ise of the client and then offering their expertise and perspective on the situation. A response and counter response or negotiated dialogue then con-tinues within the partnership. Practitioner and teacher tact and discretion are at the heart of such a dialogue.
moral and ethical decision making.	Ethical practice seeks to discover what is good for the clientele in their everyday situations. It avoids any cultural stereotyping. Personal courage is often needed to confront their own prejudices and other injustices in the moral stance they take. Acting as change agent in negotiating the resources needed to achieve the desired outcome. Risk taking is often integral to this endeavour
creative synthesis.	Bringing together all the aspects of the situation and consciously seeking solutions that fit the clientele in their context is a creative endeavour
understanding of the structure and processes of the health care service.	All health services operate within a political environ-ment. The professional brings knowledge of how this service influences the context of encounters with clientele and with students of their professions.

When presenting a case for tracking their development of cultural competence and culturally safe outcomes at increasingly sophisticated levels practitioners will need evidence of attendance at education sessions that provide their theoretical and practical background. Provision of advancement in reflexivity skills and relational competence should be integral to this education. Foundational to evolving reflexivity and relational competence are opportunities for self-growth in a safe environment.

Evidence of practice advancement to the competent and proficient levels can be developed through sources such as practice exemplars or narratives, letters of affirmation from colleagues, clients and/or their families, and electronic sources, for example audio or video tapes. This evidence should demonstrate particular reflections and insights achieved regarding own positioning, the ethical and political nature of achieving culturally safe outcomes and efforts made to 'go the extra mile' when discerned as necessary to achieve such an outcome. Special attention to the ethical implications of obtaining consent from and maintaining confidentiality with service users is needed if using materials from practice situations.

Accepting that process oriented cultural competencies develop within generic competence will require a change in thinking and valuing of these generic skills. Such skills, often taken for granted, are consequently undervalued in relation to the highly technical advances in health care. Such juxtaposition in valuing undermines the development potential of relational skills into skilled know how and practical reasoning skills that foster authentic moral comportment in practitioners in the health services. In reality, these skills are more enduring than the limited life of technical skills.

Taken from Chapter 2 Literature Review in Master's Thesis: Articulation of cultural practice within a New Zealand nursing context (Chris Baker, Nurse Co-ordinator Cultural Support, Waikato DHB, 2013)

Patient expectations of nurses

Patients have certain expectations of nurses and they appreciate specific attributes and qualities in the provision of nursing care. Empathy and compassion expressed as kindness, joy, warmth, tenderness, smiling, a positive disposition, politeness and understanding, are perceived by patients as valuable attributes for the provision of high quality care (Irurita, 1999; Thorsteinsson, 2002). Reynolds and Scott (2006, p.226) define empathy as "the ability to perceive and reason, as well as the ability to communicate understanding of the other person's feelings and their attached meanings, is held to be a core characteristic of a helping relationship". Studies suggest that when nurses are empathetic this is likely to positively influence patient health outcomes, for example; more effective pain management, improved cardiac and respiratory function, and reduced anxiety (Gerrard, 1978 & Rogers, 1957, cited by Reynolds and Scott, 2000). Although patients expect that nurses have the technical skills and knowledge to provide competent nursing care, they also recognise that nurses' ability to communicate and develop caring and compassionate nurse-patient relationships, is critical to provide quality nursing care (Calman, 2006; Conway, Culbert, Gale, Coulden, & Tulloch, 1996; Shattell, 2004). Other studies (Blockley & Alterio, 2008; O'Connell, Young, & Twigg, 1999; Sorlie, Torjuul, Ross, & Kihlgren, 2006; Walker, 2002) support these findings. Willingness to go the extra mile, taking time to get to know the patient, being helpful, sharing their own life, using humour and being friendly, are seen as essential for patients (Blockley & Alterio, 2008; O'Connell et al., 1999; Walker, 2002). When patients felt listened to and seen as a person, and cared for by nurses who went 'the extra mile', they experienced reduced feelings of vulnerability (Blockley & Alterio, 2008). These critical attributes identified by patients and the establishment of quality nurse-patient relationships, underpin the concept of cultural safety. The principles of the Treaty of Waitangi and cultural safety provide a foundation and framework for nurses to engage with and work in partnership with Māori and other patients from different backgrounds, to promote self-management and independence and positively influence health outcomes. How nurses do this in their everyday practice, within the current environment and constraints, is central to the research.

Henry's (2008) exploration of the perceptions and experiences of Māori whānau (families) caring for technology dependent children at home identifies the importance of cultural support to assist families to negotiate the care they require. Key themes emerging from her research were 'care co-ordination', 'cultural values' and 'being heard'. Continuity of care was valued by families and the ability to negotiate partnerships with health professionals in some situations, was assisted by whānau or kaitiaki (Māori patient advocate). Parents gained strength from the cultural support provided by those working within health services as they also had an understanding of the internal networks and 'culture' of organisations involved.

Koea (2008, p.10-11) identified that Māori expectations are not dissimilar to other patient expectations:

> Overall, patients valued competence, warmth, honesty, respect, and a caring attitude in their health professionals. Cultural expertise was not mentioned, rather ability to meet patients halfway in terms of cultural needs and the ethnicity of the health professional was less important than the qualities they demonstrated. Poor

experiences of Māori in the health system arose when professionals were not perceived as responsive or caring to either patients or their whānau.

Patients place high expectations on how nurses behave when interacting with them, their attributes and their communication skills. The nurse-patient relationship is the foundation for the provision of nursing care and the quality of this relationship can significantly influence the health outcomes of patients. The qualities and attributes nurses bring to developing effective therapeutic relationships with patients are enhanced by their understanding of power dynamics within nurse-patient relationships and their ability to reflect on this, along with their ability to effectively communicate with patients from culturally diverse backgrounds.

The nurse-patient relationship

The nurse-patient relationship is critical to achieve excellence in patient care. Therapeutic relationships are established when: patients perceive the nurse as friendly and helpful; nurses recognise the patient as an individual and enable them to express their needs; nurses provide information to promote informed decision making and; nurses assist patients to use their own resources to become independent and self-managing (Reynolds & Scott, 2000). Humanistic and relational nursing approaches (Christensen, 1990; Watson, 1997; Watson & Foster, 2003) underpin how nurses establish, maintain and conclude therapeutic relationships, work in negotiated partnerships with patients, families/whānau and communicate effectively (NCNZ, 2007). A holistic approach to care enables nurses to individualise care by integrating psychological, social, emotional and spiritual needs, as well as physical needs to the plan of care. Humanism enables nurses to demonstrate caring with knowledge, sincerity, humility, empathy and caring (Coulon, Mok, Krause, & Anderson, 1996). Nurses recognise the importance of establishing and maintaining therapeutic relationships with patients and their families/whānau but find this challenging in current work environments. Staff shortages, increased workloads, the need for increased productivity to meet health targets, all challenge nurses' capacity to provide holistic individualised care and meet the expectations of patients, families/whānau (Clendon & Walker, 2011; F. Richardson & Macgibbon, 2010; S. Richardson, Williams, Finlay, & Farrell, 2009). However, despite these constraints, nurses are responsible and accountable for providing a safe and competent standard of care for all patients they care for, and this includes culturally safe care.

Effective nurse-patient partnerships are established when the nurse and patient are comfortable discussing problems, nurses recognise individual patient preferences, and care is managed with patients who are able to make informed decisions/choices for on-going care and treatment. Nurses and patients are partners in all aspects of care, where information/care/empathy is provided in a timely manner and patients have an increased awareness of their illness (Calman, 2006; Irurita, 1999; Reynolds & Scott, 2000; Thorsteinsson, 2002). However, communication can be the main barrier to the development of nurse-patient partnerships when cultural differences, language, literacy, lack of interpersonal skills, barriers to listening, power and lack of compassion, interfere with building a therapeutic relationship (Keatinge et al., 2002).

The literature of Māori patient experiences of health appears to focus more on the barriers to accessing health services (Bolitho & Huntington, 2006; Theunissen, 2011; Wilson, 2006, 2008) and the actions of the nurse, more than Māori patient expectations of health professionals when accessing services. Wilson (2006, p.xii) identified four strategies to improve the quality of Māori experiences of health care services and communication:

1. Promoting 'connecting' and 'relating with indigenous patients and their families through positive strategies and an individualised approach to establish trust.

2. Maintaining the integrity of the indigenous person and their family by respecting their worldview and incorporating their knowledge and healing practices.

3. Facilitating access and use of health services by creating an environment conducive to enabling informed choice.

4. Building on existing strengths by recognising the concept of resilience, the patient's life circumstances and the knowledge and skills they possess.

Key components of cultural safety are that nurses understand the importance of attitudes, recognise and understand the powerlessness of patients and the power of nurses, and the centrality of open-mindedness and self-awareness (Papps & Ramsden, 1996; Ramsden, 1993, 1994; Wepa, 2005). Cultural safety has a close focus on (NCNZ, 2011, p.6):

> Understanding that such power imbalances can be examined, negotiated and changed to provide equitable, effective, efficient and acceptable service delivery, which minimises risk to people who might otherwise be alienated from the service.

Cultural safety acknowledges nursing power as a social and cultural construct based on a long standing hierarchical tradition (Jeffs, 2001). It can be argued that the greater power implicitly sits with the professional in relation to knowledge and skills but the challenge is to acknowledge the respective power of parties in the therapeutic relationship including the family/whānau. When power dynamics are not acknowledged in the relationship this may be detrimental to health outcomes, particularly in relation to disparity and inequality (Richardson & Williams, 2007). Providing information in meaningful ways for patients to enable them to make informed decisions about their on-going care and treatment, may overcome this. Cultural safety calls for patients to determine that they have 'felt safe' when accessing health services which then places the locus of power on the patient. Empowerment of patients supports their self-determination and independence and also facilitates and encourages the patient as their own expert, to actively engage in their health care. Nevertheless, studies indicate that some nurses may not be willing to share their decision making powers or do not encourage patient and family input in the belief that the nurse 'knows best' (Henderson, 2003; Keatinge et al., 2002).

When the nurse and patient do not share a common language other factors such as personal space, time, body posture and language may also lead to mis-communication. Effective cross-cultural communication relies on the nurse's ability to establish rapport and trust with the patient by using a range of verbal and non-verbal communication strategies. For patients from CALD backgrounds, cross-cultural communication relies heavily on the availability and access to authorised interpreters. Mortensen (2010, p.13) suggests:

> Nurses who can use interpreters effectively, and communicate cross-culturally are more likely to elicit accurate information, ensure that the client [patient] understands the result of tests and screening, and provide the client [patient] with information and instructions on medications, treatments and follow up.

This implies that nurses play a key role in ensuring high levels of health literacy. Health literacy is an empowerment strategy that makes it possible for patients to understand health information provided, make informed health decisions, have increased control over their health, take responsibility for their decisions and feel confident accessing information and health services (Clendon, 2012). Clendon concedes that research shows that the average New Zealander has low health literacy skills and that Māori have lower health literacy skills than non-Māori. Low health literacy rates increases the likelihood of hospital admissions, increased access of emergency services, and incorrect medication compliance.

Cultural safety introduces a reflective model that "is effective at the individual, institutional and professional levels, and encourages identification of the assumptions and preconceptions that structure practice" (S. Richardson & Williams, 2007, p.703). Reflection allows nurses to consider clinical decision making and analyse their actions, their feelings and opinions and the effectiveness of the intervention itself (Taylor, 2006; Timmons, 2006). Nurses are also able to consider the broader social, cultural, political and professional issues related to their practice (Cooke & Matarasso, 2005). Tanner's clinical judgment reflective model (2006, p.204):

> ….emphasises the role of nurses' background, the context of the situation, and nurses' relationship with their patients, as central to what nurses notice and how they interpret findings, respond, and reflect on their response.

There is an expectation that nurses "reflect on their own practice and values that impact on nursing care in relation to the client's [patient's] age, ethnicity, culture, beliefs, gender, sexual orientation and/or disability" (NCNZ, 2007, p.9). The principles of the Treaty of Waitangi and cultural safety provide frameworks for nurses to reflect on their cultural practice when caring for Māori patients and patients from other cultural backgrounds. Reflection allows nurse to also reflect on their professional, ethical and legal responsibilities, this includes support for patient autonomy.

Culturally competent health care (Jansen, Sorrensen, nzfp Volume 29 Number 5, October 2002)

New Zealand has an increasingly diverse community. With our community there are many unique cultures. The NZ health care system is grounded in the prevailing Western culture. The lack of cultural understanding between the prevailing health care system and many Maori and Pacific patients is reflect in the health disparities between Maori or Pacific people and Pakeha New Zealanders.

For Maori and Pacific groups cultural competence is just as important as the clinical competence of providers.

Culture has been described as the learned and share patterns of information that a group uses to generate meaning amount its members. These patterns encompass language, non-verbal communications, relationships with other people, beliefs and material goods. Within cultures the members share a belief in certain rules, roles, behaviours, and values. Concepts such as 'family', 'community', 'wellness' and 'illness' are different for various cultures and the meanings of these are contained within the language and customs of each culture. Culture shapes the individual's worldview and influences interaction with others, such as 'help-seeking' behaviours and attitudes toward health care providers.

<u>Culturally competent health care</u>
Culturally competent health care has been defined as:
A set of academic, experiential and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on the values, traditions, and customs of other cultural groups, and to work with knowledgeable persons from other cultures in developing targeted interventions, communications, and other supports.

Having a health care provider that is both understanding and understandable to the patient has consistently been shown to predict patient satisfaction and the acceptability of treatment.

The lack of cultural concordance between Maori or Pacific patients and predominantly Pakeha health providers suggest that a key factor in improving access to care, adherence to treatment and outcomes is to develop the cultural competence of health care providers.

Culturally competent care begins with community involvement. This will meant that Maori and Pacific (or other ethnic groups) are to be included at all stages of service development, including staff training, policies and resource materials development, complaints processes, assessments of patient satisfaction, relationships with Maori and Pacific providers, and also with evaluations and planning for service improvements.

Collecting and reporting demographic, epidemiological and clinical outcome data by ethnicity is the first step to making improvements to services for Maori, Pacific and other disadvantaged groups.

Maori views of cultural competence

The Maori worldview places greater emphasis on group consensus than Pakeha culture and the Maori view of health incorporates a steady-state where personal well-being is integrated with spiritual, family, community, social, and mental well-being. Key to this integrated sense of well-being are concepts as whakapapa – an understanding of the past and community connections and the concepts of tapu and noa – a balance between the profane and the ordinary that guides daily living.

Culture al competence for Maori requires that providers have a willingness and ability to draw on the values, traditions, and customs of Maori, and to work with kaumatua and other knowledgeable persons from Maori communities in developing targeted interventions, communications, and other supports for health.

Skill requirements, needs and methodology

1. Values, staffing and training – Maori providers. Alternatively providers with appropriate training and empathy for the cultural background.
2. Community involvement – Maori involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training and treatment planning.
3. Language and resource materials – Concepts of illness and health are encapsulated in Maori language and customer (te reo and tikanga)
4. Data collection – Ensure that the client's self-identified ethnicity (including all iwi and hapu that are relevant to the individual) is included in patient information management systems, as well as any patient records used by staff.
5. Complaints – Develop structure and procedures to address complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services.
6. Assessments and satisfaction – undertake ongoing organisation self-assessments of cultural competence.
7. Relationships with Maori providers – Maori providers can provide valuable linkages between communities, patients and providers in the prevailing health system.
8. Evaluation and improvements – Complete and make available reports documenting the organisation progress with implementing these criteria.

Cultural competence is to be regarded as a quality journey in which the results of all of the points noted above are integrated into a cycle of continuous service improvement that will make culturally competent care available to Maori.

Pacific views of cultural competence

Sixty per cent (60%) of Pacific people residing in New Zealand are New Zealand born, with a median age of 11.4 years.

There is an ongoing tension between adapting to change and retaining traditional values, lifestyles and attitudes.

Most Pacific cultures regards the extended family structure as central to the way of life and identity is often reinforced through family or kinship relationships, village and island. Spirituality is a fundamental component to most Pacific culture…. The church remains an integral part of most New Zealand Pacific communities.

Service delivery gaps are more often due to a lack of information, training and skill development rather than an unwillingness to become more responsive. It is critical therefore to develop a systematic approach to supporting providers, to improve services that can deliver better outcomes.

1. Values, staffing and training – Developing programmes that develop skills and an understanding for the cultural background.
2. Measuring cultural competency – Developing standards and measures of cultural competency is an important step on the journey.
3. Programme policies – Strategic plans, goals, policies and procedures will identify key areas for implementation that will be measurable in improving health status and maximising health gain for Pacific people.
4. Community Engagement – It has become clear that individual health is closely linked to community health; community health is profoundly affected by the collective behaviours, attitudes and beliefs of everyone who lives in the community. Partnerships can be an effective tool in improving health in Pacific communities.
5. Language and resource materials – are the cornerstones of maintaining cultural integrity. Therefore the support and promotion of ‘first languages’ is an important principle. The interpretation of cultural perspectives with regard to illness and health is also an integral component of diagnosis and treatment plans.
6. Data collection – data will be collected that will identify ethnicity.
7. Complaints – A key principle will be the approach of utilising the complaints and feedback system as a quality improvement mechanism. Flexibility should be a key feature that will allow tradition Pacific custom to be applied where necessary.
8. Assessment and satisfaction – undertake ongoing organisation self-assessments of cultural competence.
9. Relationships with Pacific providers – provide valuable linkages between communities, patients and mainstream providers.
10. Evaluation and Improvements – document the organisations progress with implementing these criteria.

Knowledge of the cultural identity and of the preferences of individual patients is essential to treatment of that individual.

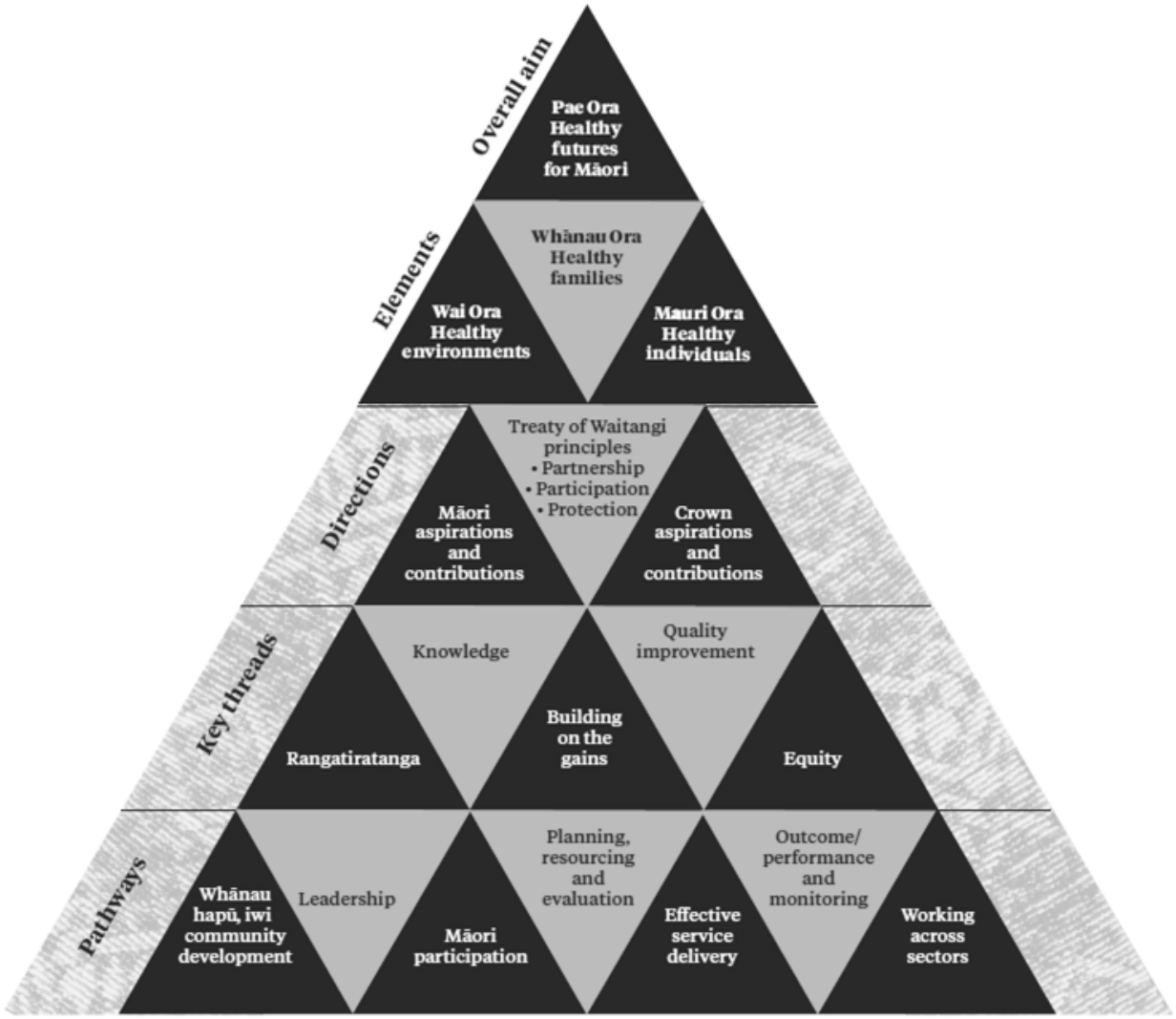
Consistent collection (and review) of ethnicity data in an approved manner underpins the delivery of culturally competent health care to individuals and communities.

Cultural competence requires a commitment to continuous improvement through continuing educations, review and feedback in the same way that clinical competence does.

He Korowai Oranga – Ministry of Health, 2014 (http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga)

As New Zealand's Māori Health Strategy, He Korowai Oranga sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori.

The strategy was updated with input from across the sector during 2013/14 to ensure its relevance for the future. Pae Ora (Healthy Futures) is the Government's vision and aim for the refreshed strategy. It builds on the initial foundation of Whānau Ora (Healthy Families) to include Mauri Ora (Healthy Individuals) and Wai Ora (Healthy Environments).



A living, web-based strategy

He Korowai Oranga is a living strategy. Updating this website with evidence, data and case studies will be integral activities in its second decade. Over time, this web-based strategy will become a 'hub of innovation' for Māori health.

You can access information on the aim, elements, key threads and pathways of the He Korowai Oranga framework using the diagram above. Over time, this information will be updated.

A downloadable Guide to He Korowai Oranga – Māori Health Strategy is also available.

The overarching aim: Pae ora – healthy futures

Pae ora is the Government's vision for Māori health. It provides a platform for Māori to live with good health and wellbeing in an environment that supports a good quality of life. Pae ora encourages everyone in the health and disability sector to work collaboratively, to think beyond narrow definitions of health, and to provide high-quality and effective services.

Pae ora is a holistic concept and includes three interconnected elements: mauri ora – healthy individuals; whānau ora – healthy families; and wai ora – healthy environments. All three elements of pae ora are interconnected and mutually reinforcing, and further strengthen the strategic direction for Māori health for the future.

The three elements

Mauri ora – healthy individuals

The concept of mauri ora captures the importance of the individual. It sets the direction for the health system to ensure that Māori, as consumers of health services, have pathways to care that meet their immediate needs as well as their future needs across all stages of life.

Achieving mauri ora will mean that individuals have good health and that the health system works to ensure that the way it delivers services across the continuum, from prevention to treatment, is appropriate for Māori at all ages.

Whānau ora – healthy families

The concept of whānau ora is about supporting Māori families to achieve their maximum health and wellbeing. Whānau ora is driven by a focus on whānau being self-managing, living healthy lifestyles and confidently participating in te ao Māori and in society. It is a key element of pae ora and is an important part of setting the foundations for healthy futures.

Each whānau is different and has a unique set of aspirations. To achieve whānau ora, the health system will work in a way that acknowledges these aspirations and the central role that whānau play for many Māori, as a principal source of strength, support, security and identity.

The health system can make a significant contribution to helping whānau to achieve these aspirations, particularly those related to their health and wellbeing. Whānau ora has been retained in He Korowai Oranga because it resonated strongly with the health and disability sector over the last decade and has led to some significant gains.

Whānau ora and Te Puni Kōkiri

Since the Whānau Ora Taskforce reported to the Government in 2010, the whānau ora approach has increasingly become a feature of work across government. The work of the Whānau Ora Taskforce informed a programme of work led by Te Puni Kōkiri to support whānau to build their capacity and capability, and empower whānau to determine their own aspirations and take control of their own futures. This work evolved to include the establishment of three whānau ora commissioning agencies to purchase a range of whānau-centred initiatives at a local level.

Working with Te Puni Kōkiri to support these initiatives is one way that the health and disability sector can support whānau ora, but it is certainly not the only way. As the work of the commissioning agencies grows, the health and disability sector will need to continue to consider how it can go about its business in a way that empowers whānau to achieve their own aspirations relating to health and wellbeing.

Wai ora – healthy environments

The concept of wai ora encapsulates the importance of the environments in which we live and that have a significant impact on the health and wellbeing of individuals, whānau and communities. Wai ora literally refers to water, both as a resource and as an essential part of the environment that provides sustenance for life. The concept reflects the need for Māori to have access to resources and to live in environments that support and sustain a healthy life.

Achieving wai ora will mean that the environment in which Māori, and all New Zealanders, live, work and play is safe. Wai ora also focuses on ensuring Māori have appropriate access to quality housing, safe drinking water and air, and healthy food, and that we are prepared for emergency events – for example, pandemics and natural hazards such as earthquakes. Dealing with the impact of climate change on health is also a focus for the future.

Wai ora is closely linked to the traditional realms of public health. It also reminds us that addressing the determinants of health, including poverty and education, is essential to improving outcomes for Māori.

Waikato DHB Annual Report 2015/16 – Our workforce at a glance (document available from Strategy and Funding – Waikato DHB)

Our workforce at a glance…(based on employee list as at 30 June 2016, includes all employees with Empl Status = “Active” and excludes parked employees and contingent workers):

As at 30 June 2016, Waikato DHB had 6,633 employees with 5,548.3 full time equivalents.

Employee diversity

New Zealand European is 53% of the workforce and Maori is 9%.

Ethnicity	Total	Percent
NZ European	3517	53%
International	2295	35%
Maori	597	9%
Pacific Islander	212	3%
Not identified	12	0%
Grand Total	**6633**	**100%**

Age range

The average age of all Waikato DHB employees is 45.5. The age range distribution is shown below:

Age range	Total	Percent
<26	434	7%
26-35	1352	20%
36-45	1384	21%
46-55	1689	25%
56-65	1481	22%
>65	293	4%
Grand Total	**6633**	**100%**

Employment status

The majority of staff are full-time (52%) and 45% are part-time. 3% of the staff are casual employees.

Employment Status	Full-Time	Part-Time	Casual	Grand Total
Administration/management	877	306	21	1204
Allied/technical	704	458	35	1197
Medical	605	148	7	760
Nursing/midwifery	1022	1902	134	3058
Support	225	184	5	414
Grand Total	**3433**	**2998**	**202**	**6633**

Non New Zealand - Staff Development

Culturally Competent Community-based Care (CCCC) (Kim-Godwin, Clarke, & Barton, 2001) **-** USA

"In the proposed Culturally Competent Community Care (CCCC) model, community-based care is viewed on a continuum from individual-focused health to whole community population-focused health and health care. " (Kim-Godwin et al. 2001)

Four dimensions of cultural competence are proposed. These dimensions are caring, cultural sensitivity, cultural knowledge, and cultural skills. (Kim-Godwin et al. 2001) (Williams, 2000)

Cultural knowledge refers to the understanding of culture specific beliefs and behaviours, and is the cognitive functioning or understanding of another's culture.

Cultural skills refer to abilities obtained in the areas of cultural assessment, advocacy and communication - connoting the roles and/or functions required in order to provide direct care to client families (community based care) as well as indirect care for populations (community and public health care).

Community health nursing refers to work that promotes health of the public.

Cultural sensitivity describes the affective aspect of care (respectful attitudes toward another's culture)

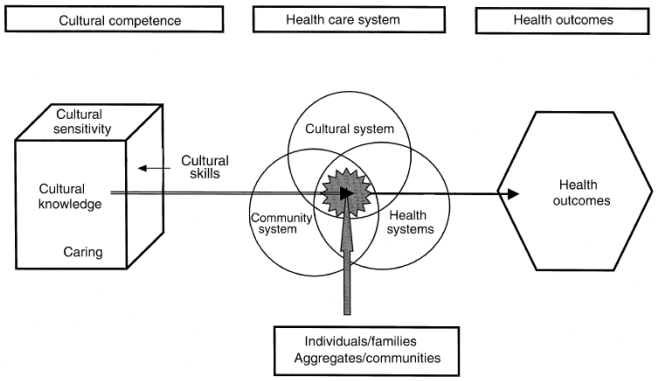


Figure 1 A model for the delivery of culturally competent community care.

Areas of dissonance within the community health care arena can occur at the intersection of the cultural system, the community system, and the health system. Culturally competent community health nurses are able to resolve issues between these systems by integrating these systems. For example, by showing understanding of the client's native cultural and health systems, nurses would be able to develop trust with the client who shows fear of existing community health services (Zoucha, 1998)

Also, culturally competent nurses can incorporate aspects of the client's cultural system in their care of the client, leading to client satisfaction and increased utilization of health care services (Smith, 1998). In addition, growing evidence has shown that sustainable change in health outcome is more likely if the community participates in a health initiative (Lindsey et al. 2001). By advocating on behalf of clients, nurses can motivate community participation. Therefore, intersections between cultural, community, and health systems are more likely to have positive health outcomes at the level of individual, family or community.

Community system

Traditional definitions of community systems have focused on geographical aspects of a locally based entity such as a city or specific neighbourhood. (Goeppinger H.J. & Schuster III, 1992). More recently, however, geographical location has become a secondary characteristic as community and public health professionals focus on specific aggregates (for example, HIV populations, elders, adolescents) (Baldwin et al. 1998). According to (Clark, 1996), a community is `a group of people who share some type of bond, who engage in interaction with each other, and who function collectively regarding common concerns'. The concept of `community as client' as the target of service has been the cornerstone of community health nursing (Association of Community Health Nursing Educators (ACHNE), 2000). In the CCCC model, community is defined as both `a cultural group and as the target of service'.

Cultural system

The cultural system is the most basic influence on people's lives. By shaping the group member's thinking, beliefs, actions, and communications (Hall, 1981), culture affects the health status of group members also. Furthermore, health beliefs, and practices, drive the evolution and direction of health care systems (Kleinman, 1980). Although some modifications in beliefs occur during the process of acculturation, many cultural groups in the USA have preserved their traditional health beliefs and practices (Andrews & Boyle, 1999). Thus, it is necessary for community and public health care professionals to be cognizant and trained in regards to culturally competent care.

Health system

Kleinman (1980) defines a health system as `illness beliefs, treatment choice, and outcomes of care of a group of people'. Thus, the definition of a health system in this model refers to culturally diverse clients' health beliefs, practices, and health status. In addition, cultural factors, health beliefs, practices, and health status are influenced by the personal background of a client, such as demographics (age, gender, education, income, and marital status), lifestyle, and the client's degree of acculturation.

Health outcomes

Health outcomes are the result of care in terms of what happens to the population living in the community as a result of culturally competent care. Smith (1998) identified seven positive outcomes of culturally competent health care, they are as follows: (1) feelings of empowerment and respect for health professionals; (2) decreased anxiety/fear of the health care system; (3) greater percentage of cultural group members seeking and receiving appropriate health care; (4) greater client satisfaction with health care services; (5) improved education experiences for health professionals; (6) improved health status of minorities; and (7) health care professionals who value and respect one another. Indicators of culturally competent care reflect positive outcomes in regards to community-based care (improved health for individuals and families) and community health care (improved health of populations).

The impact of cultural competence on health outcomes

As a first step in testing, in 1998, the authors interviewed eight community health nurses and surveyed five community nurse experts working with migrant farm workers in order to explore health outcomes of cultural competence. All 13 participants reported that culturally competent care resulted in positive health outcomes in their practice. Participants identified the following potential health outcomes of cultural competence: (1) increasing prenatal care visits; (2) higher rates of immunization; (3) increased number of migrants seeking health care; (4) reduced rates of morbidity and mortality; (5) increased compliance (taking medication); (6) improved trust in health staff; (7) increased reported feelings of self-worth; and (8) more interest in promoting health and preventing more serious diseases.

Communities have significant barriers for receiving quality health care, such as lack of health insurance, inaccessible `free' clinics, language differences, cultural conflicts with health care providers, and lack of trust. The proposed four dimensions of the CCCC model provide guidelines for community health providers when working with diverse communities. The future of health care depends on recognition of population diversity and creating humane sensitive services that are welcoming to all kinds of people.

A Model and Instrument for Addressing Cultural Competence in Health Care (Campinha-Bacote, 1999) - USA

This article discusses the ’process’ factor of cultural competence by presenting a model of cultural competence that health care providers and health care organizations can use as a framework for developing and implementing culturally responsive health care services. This article also proposes an instrument of cultural competence that will assist in the measurement and evaluation of cultural competence among health care professionals.

5 constructs make up the process, Cultural Awareness, Cultural Skill, Cultural Knowledge, Cultural Desire and Cultural Encounters.

Cultural Awareness is the deliberate, cognitive process in which health care providers become appreciative and sensitive to the values, beliefs, lifeways, practices and problem solving strategies of client's cultures. The awareness process must involve examination of one's own prejudices and biases toward other cultures and an in-depth exploration of one's own cultural background. These tasks are imperative as there is tendency to be ethnocentric regarding one's own values beliefs and practices. Without awareness there is a risk of cultural imposition.

Cultural Skill is the ability to collect relevant cultural data regarding the client health histories and presenting problems as well as accurately performing a culturally specific physical assessment. This process involves learning how to conduct a cultural assessment and culturally based physical assessments.

Cultural Knowledge is the process of seeking and obtaining a sound educational foundation concerning the various world views of different cultures. 'World view' defined as the way individuals or groups of people view the universe to form values about their lives and the world around them. The goal of cultural knowledge is to understand the client's world view.

Cultural Encounter is the process which encourages health care providers to engage directly in cross-cultural interactions with clients from culturally diverse back grounds. Often, meeting and learning from 3, 4 or even 10 people from a certain culture will still not reflect the stated beliefs, values, and practices of the specific culture. Therefore continuous immersion into other cultures is often extremely beneficial for fully understanding the views.

Cultural Desire is the motivation of health care providers to "want to" engage in the process of cultural competence. Although health care providers may possess all other qualities of the process, they must also possess the genuine desire and motivation to work with culturally different clients.

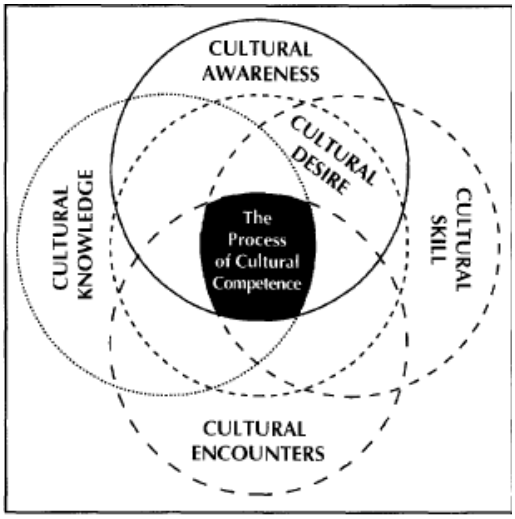


Figure. *The Process of Cultural Competence in the Delivery of Healthcare Services.* Reprinted with permission from Campinha-Bacote (1998a).

IAPCC – tool for measuring cultural competence.

Stands for: Inventory to Assess the Process of Cultural Competency

20 item instrument that measures the constructs of cultural awareness, cultural knowledge, skill, and encounters.

Culturally competent health care: aon consulting - (Hiles, 2010) - USA

Employers have become increasingly aware of health care disparities attributable to race, ethnicity, and socioeconomic status. However, they have been slow to address these disparities and are often hindered by measurement challenges and even debate about the return on investment associated with programs that explicitly recognize workforce diversity.

Actions to reduce or eliminate health care disparities share the same social justice argument as all diversity programs–i.e., they are the right thing to do. But when it comes to health care programs, reducing health care disparities offers employers an added benefit: a tangible and measurable way to lower medical plan spend and improve worker productivity.

"A health care disparity is substandard access, treatment, or outcomes based on racial, ethnic, or socioeconomic factors."

Health care disparities affect both the insured and uninsured. Minorities experience lower rates of many preventive services, higher incidence of disease, and often substandard treatment. The National Business Group on Health4 identifies the most common health care disparities for minorities as:

- Access to care - System structural and financial barriers prevent minorities from receiving high-quality care.
- Safe care - Minorities experience more medical errors with great clinical consequences.
- Evidence-based care - Minorities receive less evidence-based care and are less likely to receive preventive health services.
- Timely care - Minorities are more likely to wait for the same procedure.
- Efficient care - Minorities often have higher rates of emergency room utilization and hospital admissions as well as longer inpatient stays.

The Cost of Disparities

Employers who are committed to the goals of diversity and inclusion have a powerful social justice argument for addressing health care disparities (i.e., all participants in the health plan should have equal access and opportunity to receive quality, efficient care).

They also have a strong financial argument. A recent study by the Johns Hopkins Centre for Health Disparities Solutions, commissioned by the Joint Centre for Political and Economic Studies, used econometric modelling to calculate the direct and indirect costs of racial and ethnic disparities in health care in the United States. It estimated the cost for the period 2003 through 2006 to be $229.6 billion.

Health care disparities also act as an unseen tax on employee productivity and an accelerator of medical plan costs. Although the science is new and the financial impact varies significantly by employer, the same study found that 30.6 percent of the direct costs of medical care for blacks, Asians, and Hispanics was attributable to health care disparities—and this is not inclusive of the cost of lost productivity.

In a recent study of disparities for an employer-sponsored program by Aon Consulting, we found that the impact of disease burden and related purchasing efficiency varied across racial/ethnic groups. The data for four major diagnostic groups studied (asthma, back pain, coronary artery disease, and diabetes) indicated a clear pattern of blacks and Hispanics underutilizing physician office visits while being associated with significantly higher rates of emergency room utilization and inpatient admissions. For example, data for coronary artery disease and diabetes showed physician office visit utilization by blacks to be 7 to 12 percent below whites. Costly emergency room and inpatient admissions ranged from 38 percent to 70 percent higher for blacks as compared with whites.

When looking at disparities and calculating productivity loss and added medical costs, employers should examine such factors as size and cultural diversity of the workforce, relative pay level of employees, turnover, and geographic location. It is important to note that whether addressing disparities directly or through other quality initiatives, improving the quality of care can increase certain short-term costs. In many cases, this cost increase is offset by lower short-term costs in other areas.

Achieving Culturally Competent Health Care

For an organization to achieve Culturally Competent Health Care, it must address the employer's role as plan sponsor as well as the role of the health care system (and medical providers), and the interconnected role of community and family.

Culturally Competent Health Care is not a new diversity program. Rather, it is a new way to view the various roles and activities of the stakeholders within and around the health care system. With the individual at the centre, the broad context of Culturally Competent Health Care includes the employer, health care providers/system, and the community/family. The employer has an important role in all three areas.

- Employer - The employer can control development of the plan design and financing structure, creating access points to care, allocating work scheduling, etc.
- Health care providers/system - The employer can influence the health plan's selection of network providers, quality standards, results monitoring, and execution of health promotion and condition management programs. If the employer does not feel it can influence the health plan/vendor towards Culturally Competent Health Care, it can select other vendor partners to manage this aspect of the employee health and medical care program.
- Community/family - The employer can reach into the community to find and then support programs that promote culturally appropriate patient self-management, social networks, and recreational programs for children, and address environmental factors like neighbourhood immunization programs and condition support groups.

Six Steps for Employers to Achieve Culturally Competent Health Care

Employers can take a variety of actions to address health care disparities and deliver Culturally Competent Health Care to employees and covered dependents. Steps include:

Educate the senior leadership team and ask for their active participation. Without leadership, Culturally Competent Health Care may be trivialized as the "initiative of the month." Make sure your leadership team understands what is at stake for your workforce and the overall financial success of the organization. Visible engagement by the leadership team can mean the difference between success and failure.

Expand the benefits team to include expertise in cross-cultural issues. Add someone from the office of the Chief Diversity Officer to your benefits team, or get input from an external source. Reach out to employees directly, including leveraging your organization's existing diversity and inclusion programs through focus groups and/or surveys. Instead of confining your questions to the mechanics of the health plan, ask about job structure and location issues to gain insights into employment structure-level variables. Employees will know the problems and might even offer solutions.

Collect data on health care disparities. Uncover data with your vendors (direct and indirect sources) or by appropriately matching EEOC data with program participation, outcomes, and utilization results. Review recent health plan data to determine your primary cost drivers. This could lead to disease-specific initiatives (e.g., increasing minority participation in diabetes management programs) or working with your health plan to improve the cultural competence of their programs (e.g., auditing the program to collect baseline data and then working with the pharmacy benefit manager to implement programs to improve minority adherence to specific therapeutic regimes).

Learn what programs your vendors already have in place to uncover disparities, and consider an audit of current programs and vendor performance. Vendors are anxious to improve their cultural competence, and employers who show leadership in this area will have the opportunity to help shape vendor programs.

Look into your communities. Review community initiatives in areas of heavy employee concentration. Many states and localities already have programs in place. With a little research, you may be able to help your employees get connected to needed services.

Build a multi-year plan to eliminate disparities. As part of your overall employee health and medical care strategy, build a set of actions targeted to access, participation, and outcome disparities. Recognize that some disparities will be easier to address than others, and a multi-year action plan is required.

Execute your plan. Make use of all available levers, going beyond the direct actions you can take as an employer. First, address the disparities of greatest impact to your organization, including what your health plan providers/system (vendors) can do to address structural issues and provider disparities. Leverage the strengths of the community and family by improving awareness and access to initiatives. Build smarter rules around job and location to incent healthy behaviours. Finally, make an investment in society by participating in local, regional, and national programs to build standards and practices to eliminate health care disparities overall.

Hospital service quality preferences among culture diversity - (Wongrukmit & Thawesaengskulthai, 2014) **-** Thailand

This study proposes a new methodology to analyse hospital service quality. The new methodology was used at the largest private international hospital in Thailand. To understand differences in the perceived service quality among patients from different nationalities (Japan, Myanmar, Arabic States, and Thailand), a comparative analysis was conducted. An integration of a modified SERVQUAL scale and the Kano model was used to categorise and prioritise the hospital's service quality attributes. Analysis of variance was applied to differentiate market segmentation based on nationality, and a proposed importance analysis grid for improvement was applied to prioritise areas of improvements. The quality attributes showed a significantly different level among different nationalities. The results obtained by this research can provide important clues to improve the perceived service quality by offering different quality improvement strategies to meet different nationalities' needs.

How to improve service quality: Internal marketing as a determining factor - (Tsai & Tang, 2008) - China

The purpose of this study was to investigate the relationship between three internal marketing practices and service quality. This research adopts a cross-sectional design to examine the relationship between internal marketing and service quality with structural equation modelling. The result of the research clearly shows that there are significant positive relationships between internal marketing practices and service quality. In particular, the results of the present research demonstrate that training programmes have a strong association with service quality. However, the relationship from performance incentives to service quality was not found. Consequently, to deliver excellence service to patients, a hospital must provide training programmes and establish a clear vision about service excellence to nurses.

Motivational Interviewing 101: The manager's toolkit for helping frontline clinicians tap into patients' motivation to change - (Nursing Executive Centre) - USA

Look inside for:

- Manager's Cheat Sheet on Motivational Interviewing
- Primer on Motivational Interviewing for Frontline Clinicians
- Sample Scripting Using the OARS Framework
- Motivational Interviewing Role-Play Workshop

Nurses Cultural Conscience and Nursing Practice - (Zyga, 2011) - Greece

The prevalent immigration status and the appearance of new social groups re-defined the benefit of care provided by healthcare professionals, giving, in the past few years, particular emphasis on patients' cultural characteristics, which are taken into consideration during nursing evaluation. Therefore, in this "cultural diversity", the need for healthcare professionals' education is emerged, so that they will be capable to provide cross-cultural care always respecting patients' rights. Nurses with cultural conscience can provide suitable care in various cultural social groups.

Non New Zealand - Health Care Customer

The right to traditional, complementary, and alternative health care (Stuttaford, et al., 2014) - USA

"State parties to human rights conventions and declarations are often faced with the seemingly contradictory problem of having an obligation to protect people from harmful practices while also having an obligation to enable access to culturally appropriate effective healing**.** As people increasingly migrate across the globe, previous distinctions between 'traditional' and 'complementary and alternative medicine' practices are being transcended. There are connections across transnational healing pathways that link local, national, and global movements of people and knowledge." (Stuttaford et al. 2014)

Achieving cultural safety in Aboriginal health services: implementation of a cross-cultural safety model in a hospital setting – READ FULL ARTICLE FROM JOURNAL, A LOT OF GOOD EXAMPLES AND IDEAS. - Australia

Beyond traditional risk factors

The SLMHC (Sioux Lookout Meno Ya Win Health Centre) defines cross-cultural patient safety as the safe and successful delivery of healthcare services across cultural, linguistic and related barriers to the understanding and identification of patient/client needs. It includes overcoming the obstacles to implementing prescribed remedial or supportive actions. Cultural safety encompasses a broader set of constructs than conventional notions of patient safety, such as infection control, medication errors, adverse events, and other typical health service safety issues (see Box 1).

Box 1 Cross-cultural patient safety risk factors

1. Linguistic issues: the potential for miscommunication, misunderstanding of descriptions of symptoms and therapeutic intervention; limitations in language, idiom, vernacular and non-verbal communication
2. Cultural issues: the potential for misunderstanding the cultural context of the presenting pathology; the challenge of implementing a prescribed course of action in the face of contradictory worldviews, values sets, norms and mores
3. Medical literacy: varies among different populations, particularly where:
- native languages do not include medical or related terminology
- cultural or ethnic variations in access to and use of medical services impact on the effectiveness and outcomes of those services in reaching diverse populations
- patients are unable to navigate the system due to lack of familiarity

4. Programme or practice issues: where conventional services and practices contrast with traditional practices
5. Contextual or structural issues: the potential for misunderstanding or mishap due to cultural habits and associated knowledge
6. Systemic issues: disconnectedness between mainstream systems and specific population providers, including territoriality, overlaps, gaps due to differing approaches and jurisdictional differences, often involving access and availability issues
7. Genetics: the failure to take into account inherent issues in a population
8. Racism/discrimination: the manifestations of bigotry, prejudice or intolerance that result in the differential provision of services as a result of ethnic or racial factors

Developing a zone of cultural safety

The SLMHC has developed a conceptual model to guide us in transitioning both the organisation and individuals to a zone of cultural safety (see Figure 1). It charts the path towards cultural integration at the organisational level, and towards cultural congruence for the individual. It is primarily based on Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health (Nursing Council of New Zealand, 2005). It also draws upon the continuum of cultural competency for mental healthcare services developed by Cross et al (1989). This continuum sets out six stages, ranging from cultural destructiveness to cultural proficiency (Cross et al, 1989). Our developmental path identifies an institutional process of change from ‘them’ to ‘us’, in which the cultural safety zone begins with cultural awareness and ends with cultural integration at an institutional level.

In this model, marginalisation or power imbalance positions are reduced or eliminated by moving the organisation and participants to progressively higher levels of equity in health service access, service and quality. The development and deployment of sensitive remedial action and behaviour require an awareness of cultural diversity, inequity in service and treatment, and their underlying causes and relationships. In turn, culturally attuned

responsiveness builds on a foundation of cultural sensitisation and sensitivity. Cultural appropriateness depends on the ability and willingness of providers to respond with sensitivity, understanding and awareness. Cultural competence – that is, the ability to provide services in a manner that succeeds in large measure because of the acceptability to the client of the type of service and the manner in which it is provided – likewise builds on these foundations. Cultural congruence – that is, the individual internalisation of diversity-based values and understanding, and the consistent externalisation of equitable, value-based behaviours – is at the endpoint of the continuum with fully integrated practices and services at organisational level.

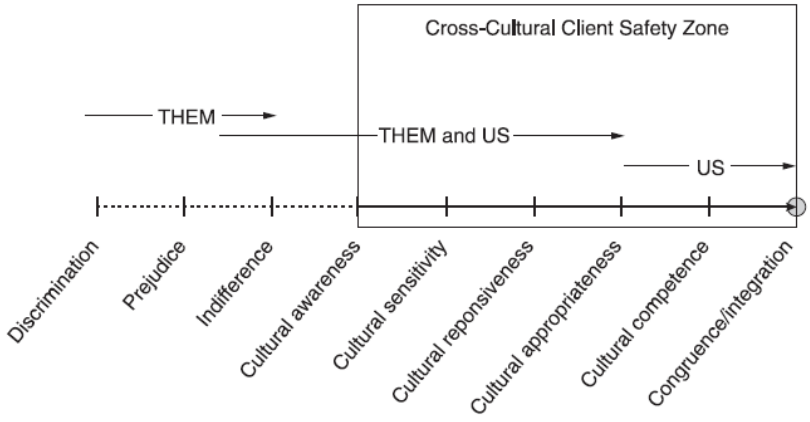


Figure 1 The continuum of cross-cultural client safety (Walker and Cromarty, 2006).

An investigation of culturally competent terminology in healthcare policy finds ambiguity and lack of definition – (Grant, Parry, & Guerin, 2013) - Australia

Are We Doing Enough to Develop Cross-Cultural Competencies for Social Work? - (Mlcek, 2013) - UK

Cultural competency in the delivery of health services for Indigenous people - (Bainbridge, McCalman, Clifford, & Tsey, 2015) - Australia

What Works

The limitations in the evidence base meant that it was not possible to draw definitive conclusions about the effectiveness of culturally competent practices and frameworks in providing health care benefits for Indigenous people. But there was both international and Australian evidence of its potential in a number of studies.

There were some studies that found that bringing together the cultures of health care organisations with Indigenous communities can improve access to health care for Indigenous Australians. This process involves health care organisations:

– consulting with Indigenous Australian health services and communities

– tailoring service delivery to the needs and preferences of specific communities

– embedding cultural competence within the health care organisational culture, governance, policies and programs.

• Education for health care students that incorporates cultural perspectives and experiences can improve health students' preparedness for working in Indigenous health and their future commitment to working for change.

– It can lead to more open attitudes, increased awareness, more effective advocacy, a preparedness to engage with Indigenous people, and a better understanding of Indigenous health issues.

– Field experience can also make an important and positive contribution to health students' perspectives.

• Several studies suggested that key to reducing health disparities for Indigenous populations was health care workers developing partnerships, eliminating bias through self-reflection, and building relationships with Indigenous people.

• Embedding cultural competency principles within legislation or policy (as has been done in the United States and New Zealand) is a strategy that could be useful across Australia's health systems as part of an ongoing commitment to Indigenous Australians and delivering culturally competent care.

• Internationally validated instruments that measure health service access and use, service quality, perceived discrimination, language barriers and trust of practitioners could be useful if tailored to Indigenous Australian health services.

What Doesn't Work

• Cultural awareness training is not enough in itself.

– While such training might be expected to impart knowledge upon which behavioural change will develop, it has generally not been enough when it is delivered in isolation or rapidly delivered over short timeframes.

• Program transfer and implementation without cultural-tailoring are ineffective.

– There are no homogenous approaches to developing and implementing cultural competence.

– Cultural competency programs that are successful in one context cannot be assumed to work in another.

– Programs need to be developed and delivered in partnership with and input from local Indigenous people.

VERY USEFUL INFO PAGE 11-18 – summary of findings for each piece of literature.

Cultural safety assessment of an urban Canadian hospital - (Gurm & Cheema, 2013) - Canada

In the region where the study was conducted, 38% of the population are immigrants (born outside of Canada), and 46% are visible minorities (City of Surrey, 2010). The most common language, in the region of the study, after the official languages is Panjabi. The result of these changing demographics may lead to more communication challenges and potential health disparities. The challenge for Canada's health professionals is to ensure that the

health care system responds appropriately to this growing diversity in population, and adopts culturally safe practices to provide efficacious care to clients.

The Agency for Healthcare Research and Quality in the United States (2006) noted the following disparities:

• Blacks received poorer quality care than Whites for 73% (16/ 22) of core measures. Blacks received better quality care than Whites for 9% (2/22) of core measures.

• Asians received poorer quality care than Whites for 32% (7 / 22) of core measures and better quality care for 36% (8/22) of core measures.

• American Indians and Alaska Natives received poorer quality care than Whites for about 41% (9/22) of core measures and better quality care for 14% (3/22) of core measures.

• Hispanics received poorer quality of care than non-Hispanic Whites for 77% (17/22) of core measures and better quality care for 18% (4/22) of core measures.

• Poor people received lower quality of care than high income people for 71% (12/17) of core measures and better quality care for 6% (1 /17) of core measures.

Based on these findings, recommendations include hiring more health professionals from minority populations and including cultural competency in educational programs.

Communication between patients and professional colleagues is important for effective assessment and treatment purposes. It is important for health care professionals to provide culturally safe care for populations of different cultures.

Practicing cultural safety ensures that health care staff becomes respectful of nationality, culture, age, sex, political and religious beliefs, and position. Health care staff should acknowledge that personal cultural beliefs and attitudes and privileged position have the potential, consciously or unconsciously, to influence the power balance with patients and colleagues.

Study Conducted in report

The purpose of this study was to determine if there is a variation between the policy of cultural safety as written and as practiced in a large (500 bed) teaching urban hospital on the west coast of British Columbia. The study sought to determine if there were any discriminatory practices based on diversity as judged by the recipients of the interactions, patients and staff. In addition, the intention of the study was to compare the diversity of patients and staff to that of the population of the surrounding communities.

Method

This study had a survey design that involved the administration of two instruments created to measure the cultural/ethnic background and discriminatory practices perceived by both patients and staff members of the hospital. An instrument that had been developed to assess the operations of the hospital previously was adapted for the current study. Two instruments were developed: one for employees and one for patients. The employee instrument contained 37 items for all employees and an additional two for managers related to copying of material into different languages and the budget for interpreters. There were 19 items related to demographic information as well as space for comments. The patient instrument consisted of 32 items including demographics plus space for comments. To assess the diversity and cultural safety of staff, instruments were distributed via the

hospital's user e-mails and bulletin boards to all employees. Employees were sent two email reminders to complete the survey during the time frame and posters about the study were placed in strategic locations throughout the hospital including elevators and washroom stalls. Staff was provided with a hyperlink to "Survey Monkey" where they could access and complete the instrument. Patients volunteered in all the inpatient units upon being approached by student research assistants. Instruments were left at the bedside of 132 patients along with a letter explaining the purpose of the survey. The instrument was left with the patients and four hours were allowed for completion. After four hours, the student research assistants returned to collect the completed instruments. All 132 of the patients who were approached completed the instrument. All data were analysed using the Statistical Package for the Social Sciences (SPSS Version 16). All instruments were administered over a two week period.

Results

Patient Demographics

The majority of these patients were female (67%). Their mean age was 49.9 years (range 16 to 92 years). These patients also represented a broad spectrum of highest educational achievement. Approximately 22% did not have a High School diploma while 31% had graduated from High School and 28% had some University or Technical school education. Majority of these patients (n= 132, 73%) reported they worked most effectively in English while another 17 percent preferred Panjabi and 10 percent reported they preferred "other" languages such as French. However, many of these clients were multilingual and together they spoke or read a total of 17 languages. Two hearing impaired clients reported, that they preferred to communicate in sign language. The patients were ethnically diverse, representing a total of 25 different ethnic groups. The demographics revealed the majority of patients identified themselves as Canadian (45.5%), East Asian (referring to East Indian, Filipino, Pakistani, Korean, and Japanese) (25%), and English (12.9%). Furthermore, the minority ethnic groups included German (6.1%), Dutch (3%), French (2.3%), Chinese (2.3%), and Fijian (2.3%). It is important to recognize that interpreting these results was difficult. For example, many Canadians whose predecessors came from India, self-identify as Canadian while others claim South Asian ethnicity.

Patient Data

To measure clients' perception of cultural safety directly, two questions were asked about experience of disrespectful or insensitive treatment while at the hospital and whether there were difficulties getting needs met. Half the patients (50%) indicated satisfaction with the hospital experience. The majority of the patients (90.7%) did not indicate experience with disrespectful or insensitive treatment. Some patients (7.6%) reported experiencing bias as a result of age (2.3%), while a smaller percentage of patients (1.5%) reported ethnicity as the main source of bias in their care. Just less than 20 percent of the patients reported difficulties getting their needs met (19.1 percent). As discrimination may be based on diversity factors, chi square analysis were performed to determine if there were greater than expected numbers of patients who experienced discrimination or difficulty getting their needs met compared with language spoken, ethnicity, age, education, religion and gender. The only significant findings were for patient age. Interestingly, younger clients aged less than the mean (50 years) reported significant ($p = .006$) disrespectful or insensitive treatment while at the hospital. It should be noted that one cell had only one person in it because 9 of the 10 clients who experienced disrespect were in the younger age category. When age and getting ones needs met were entered into the chi square the result was also significant ($p = .005$) with patients aged less than 50 years indicating their needs were not met.

NOTE ALSO CARRIED OUT STAFF TESTS, NOT INCLUDED IN REVIEW DUE TO LENGTH pg. 181

Discussion

There are multiple diversities amongst the participants: ethnicity, languages spoken, gender and age. Twenty-five different ethnicities were represented by the participants with 45.5% of patients and 55.7% of staff self-identifying as Canadian. About three quarters of patients indicated proficiency in English and about the same number of staff were most comfortable in English. The participant age varied from 16-93 with Language as an issue for about one quarter of the participants. Gender is over-represented by females (67%). Age range 16-92 is broad and reflects the adult acute inpatient units that were targeted. With such diversity, understanding and respecting beliefs, values and perspectives may be challenging. It is surprising that the only significant discriminatory factor for patients was age. This may be because interactions with health professionals are all in relation to health challenges and very focused on the physical symptoms of the patient. It may also be due to internalized oppression. Over time oppressed groups begin to believe negative stereotypes about ethnic groups and accept them as truths. The staff who responded generally did not feel discriminated against. Some identified colour (10.6%), gender (7.2%) and race (6.3%) as discriminatory factors.

Culturally safety requires three prerequisites: cultural awareness, cultural sensitivity and cultural competence. Given the diversity within the participants, it is not surprising that some feel culturally unsafe. When following this model, staff would need to become proficient across multiple diversities. Curricula in professional programs may not have the time to teach about the diversity within ethnic groups. From personal experience in nursing education, it is concluded that generalities about ethnic and gender diversities are transmitted. From studies done (Bacote, 2004; Gurm, Stephen, MacKenzie, Doll, Barroetavena & Cadell, 2006; Gurm, Lynam, & Dhari, 2000) it is clear that there is as much variation within a group as across groups. This poses a huge challenge in becoming culturally aware, culturally sensitive and culturally competent when each individual that you interact with may have a very unique culture.

Communication is important for all interactions and is shaped by culture and language. The patients stated that almost one fourth are not fluent in English and about one quarter of the staff indicated they are more comfortable in a language other than English. This may lead to inequities so the hospital has interpreters that can be booked by employees. The participants indicated that they are not satisfied with the interpreter services (ineffective: 18.3%; not effective in meeting patient needs: 34%). This may be due to the fact that the interpreters perform word for word translation and some words in other languages do not directly translate to English words, and it may be because the language of health is specialized and the interpreters are not aware of health terminology.

CONCLUSION

The population of Canada is becoming increasingly diverse as more people immigrate into the country. Diverse expansion of the population means that the concept of cultural safety needs to be understood more thoroughly by healthcare staff. This study reflects the importance of cultural safety in the healthcare environment. The findings revealed the presence of discrimination and equity issues within the hospital. This serves as motivation for the hospital to implement various strategies such as hiring diverse healthcare staff to meet the unique needs of patients. Moreover, education on cultural safety should be incorporated in hospital orientation for new employees to broaden their understanding around cultural safety and ways of assessing it in practice. Furthermore, this education can be included in professional healthcare programs such as nursing to prepare undergraduate

students in advance, thus allowing them to become culturally safe practitioners. The generalizability of the findings of this study is limited even though diversity issues are widespread around the globe. An important limitation in the study was that the hospital is located in a place that is very multicultural and is therefore prone to having such issues arise. Future studies on discrimination issues and equality barriers in other geographical locations are needed to further examine the prevalence of this issue in those settings and to analyse the initiatives, if any, that have been taken to resolve the issues. In addition, more research is recommended to help determine if discrimination issues are being addressed properly in response to the increasing diverse population in Canada. This study was an important step in providing an insight into the key issues of discrimination and inequity that exist due to the lack of awareness around the concept of cultural safety. With further investigation into these issues, unique strategies beyond the ones mentioned in this study can be developed to eliminate barriers to a culturally safe environment for both the healthcare staff and patients.

Culturally competent healthcare systems - (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003) - USA

Cultural and linguistic competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable effective work in cross-cultural situations. Culture refers to integrated patterns of human behaviour that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviours, and needs presented by consumers and their communities.

A culturally competent healthcare setting should include an appropriate mix of the following:

• A culturally diverse staff that reflects the community(ies) served,

• Providers or translators who speak the clients' language(s),

• Training for providers about the culture and language of the people they serve,

• Signage and instructional literature in the clients' language(s) and consistent with their cultural norms, and

• Culturally specific healthcare settings.

Racial and Ethnic Disparities in the Processes and Outcomes of Care

Differences in referral and treatment patterns by providers (after controlling for medical need) have been shown to be associated with a client's racial or ethnic group. Negative attitudes toward a person, based on that person's ethnicity or race, constitute racial prejudice or bias. Whether conscious or unconscious, negative social stereotypes shape behaviours during the clinical encounter and influence decisions made by providers and their clients. This phenomenon has been shown in the clinical literature. For example, differences between African Americans and whites in referral for cardiac procedures, analgesic prescribing patterns for ethnic minorities compared with nonminority clients, racial differences in cancer treatment, receipt of the best available treatments for depression and anxiety by ethnic minorities compared with nonminority clients, and differences in HIV treatment modalities, are just a few ways in which race and ethnicity can affect care. On the part of clients, delay or refusal to seek needed care can result from mistrust, perceived

discrimination, and negative experiences in interactions with the healthcare system. A recent Institute of Medicine report on unequal medical treatment noted: “The sources of these disparities are complex, are rooted in historic and contemporary inequalities, and involve many participants at several levels, including health systems, their administrative and bureaucratic processes, utilization managers, healthcare professionals, and clients.”

Table 2. National standards for culturally and linguistically appropriate services[4]

Preamble (excerpt)

The following national standards issued by the U.S. Department of Health and Human Services' Office of Minority Health respond to the need to ensure that all people entering the healthcare system receive equitable and effective treatment in a culturally and linguistically appropriate manner. These standards for culturally and linguistically appropriate services (CLAS) are proposed as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients or consumers. The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.

Culturally competent care

Standard 1. Healthcare organizations should ensure that patients or consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2. Healthcare organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3. Healthcare organizations should ensure that staff members at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Language access services

Standard 4. Healthcare organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient or consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5. Healthcare organizations must provide to patients or consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6. Healthcare organizations must assure the competence of language assistance provided to limited English proficient patients or consumers by interpreters and bilingual staff members. Family and friends should not be used to provide interpretation services (except on request by the patient or consumer).

Standard 7. Healthcare organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups or groups represented in the service area.

Organizational supports for cultural competence

Standard 8. Healthcare organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability or oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9. Healthcare organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10. Healthcare organizations should ensure that data on the individual patient's or consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11. Healthcare organizations should maintain a current demographic, cultural, and epidemiologic profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12. Healthcare organizations should develop participatory, collaborative partnerships with communities and use a variety of formal and informal mechanisms to facilitate community and patient or consumer involvement in designing and implementing CLAS-related activities.

Standard 13. Healthcare organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients or consumers.

Standard 14. Healthcare organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

This section briefly describes the conceptual approach and search strategy for interventions to promote cultural competence in healthcare systems. These interventions are designed to improve providers’ cultural understanding and sensitivity, as well as their linguistic acumen and comprehension, and to provide a welcoming healthcare environment for clients. Five interventions were selected for review:

• Programs to recruit and retain staff members who reflect the cultural diversity of the community served,

• Use of interpreter services or bilingual providers for clients with limited English proficiency,

• Cultural competency training for healthcare providers,

• Use of linguistically and culturally appropriate health education materials, and

• Culturally specific healthcare settings (e.g., neighbourhood clinics for immigrant populations or “clinicas de campesinos” for Mexican farmworker families).

We did not review organizational supports for cultural competence, such as policies and procedures for collecting information on race or ethnicity for accountability or incorporation into organizational performance improvement plans.

Analytic Frameworks

The conceptual model (or “analytic framework”) used to evaluate the effectiveness of healthcare system interventions to increase cultural competence is shown in Figure 1. Culturally competent healthcare systems provide an array of services for clients that accommodate differences in language and culture. Services such as interpreters or bilingual providers, cultural diversity training for staff members, linguistically and culturally appropriate health education, and culturally specific healthcare settings may improve health because of the following:

• Clients gain trust and confidence in accessing health care, thereby reducing differentials in contact or follow-up that may result from a variety of causes (e.g., communication difficulties, differences in understanding of health issues, or perceived or actual discrimination).

• Healthcare providers increase their ability to understand and treat a culturally diverse clientele with varied health beliefs and practices, thus improving accuracy of diagnoses and selection of appropriate treatment. The ultimate goal of interventions to increase the delivery of culturally competent health care is to make the healthcare system more responsive to the needs of all clients and to increase their satisfaction with and access to health care, decrease inappropriate differences in the characteristics and quality of care provided, and close the gaps in health status across diverse populations within the United States. For each intervention reviewed, the outcome measures evaluated to determine their success were

• Client satisfaction with care,

• Racial or ethnic differentials in utilization of health services or in received or recommended treatment, and

• Improvements in health status measures.

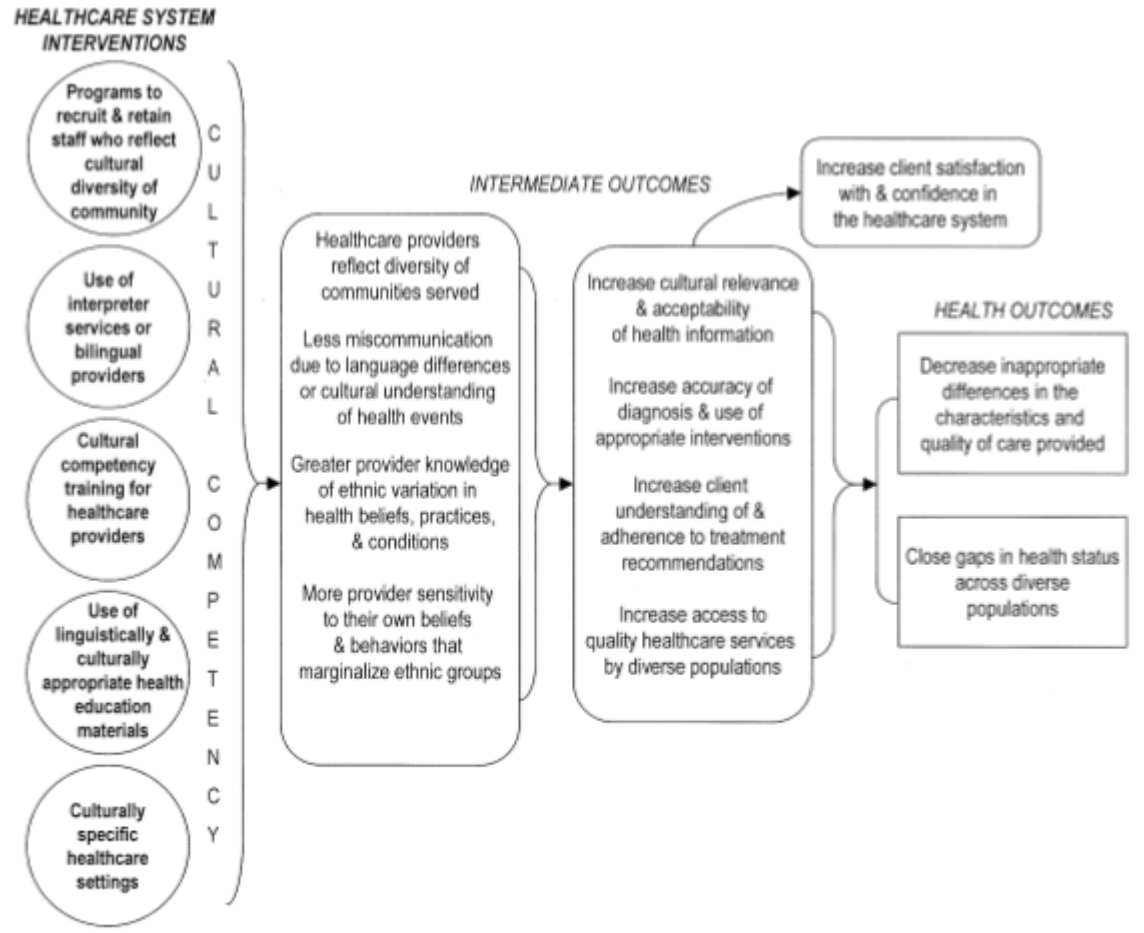


Figure 1. Analytic framework used to evaluate the effectiveness of healthcare system interventions to increase cultural competence.

Cultural Competency Training for Healthcare Providers

A person's health is shaped by cultural beliefs and experiences that influence the identification and labelling of symptoms; beliefs about causality, prognosis, and prevention; and choices among treatment options. Family, social, and cultural networks reinforce these processes. Cultural competency includes the capacity to identify, understand, and respect the values and beliefs of others. Cultural competency training is designed to (1) enhance self-awareness of attitudes toward people of different racial and ethnic groups; (2) improve care by increasing knowledge about the cultural beliefs and practices, attitudes toward health care, healthcare-seeking behaviours, and the burden of various diseases in different populations served; and (3) improve skills such as communication. We searched for studies that examined the effectiveness of cultural competency training programs for healthcare providers on improving outcomes of client satisfaction, racial or ethnic differentials in utilization and treatment, and health status measures.

Culturally Specific Healthcare Settings

Healthcare settings may raise both linguistic and cultural barriers for ethnic subgroups, particularly recent immigrants with limited acculturation to majority norms and behaviours. Limited English language proficiency and lack of ethnic match between staff members and client may decrease or delay healthcare-seeking behaviour. For this review we searched for

studies that evaluated the effectiveness of culturally or ethnically specific clinics and services, located within the community served.

Effectiveness

The ability to communicate in the clinical encounter is critical to good medical outcomes. Not all communications problems are attributable to language barriers. Effectiveness studies must take into account the additional effect of language on existing provider–client communication patterns. In 1964, the Civil Rights Act, Title VI, mandated provisions for the language needs of clients. Healthcare organizations cite cost as an important factor that limits their ability to provide trained interpreters. Very little research has been done on the effectiveness and cost-effectiveness of providing linguistically competent healthcare services in the United States or on ways to reduce the costs of providing such services. Questions such as the following need to be answered.

• Do trained interpreters compare favourably with family or ad hoc staff interpreters in improving outcomes of satisfaction, appropriate utilization, and health status?

• What are the relative contributions of improvements in linguistic competence and cultural sensitivity skills to reducing miscommunication and the resulting medical errors?

• Are linguistically and culturally appropriate health education materials more effective than standard materials in improving health outcomes?

Healthcare providers and provider organizations are concerned about the burden placed on resources by implementing interventions to improve the cultural competence of healthcare systems, particularly in the absence of proven effectiveness. Answers to the following questions should be sought:

• What role should communities play in collaborating with area healthcare organizations to communicate the needs of ethnically diverse populations?

• At what levels (e.g. management, provider, staff) in a healthcare organization does investment in linguistic and cultural competencies create the greatest improvement in health or other outcomes?

• Which cultural competencies within a healthcare system increase client satisfaction and improve health outcomes?

• Does cultural competency training of healthcare providers have a lasting effect or should it be repeated periodically?

Other Positive or Negative Effects

• Do ethnic-specific health messages generate negative stereotypes?

• Do the client benefits of engaging in culturally competent healthcare systems carry over to other social institutions (e.g., education, employment)?

Cultural competence is increasingly important for healthcare quality. The burgeoning interest in culturally competent model programs is apparent in the healthcare literature, but a research base on program effectiveness to inform decision making is absent.

Culture of patient safety in the hospital setting: an integrative review - (Baratto, et al., 2016) **-** Brazil

Objective: to identify productions related to patient safety and organizational culture, which used as data collection instrument the Safety Attitudes Questionnaire.

Method: an integrative review, in the databases LILACS, MEDLINE/PubMed, Scopus and Web of Science, with patient safety descriptors, organizational culture, climate, attitude of health personnel and the keyword safety attitudes questionnaire, with articles published online, in full, by the year 2013.

Results: we obtained 16 publications for analysis and discussion, presented in two categories. The studies used as subjects health professionals. The inclusion of other professionals was not sufficiently covered, but represents an important role in creating safe work environments. An association of organizational culture with safety environment for the professionals was verified.

Conclusion: it is believed that this study will bring contributions to the health team, especially to nursing, regarding the implementation of improvement actions in health institutions. Descriptors: Nursing; Patient Safety; Organizational Culture; Attitude of Health Personnel; Review.

Design and validation of a questionnaire to assess organizational culture in French hospital wards - (Domecq, et al., 2016) - France

Background: Although many organizational culture questionnaires have been developed, there is a lack of any validated multidimensional questionnaire assessing organizational culture at hospital ward level and adapted to health care context. Facing the lack of an appropriate tool, a multidisciplinary team designed and validated a dimensional organizational culture questionnaire for healthcare settings to be administered at ward level.

Methods: A database of organizational culture items and themes was created after extensive literature review. Items were regrouped into dimensions and sub dimensions (classification validated by experts). Pre-test and face validation was conducted with 15 health care professionals. In a stratified cluster random sample of hospitals, the psychometric validation was conducted in three phases on a sample of 859 healthcare professionals from 36 multidisciplinary medicine services: 1) the exploratory phase included a description of responses' saturation levels, factor and correlations analyses and an internal consistency analysis (Cronbach's alpha coefficient); 2) confirmatory phase used the Structural Equation Modelling (SEM); 3) reproducibility was studied by a test-retest.

Results: The overall response rate was 80 %; the completion average was 97 %. The metrological results were: a global Cronbach's alpha coefficient of 0.93, higher than 0.70 for 12 sub-dimensions; all Dillon-Goldstein's rho coefficients higher than 0.70; an excellent quality of external model with a Goodness of Fitness (GoF) criterion of 0.99. Seventy percent of the items had a reproducibility ranging from moderate (Intra-Class Coefficient between 50 and 70 % for 25 items) to good (ICC higher than 70 % for 33 items).

Conclusions: COMEt (Contexte Organisationnel et Managérial en Etablissement de Santé) questionnaire is a validated multidimensional organizational culture questionnaire made of 6 dimensions, 21 sub-dimensions and 83 items. It is the first dimensional organizational culture questionnaire, specific to healthcare context, for a unit level assessment showing robust psychometric properties (validity and reliability). This tool is suited for research

purposes, especially for assessing organizational context in research analysing the effectiveness of hospital quality improvement strategies. Our tool is also suited for an overall assessment of ward culture and could be a powerful trigger to improve management and clinical performance. Its psychometric properties in other health systems need to be tested.

Diversity in Healthcare: time to get real - (Armada & Hubbard, 2010) - USA

SUMMARY

• Cross-cultural healthcare involves three key issues: racial and ethnic disparities in the quality of healthcare provided to minority patients; cross-cultural value differences between immigrant patients and Western medical providers; and providing language access and assistance to limited English proficient (LEP) and disabled persons. Addressing these key issues represents a compelling diversity agenda for a new generation of healthcare executives. This article describes each of these challenges and the cutting-edge strategies that leading healthcare organizations are using to address them**.**

How should health service organizations respond to diversity? A content analysis of six approaches - (Seeleman, Essink-Bot, Stronks, & Ingleby, 2015) - Amsterdam

Abstract

Background: Health care organizations need to be responsive to the needs of increasingly diverse patient populations. We compared the contents of six publicly available approaches to organizational responsiveness to diversity. The central questions addressed in this paper are: what are the most consistently recommended issues for health care organizations to address in order to be responsive to the needs of diverse groups that differ from the majority population? How much consensus is there between various approaches?

Methods: We purposively sampled six approaches from the US, Australia and Europe and used qualitative textual analysis to categorize the content of each approach into domains (conceptually distinct topic areas) and, within each domain, into dimensions (operationalizations). The resulting classification framework was used for comparative analysis of the content of the six approaches.

Results: We identified seven domains that were represented in most or all approaches: organizational commitment, empirical evidence on inequalities and needs, a competent and diverse workforce, ensuring access for all users, ensuring responsiveness in care provision, fostering patient and community participation, and actively promoting responsiveness. Variations in the operationalization of these domains related to different scopes, contexts and types of diversity. For example, approaches that focus on ethnic diversity mostly provide recommendations to handle cultural and language differences; approaches that take an intersectional approach and broaden their target population to vulnerable groups in a more general sense also pay attention to factors such as socio-economic status and gender.

Conclusions: Despite differences in labelling, there is a broad consensus about what health care organizations need to do in order to be responsive to patient diversity. This opens the way to full scale implementation of organizational responsiveness in healthcare and structured evaluation of its effectiveness in improving patient outcomes.

Human rights in patient care: a theoretical and practical framework - (Cohen & Ezer, 2013) - USA

Abstract

The concept of “human rights in patient care” refers to the application of human rights principles to the context of patient care. It provides a principled alternative to the growing discourse of “patients’ rights” that has evolved in response to widespread and severe human rights violations in health settings. Unlike “patients’ rights,” which is rooted in a consumer framework, this concept derives from inherent human dignity and neutrally applies universal, legally recognized human rights principles, protecting both patients and providers and admitting of limitations that can be justified by human rights norms. It recognizes the interrelation between patient and provider rights, particularly in contexts where providers face simultaneous obligations to patients and the state (“dual loyalty”) and may be pressured to abet human rights violations.

The human rights lens provides a means to examine systemic issues and state responsibility. Human rights principles that apply to patient care include both the right to the highest attainable standard of health, which covers both positive and negative guarantees in respect of health, as well as civil and political rights ranging from the patient’s right to be free from torture and inhumane treatment to liberty and security of person. They also focus attention on the right of socially excluded groups to be free from discrimination in the delivery of health care. Critical rights relevant to providers include freedom of association and the enjoyment of decent work conditions. Some, but not all, of these human rights correspond to rights that have been articulated in “patients’ rights” charters.

Complementary to—but distinct from—bioethics, human rights in patient care carry legal force and can be applied through judicial action. They also provide a powerful language to articulate and mobilize around justice concerns, and to engage in advocacy through the media and political negotiation. As “patients’ rights” movements and charters grow in popularity, it is important to link patient rights back to human rights standards and processes that are grounded in international law and consensus.

Impact of telemedicine in hospital culture and its consequences on quality of care and safety - (Steinman, et al., 2015) - Brazil

Objective: To describe the impact of the telemedicine application on the clinical process of care and its different effects on hospital culture and healthcare practice methods: The concept of telemedicine through real time audio-visual coverage was implemented at two different hospitals in São Paulo: a secondary and public hospital, Hospital Municipal Dr. Moysés Deutsch, and a tertiary and private hospital, Hospital Israelita Albert Einstein. Results: Data were obtained from 257 teleconsultations records over a 12-month period and were compared to a similar period before telemedicine implementation. For 18 patients (7.1%) telemedicine consultation influenced in diagnosis conclusion, and for 239 patients (92.9%), the consultation contributed to clinical management. After telemedicine implementation, stroke thrombolysis protocol was applied in 11% of ischemic stroke patients. Telemedicine approach reduced the need to transfer the patient to another hospital in 25.9% regarding neurological evaluation. Sepsis protocol were adopted and lead to a 30.4% reduction mortality regarding severe sepsis. conclusion: The application is associated with differences in the use of health services: emergency transfers, mortality, implementation of protocols and patient management decisions, especially regarding thrombolysis. These results highlight the role of telemedicine as a vector for transformation of hospital culture impacting on the safety and quality of care.

Intercultural therapy and the limitations of a cultural competency framework: about cultural differences, universalities and the unresolvable tensions between them - (Rober & De Haene, 2014) - Belgium

Working with a family from a cultural background other than one's own is considered to be challenging for the therapist. Influenced by social constructionism, the family therapy field highlights the importance of contingency and cultural differences and therapists are encouraged to develop their cultural competency in order to deal with these differences. In this article, starting from contemporary critiques of notions of Western societies' cultural diversity, we address the way in which the cultural competency framework, by highlighting the importance of cultural differences and the therapist's culture-specific knowledge, may underestimate the importance of the social dimensions of the issues involved. Furthermore, highlighting cultural differences may obscure the shared humanity present in a transcultural encounter. In this article, as an alternative to the cultural competency framework, we propose a view of intercultural family therapy in which the unresolvable dialectical tension between differences and universalities is central.

Intersections between interprofessional practice, cultural competency and primary healthcare - (Oelke, Thurston, & Arthur, 2013) - Canada

The concepts of interprofessional collaborative practice (IPCP), cultural competency and primary healthcare (PHC) appear to be linked in theory and practice. This discussion article provides arguments explicating the potential linkages between IPCP and cultural competency. We argue that cultural competency is an important component of IPCP both for relationships with patients and/or communities in which providers work and between team members. Organizational structures also play an important role in facilitating IPCP and cultural competency. The integration of both IPCP and cultural competency has the potential to enhance positive health outcomes. Furthermore, we argue IPCP and cultural competency have important implications for PHC service design, given interprofessional teams are a key component of PHC systems. Linking these concepts in providing PHC services can be essential for impacting outcomes at all levels of primary healthcare, including patient, provider and systems.

Investigating patient safety culture across a health system: multilevel modelling of differences associated with service types and staff demographics - (Gallego, Westbrook, Dunn, & Braithwaite, 2012) - Australia

Objective. To use multilevel modelling to compare the patient safety cultures of types of services across a health system and to determine whether differences found can be accounted for by staffs' professions, organizational roles, ages and type of patient care provided.

Design. Application of a hierarchical two-level regression model.

Setting. All services in the South Australian public health system.

Participants. Approximately half of the health staff (n ¼ 14054) in the 46 organizations, classified into 18 types of service, which made up the South Australian public health system.

Interventions. Staff completed the Safety Attitudes Questionnaire.

Main Outcome Measures. Attitudes regarding Teamwork Climate, Safety Climate, Job Satisfaction, Stress Recognition, Perception of Management and Working Conditions in participants' workplaces.

Results. All SAQ indices showed statistically significant although modest variations according to service type. However, most of these differences were not accounted for by the differences in the demographic composition of services' staff. Most favourable safety attitudes were found in the breast screening, primary/community health services, community nursing and metropolitan non-teaching hospitals. Poorer cultures were reported in the psychiatric hospital, mental health, metropolitan ambulance services and top-level teaching hospitals. Demographic differences in safety attitudes were observed; particularly, clinical, senior managerial, aged care and older staff held more favourable attitudes.

Conclusions. Differences in staff attitudes have been demonstrated at a macro-level across the type of health services but for the most part, differences could not be explained by staffing composition.

Measuring the safety climate in NHS organisations - (Currie & Watterson, 2010) - UK

This article discusses the differences between organisational culture and organisational climate, and provides an overview of the relationship between safety culture and safety climate within these wider concepts. The article concludes with a brief description of an initiative to test a safety climate measurement tool for use in NHS organisations.

Owning solutions: a collaborative model to improve quality in hospital care for Aboriginal Australians - (Durey, et al., 2012) - Australia

Well-documented health disparities between Aboriginal and Torres Strait Islander (hereafter referred to as Aboriginal) and non-Aboriginal Australians are underpinned by complex historical and social factors. The effects of colonisation including racism continue to impact negatively on Aboriginal health outcomes, despite being under-recognised and under-reported. Many Aboriginal people find hospitals unwelcoming and are reluctant to attend for diagnosis and treatment, particularly with few Aboriginal health professionals employed on these facilities. In this paper, scientific literature and reports on Aboriginal healthcare, methodology and cross-cultural education are reviewed to inform a collaborative model of hospital-based organisational change. The paper proposes a collaborative model of care to improve health service delivery by building capacity in Aboriginal and non-Aboriginal personnel by recruiting more Aboriginal health professionals, increasing knowledge and skills to establish good relationships between non-Aboriginal care providers and Aboriginal patients and their families, delivering quality care that is respectful of culture and improving Aboriginal health outcomes. A key element of model design, implementation and evaluation is critical reflection on barriers and facilitators to providing respectful and culturally safe quality care at systemic, interpersonal and patient/family-centred levels. Nurses are central to addressing the current state of inequity and are pivotal change agents within the proposed model.

Patient-centered care: the key to cultural competence - (Epner & Baile, 2012) - USA

Much of the early literature on ‘cultural competence’ focuses on the ‘categorical’ or ‘multicultural’ approach, in which providers learn relevant attitudes, values, beliefs, and behaviours of certain cultural groups. In essence, this involves learning key ‘dos and don’ts’ for each group. Literature and educational materials of this kind focus on broad ethnic, racial, religious, or national groups, such as ‘African American’, ‘Hispanic’, or ‘Asian’. The problem with this categorical or ‘list of traits’ approach to clinical cultural competence is that culture is multidimensional and dynamic. Culture comprises multiple variables, affecting all aspects of experience. Cultural processes frequently differ within the same ethnic or social group because of differences in age cohort, gender, political association, class, religion, ethnicity, and even personality. Culture is therefore a very elusive and nebulous concept, like art. The multicultural approach to cultural competence results in stereotypical thinking rather than clinical competence. A newer, cross cultural approach to culturally competent clinical practice focuses on foundational communication skills, awareness of cross-cutting cultural and social issues, and health beliefs that are present in all cultures. We can think of these as universal human beliefs, needs, and traits. This patient centred approach relies on identifying and negotiating different styles of communication, decision-making preferences, roles of family, sexual and gender issues, and issues of mistrust, prejudice, and racism, among other factors. In the current paper, we describe ‘cultural’ challenges that arise in the care off our patients from disparate cultures, each of whom has advanced colon cancer that is no longer responding to chemotherapy. We then illustrate how to apply principles of patient centred care to these challenges.

Physician and patient perceptions of cultural competency and medical compliance - (Ohana & Mash, 2015) - Israel

To examine the relationship between the different perceptions of medical teams and their patients of the cultural competence of physicians, and the influence of this relationship on the conflict between them. Structured questionnaires were distributed to 90 physicians working in outpatient clinics in a central hospital in Israel, and to 417 of their patients. Each physician had four to six sampled patients. The findings showed a significant negative correlation ($r= -0.50$, $P<0.05$) between the physicians’ perception of their cultural competence and the patients’ perception of physician competence. The more patients perceive the physician as culturally competent, the more they comply with their medical recommendations. In addition, the findings show that ethnicity significantly affects patients’ perception of the cultural competence of physicians, and their satisfaction with the medical care they receive.

Quality management and perceptions of teamwork and safety climate in European hospitals - (Kristensen, et al., 2015) - European

Objective: This study aimed to investigate the associations of quality management systems with teamwork and safety climate, and to describe and compare differences in perceptions of teamwork climate and safety climate among clinical leaders and frontline clinicians.

Method: We used a multi-method, cross-sectional approach to collect survey data of quality management systems and perceived teamwork and safety climate. Our data analyses included descriptive and multilevel regression methods.

Setting and Participants: Data on implementation of quality management system from seven Europeancountrieswereevaluatedincludingpatientsafetyculturesurveysfrom3622clinicalleaders and 4903 frontline clinicians.

Main Outcome Measures: Perceived teamwork and safety climate.

Results: Teamwork climate was reported as positive by 67% of clinical leaders and 43% of frontline clinicians. Safety climate was perceived as positive by 54% of clinical leaders and 32% of frontline clinicians.Wefoundpositiveassociationsbetweenimplementationofqualitymanagementsystems and teamwork and safety climate.

Conclusions: Our findings, which should be placed in a broader clinical quality improvement context, point to the importance of quality management systems as a supportive structural feature for

UNREVIEWED ARTICLES (CITATION AND DOCUMENT INCLUDED)

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A STUDY OF THE CULTURAL COMPETENCE OF NURSES WORKING SAUDI ARABIA - (Al-Wahbi, Kernohan, & Curran, 2014)

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Exploring culturally and linguistically diverse consumer needs in relation to medicines use and health information within the pharmacy setting. http://www.sciencedirect.com/science/article/pii/S1551741114003908

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Integrating Culturally Appropriate Care into Telemental Health Practice. http://www.sciencedirect.com/science/article/pii/B9780124160484000051

Using Clinical Simulation to Enhance Culturally Competent Nursing Care: A Review of the Literature. http://www.sciencedirect.com/science/article/pii/S1876139915000055

Ole Taeao Afua, the New Morning: A Qualitative Investigation Into Samoan Perspectives on Mental Health and Culturally Appropriate Services. http://journals.sagepub.com/doi/pdf/10.1080/j.1440-1614.2005.01572.x

Works Cited

Al-Wahbi, M., Kernohan, W., & Curran, C. (2014). A study of the cultural competence of nurses working in multicultural healthcare organisations within the kingdom of Saudi Arabia. *Humanities and Social Sciences Review, 3*(4), 325-342.

Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., Fielding, J. E., & Normand, J. (2003). Culturally competent healthcare systems: A systematic review. *American Journal of Preventive Medicine, 24*(3), 68-79.

Andrews, M. M., & Boyle, J. S. (1999). *Transcultural Concepts in Nursing Care.* Philadelphia: Lippincott,.

Armada, A. A., & Hubbard, M. F. (2010). Diversity in healthcare: Time to get real. *Frontiers of Health Services Management*, 1-17.

Association of Community Health Nursing Educators (ACHNE). (2000). Graduate Education for Advanced Practice in Community. *Public Health Nursing*.

Bainbridge, R., McCalman, J., Clifford, A., & Tsey, K. (2015). *Cultural competency in the delivery of health services for Indigenous people. Issues paper no. 13.* Canberra: Australian Institute of Health and Welfare.

Baldwin, J., Conger, C., Abegglen, J., & Hill, E. (1998). Population focused and community-based nursing - moving toward clarification of concepts. *Public Health Nursing 15*, 12-18.

Baratto, M., Pasa, T., Cervo, A., Dalmolin, G., Pedro, C., & Magnago, T. (2016). Culture of patient safety in the hospital setting: An integrative review. *Journal of Nursing*, 26-36.

Campinha-Bacote, J. (1999). A Model and Instrument for Addressing Cultural Competence in Health Care. *Journal of Nursing Education*, 203-207.

Centre's for Disease Control and Preventions. (2014). *Health equity: in tobacco prevention and control.* St. Louis: Center for Public Health Systems Science.

Clark, M. J. (1996). The community context. In M. J. Clark, *Nursing in the community* (pp. 3-16). Stanford: Appleton & Lange.

Cohen, J., & Ezer, T. (2013). Human rights in patient care: A theoretical and practical framework. *Health and Human Rights, 15*(2), 7-19.

Currie, L., & Watterson, L. (2010). Measuring the safety climate in NHS organisations. *Nursing Standard, 24*(24), 35-38.

Domecq, S., Dumond, J. P., Kret, M., Michel, P., Saillour-Glenisson, F., & Sibe, M. (2016). Design and validation of a questionnaire to assess organizational culture in French hospital wards. *BMC Health Services Research*, 1-14.

Duke, J., Conner, M., & McEldowney, R. (2009). Becoming a culturally competent health practitioner in the delivery of culturally safe care: A process orientated approach. *Journal of Cultural Diversity, 16*(2), 40-49.

Durey, A., Wynaden, D., Thompson, S., Davidson, P., Bessarab, D., & Katzenellenbogen, J. (2012). Owning solutions: a collaborative model to improve quality in hospital care for Aboriginal Australians. *Nursing Inquiry, 19*(2), 144-152.

Epner, D. E., & Baile, W. F. (2012). Patient-centered care: the key to cultural competence. *Annals of Oncology, 23*(3), 34-42.

Gallego, B., Westbrook, M. T., Dunn, A. G., & Braithwaite, J. (2012). Investigating patient safety culture across a health system: multilevel modelling of differences associated with service types and staff demographics. *International Journal for Quality in Health Care, 24*(4), 311-320.

Goeppinger H.J. & Schuster III, G. (1992). Community as client: using the nursing process to promote health. In *Community Health Nursing: Process and Practice for Promoting Health* (3rd ed., pp. 253-276). Mosby, St. Louis.

Grant, J., Parry, Y., & Guerin, P. (2013). An investigation of culturally competent terminology in healthcare policy finds ambiguity and lack of definition. *AUSTRALIAN AND NEW ZEALAND JOURNAL OF PUBLIC HEALTH, 37*(3), 250-256.

Gurm, B. K., & Cheema, J. (2013). Cultural safety assessment of an urban Canadian hospital. *Journal of Cultural Diversity, 20*(4), 177-183.

Hall, E. T. (1981). *Beyond Culture.* New York: Doubleday.

Hiles, A. (2010). *Culturally Competent Health Care: A plan for employers to improve employee health and medical plan efficiency by eliminating disparities in care.* AON Consulting.

Kia Tiaki Nursing. (2016). Nurse managers: Creating healthy workplaces. *Kia Tiaki Nursing Journal, 21*(11), 42.

Kim-Godwin, Y. S., Clarke, P. N., & Barton, L. (2001). A model for the delivery of culturally competent community care. *NURSING THEORY AND CONCEPT DEVELOPMENT OR ANALYSIS*, 918-925.

Kleinman, A. (1980). *Patient and Healers in the Context of Culture: An Exploration of Borderland between Anthropology, Medicines, and Psychiatry.* Berkeley: University of California Press.

Kristensen, S., Hammer, A., Bartels, P., Sunol, R., Groene, O., Thompson, C., . . . Wagner, C. (2015). Quality management and perceptions of teamwork and safety climate in European hospitals. *International Journal for Quality in Health Care, 27*(6), 498-505.

Lindsey, E., Stajduhar, K., & McGuimmess, L. (2001). Examining the process of community development. *Journal of Advanced Nursing 33*, 828-835.

Longmore, M. (2016). Building 'super-diversity'. *Kai Tiaki Nursing New Zealand, 22*(9), 37.

Mannella, H. (2016). *Risk Management: Creating a Culture of Safety.* Glendale: Cinahk Information Systems.

Mlcek, S. (2013). Are We Doing Enough to Develop Cross-Cultural Competencies for Social Work? *British Journal of Social Work*, 1984-2003. doi:doi:10.1093/bjsw/bct044

Nursing Executive Centre. (n.d.). *Motivational Interviewing 101: The manager's toolkit for helping frontline clinicians tap into patients' motivation to change.* Washington DC: The Advisory Board Company.

Oelke, N., Thurston, W., & Arthur, N. (2013). Intersections between interprofessional practice, cultural competency and primary healthcare. *Journal of Interproffessional Care*, 367-372.

Ohana, S., & Mash, R. (2015). Physician and patient perceptions of cultural competency and medical compliance. *HEALTH EDUCATION RESEARCH, 30*(6), 923-934.

Rober, P., & De Haene, L. (2014). Intercultural therapy and the limitations of a cultural competency framework: about cultural differences, universalities and the unresolvable tensions between them. *Journal of Family Therapy, 36*(1), 3-20.

Seeleman, C., Essink-Bot, M.-L., Stronks, K., & Ingleby, D. (2015). How should health service organizations respond to diversity? A content analysis of six approaches. *BMC Health Services Research*, 1-18.

Smith, L. S. (1998). Concept analysis: cultural competence. *Journal of Cultural Diversity*, 4-10.

Steinman, M., Morbeck, R. A., Pires, P. V., Filho, C., Andrade, A., Terra, J., . . . Kanamura, A. (2015). Impact of telemedicine in hospital culture and its consequences on quality of care and safety. *Health Economics and Management, 13*(4), 580-585.

Stuttaford, M., Al Makhamreh, S., Coomans, F., Harrington, J., Himonga, C., & Hundt, G. L. (2014). The right to traditional, complementary, and alternative health care. *Global Health Action, 7*, 24121. doi:10.3402/gha.v7.24121

Tervalon, M., & Murray-Garcia, J. (1998). Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117-125.

Tsai, Y., & Tang, T.-W. (2008). How to improve service quality: Internal marketing as a determining factor. *Total Quality Management, 19*(11), 1117-1126.

Williams, C. A. (2000). *Community-orientated population-focused practice. In Community and Public Health Nursing* (5th (Stanhope M. & Lancaster J. eds) ed.). St. Louis: Mosby.

Wongrukmit, P., & Thawesaengskulthai, N. (2014). Hospital service quality preferences among culture diversity. *Total Quality Management, 25*(8), 908-922.

Zoucha, R. D. (1998). The experiences of Mexican-Americans receiving professional nursing care:an ethonursing study. *Journal of Transcultural Nursing 9*, 34-44.

Zyga, S. (2011). Nurses Cultural Conscience and Nursing Practice. *International Journal of Caring Sciences, 4*(1), 2.

Barton, P. & Wilson, D. (2008). Te Kapunga Putohe (Ther restless hands): A Māori centred nursing practice model. *Nursing Praxis in New Zealand,* 24(2) 6-15.

Durie, M. (1998). *Whaiora Māori Health Development*. Auckland: Oxford University Press.

http://www.health.govt.nz/our-work/nursing/office-chief-nursing-officer-sector-update

http://www.nursingreview.co.nz/issue/february-2016-vol-16-1/Māori -and-pacific-nurses/#.V42Kvv5f2Uk

Lyford, S. & Cook, P. (2005). The Whanaungatanga Model of Care. *Nursing Praxis in New Zealand,* 21 (2) 26-35.

Maloney-Moni, J. (2004). Kia Mana A Synergy of Wellbeing. Masters Thesis, University of Auckland

Nursing Workforce Programme Governance Group. (2015). *Nursing Taskforce Working Programme Governance Group Key Messages.* Health Workforce New Zealand: Wellington.

Simon, V. (2006). "Characterising Māori nursing practice". *Contemporary Nurse*, 22 (2) 203-13.

Theunissen, K. (2011). The nurse's role in improving health disparities experienced by indigenous Māori in New Zealand. *Contemporary Nurse,* 39(2), 281-286.

Wilson, D. & Baker, M. (2012). Bridging two worlds: Māori mental health nursing. *Qualitative Health Research,* 22(8) 1073-1082.

Wilson, D., McKinney, C., & Rapata-Hanning, M. (2011). Retention of Indigenous nursing students in New Zealand: A cross-sectional survey. *Contemporary Nurse,* 38(1-2), 59-75.

Blockley, C., & Alterio, M. (2008). Patient's experiences of interpersonal relationships during first time acute hospitalisation. *Nursing Praxis in New Zealand, 24*(2), 16-26.

Calman, L. (2006). Patients' views of nurses' competence. *Nurse Education Today, 26*, 719-725.

Christensen, J. (1990). *Nursing Partnership A model for nursing practice: Hauora Tikirua He Tauira mo nga Kaupapa Hauora*. Wellington: Daphne Brasell Associates Press.

Clendon, J. (2012). Working to improve health literacy. *Kai Tiaki Nursing New Zealand,* 18(6), 25.

Clendon, J., & Walker, L. (2011). *Young nurses in Aotearoa New Zealand*. Wellington: New Zealand Nurses Organisation.

Conway, C., Culbert, E., Gale, S., Coulden, & Tulloch, J. (1996). Patients' expectations of the nurse-role negotiation. *Nursing Praxis in New Zealand, 11*(3), 32-37.

Cook M. & Matarasso, B. (2005). Promoting reflection in mental health nursing practice: A case illustration using problem-based learning. *International Journal of Mental Health Nursing,* 14, 243-248.

Henderson, S. (2003). Power imbalance between nurses and patients: a potential inhibitor of partnership in care. *Journal of Clinical Nursing, 12*, 501-508.

Henry, P. (2008). Negotiating an unstable ladder. *Kai Tiaki Nursing New Zealand, 14*(1), 17-20.

Irurita, V. (1999). Factors affecting the quality of nursing care: The patient's perspective. *International Journal of Nursing Practice, 5*, 86-94

Jeffs, L. (2001). Teaching cultural safety the culturally safe way. *Nursing Praxis in New Zealand, 17*(3), 41-49.

Keatinge, D., Bellchambers, H., Bujack, E., Cholowski, K., Conway, J., & Neal, P. (2002). Communication: Principal barrier to nurse-consumer partnerships. *International Journal of Nursing Practice, 8*, 16-22.

Koea, J. (2008). Ghosts in the machine: the experience of Maori in the New Zealand health system. *The New Zealand Medical Journal, 121*(1279), 10-12.

Mortensen, A. (2010). Cultural safety: Does the theory work in practice for culturally and linguistically diverse groups? *Nursing Praxis in New Zealand, 26*(3), 6-16.

Nursing Council of New Zealand. (2007). *Competencies for registered nurses.* Wellington: Nursing Council of New Zealand.

Nursing Council of New Zealand. (2011a). *Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice.* Wellington: Nursing Council of New Zealand.

O'Connell, B., Young, J., & Twigg, D. (1999). Patient satisfaction with nursing care: A measurement conundrum. *International Journal of Nursing Practice, 5*, 72-77.

Papps, E., & Ramsden, I. (1996). Cultural safety in nursing: the New Zealand experience. *International Journal for Quality in Health Care, 8*(5), 491-497.

Ramsden, I. (1993). Kawa Whakaruruhau Cultural safety in nursing education in Aotearoa (New Zealand). *Nursing Praxis in New Zealand, 8*(3), 4-10.

Ramsden, I. (1994). A challenge to education. *Social Policy Journal of New Zealand, 3*, 18-25.

Reynolds, W., & Scott, B. (2000). Do nurses and other professional helpers normally display much empathy? *Journal of Advanced Nursing, 31*(1), 226-234.

Richardson, F., & MacGibbon, L. (2010). Cultural safety: Nurses' accounts of negotiating the order of things. *Women's Studies Journal, 24*(2), 54-65.

Richardson, S., Williams, T., Finlay, A., & Farrell. (2009). Senior nurses' perceptions of cultural safety in an acute clinical practice area. *Nursing Praxis in New Zealand, 25*(3), 27-36.

Shattell, M. (2004). Nurse-patient interaction: a review of the literature. *Journal of Clinical Nursing, 13*, 714-722.

Sorlie, V., Torjuul, K., Ross, A., & Kihlgren, M. (2006). Satisfied patients are also vulnerable patients-narratives from an acute care ward. *Journal of Clinical Nursing, 15*, 1240-1246.

Taylor, B. (2006). *Reflective Practice A Guide for Nurses and Midwives.* Maidenhead England: Open University Press.

Timmons, J. (2006). Using case reports to aid reflective practice in wound care. *British Journal of Community Nursing,* 11(3), S14-S20).

Thorsteinsson, L. (2002). The quality of nursing care as perceived by individuals with chronic illnesses: the magical touch of nursing. *Journal of Clinical Nursing, 11*, 32-40.

Walker, A. (2002). Safety and comfort work of nurses glimpsed through patient narratives. *International Journal of Nursing Practice, 8*, 42-48.

Watson, J. (1997). The theory of human caring: Retrospective and prospective. *Nursing Science Quarterly, 10*(1), 49-52.

Watson, J., & Foster, R. (2003). The attending nurse caring model: Integrating theory, evidence and advanced caring-healing therapeutics for transforming professional practice. *Journal of Clinical Nursing, 12*, 360-365.

Wepa, D. (Ed.). (2005). *Cultural Safety in Aotearoa New Zealand*. Auckland: Pearson Education New Zealand.

Wilson, D. (2006). The practice and politics of Indigenous health nursing. *Contemporary Nurse, 22*(2), x-xiii.

Wilson, D. (2008). The significance of a culturally appropriate health service for Indigenous Maori women. *Contemporary Nurse, 28*, 173-188.

HEAT

HEAT aims to promote equity in health in New Zealand. It consists of a set of 10 questions that enable assessment of policy, programme or service interventions for their current or future impact on health inequalities. The questions cover four stages of policy, programme or service development.

1. Understanding health inequalities.
2. Designing interventions to reduce inequalities.
3. Reviewing and refining interventions.
4. Evaluating the impacts and outcomes of interventions.

HEAT enables health initiatives to be assessed for their current or future impact on health equity. The questions challenge users to think broadly about equity issues.

1. What inequalities exist in relation to the health issue under consideration?
2. Who is most advantaged and how?
3. How did the inequalities occur? What are the mechanisms by which the inequalities were created, maintained or increased?
4. Where/how will you intervene to tackle this issue?
5. How will you improve Māori health outcomes and reduce health inequalities experienced by Māori?
6. How could this intervention affect health inequalities?
7. Who will benefit most?
8. What might the unintended consequences be?
9. What will you do to make sure the intervention does reduce inequalities?
10. How will you know if inequalities have been reduced?

These questions prompt users to consider the health inequalities that exist in a particular area of health, how to intervene to address them, and finally to evaluate whether the intervention has been successful in reducing health inequalities.

The Health Equity Assessment Tool: A User's Guide, Ministry of Health 2008

This evidence base has used questions 1, 2, 3, 4 of the HEAT to assess whether the information presented in the evidence base considered Māori. Questions 5, 6, 7 were asked during the development of the wider project. There was additional information included in the literature review to respond more thoroughly to question 4; this information was incorporating He Korowai Oranga into the literature review.

Current Measures and Indicators

In Progress

Appendix D: Current Activity Assessment

PPP 1.4 - Identified activities (Project or BAU)	PPP helps activity 1= Hinders 2=no significance 3= helpful 4= very helpful	Activity helps PPP 1= Hinders 2=no significance 3= helpful 4= very helpful	Total A score of 4 or higher is a positive correlation	Notes
Quest for new Medical School	3	4	7	Allows approaches to curriculum and type of doctors and clinicians needed for our diverse population
eSPACE Programme	3	2	5	Accurate, available, accessible patient information supports good clinical decisions and healthy outcomes for the people of the Midland region. The eSPACE Programme is designed to develop and deliver a Midland Clinical Portal (MCP), where Midland region patient records will be consolidated and available within one digital space for the benefit of patients and clinicians. The programme is governed and funded by the five Midland DHBs and is an important foundation for achieving the Midland vision: "all residents of Midland District Health Boards lead longer, healthier and more independent lives."
Priority Programme Plan process	4	4	8	Intended to increase collaboration, reduce silos, and increase clarity on responsibilities and accountabilities.
Cultural Safety work plan	4	4	8	The working group and work streams provide a platform to facilitate the improvement of culture over time. The change for staff enables: • Values being translated into workplace application and sustainability; along with strategy • Role modelling of expected behaviours by all staff; and particularly managers Process measures thus far: • Pilot workshops have identified ideas for keeping the values alive • Included in position descriptions, performance reviews • Expectations included in values workshops

PPP 1.4 - Identified activities (Project or BAU)	PPP helps activity 1= Hinders 2=no significance 3= helpful 4= very helpful	Activity helps PPP 1= Hinders 2=no significance 3= helpful 4= very helpful	Total A score of 4 or higher is a positive correlation	Notes
				• Good examples of role modelling highlighted
Health Integrity Line	4	4	8	A free anonymous 24/7 phone line to report fraud or any other activities relating to the health industry. This includes but Is not limited to: • Dishonesty or inappropriate use of public money • Inappropriate use of technology • Workplace bullying • Theft • Drug use • Harassment All calls are passed onto the appropriate team or agency to follow up.
Rural Health	3	3	6	A comprehensive review and redesign of rural health service capacity, capability, service delivery and human, facility and technological infrastructure.
Patient flow improvements	2	3	5	Performance improvement programme of work, covering a series of process improvement projects, change support, benefits measurement and technology enablement (iMPACT), Electronic whiteboard, information particularly what a patient is waiting on will become visible. The goal of the Patient Flow Programme of work is to provide timely, efficient patient care to enable better flow of patients through our hospital system, reduction of non-value added time in hospital, reduction in non-value added staff activity and thus allow the organisation to meet Ministry of Health targets and deliver a reduced average length of stay, which in turn will free up bed capacity. Scope covers end-to-end patient pathways and all of the DHB. This package of work addresses each part of the acute flow process to deliver improved

PPP 1.4 - Identified activities (Project or BAU)	PPP helps activity 1= Hinders 2=no significance 3= helpful 4= very helpful	Activity helps PPP 1= Hinders 2=no significance 3= helpful 4= very helpful	Total A score of 4 or higher is a positive correlation	Notes
				performance against the 6 hr acute target and mitigate risk to patients in the emergency department: 1. ED Staffing Business Case 2. Patient flow programme of work a) Acute Flow (emergency presentation until ward admission) b) Elective Flow (elective referral to hospital specialty until ward admission) Inpatient stay / Discharge (ward admission until discharge home). 3. Revised Bed Management Policy 4. Strengthening of Specialty Referral Guidelines and Escalation Protocol 5. Creation and use of an Acute Flow Dashboard 6. Review of acute medical / AEC / frail elderly service configuration Implementation of patient flow management tool to provide improved visibility of each patient's status in the hospital. This visibility takes the form of clinical whiteboards on the wards, centralised bed board and escalation dashboards for bed management and workflow task lists for staff working in the process.
Production planning	2	2	4	Establishment of robust production planning routines, planning tools, meeting forums to take more pro-active production decisions in the long, medium and short term horizon. Enhancement of annual planning process, new monthly service plan reviews and weekly waitlist and theatre capacity reviews.
Women's Health Model of Care	2	2	4	Review of Model of Service Delivery for: · Elective Caesareans · E1 Gynaecology and Antenatal ward · Scope of Women's Assessment Unit

PPP 1.4 - Identified activities (Project or BAU)	PPP helps activity 1= Hinders 2=no significance 3= helpful 4= very helpful	Activity helps PPP 1= Hinders 2=no significance 3= helpful 4= very helpful	Total A score of 4 or higher is a positive correlation	Notes
				Outpatient clinics and patient pathway, including the use of Virtual Health
Mental Health & Addictions Models of Care	4	4	8	The current models of care for the delivery of mental health & addictions services in New Zealand are not sustainable into the future. Will not meet growing demand not be affordable in its current format
CBD Offices and Facilities Consolidation	2	2	4	Acquisition and fit out of a single CBD facility (12,000sqm) providing consolidated accommodation for: Mental Health, Diabetes, Population Health, Payroll, IT, Healthshare, Strategy & Funding, Accounts P&R
Sterile Services Unit (Project Alloy)	3	3	**6**	The project will create a standardised operating model with scalable repeatable processes, work practices, and flow within and between the three departments. The operating model then becomes a solid foundation for continuous improvement to achieve best practice in a clinically critical high volume operational area. The programme of work has a number of facets which incorporate the full spectrum of people, process and technology and is expected to run over a minimum of a three year period
National Patient Flow (NPF)	2	2	4	The National Patient Flow programme is a multi-year programme of work aimed at measuring the patient journey through secondary care services. It is primarily focussed on a Ministry of Health (MoH) mandated data collection but requires both system development and ongoing large scale process review and changes in order for Waikato DHB to meet the MoH requirements.
Maternity Quality and Safety Programme: Primary Care and Maternity Services Alliancing	4	4	8	Primary Care and Maternity Services Alliancing - working across the sector to improve maternity services in primary care - GP practices, pharmacy and LMC practice. Improve quality and access to maternity services in the community for primary health needs of pregnant women
Maternity Quality and Safety Programme: Increasing Consumer	4	4	8	Key aspect of MQSP is to enable consumers to monitor and be part of improvements in the maternity sector alongside health professionals.

PPP 1.4 - Identified activities (Project or BAU)	PPP helps activity 1= Hinders 2=no significance 3= helpful 4= very helpful	Activity helps PPP 1= Hinders 2=no significance 3= helpful 4= very helpful	Total A score of 4 or higher is a positive correlation	Notes
Engagement				
Maternity Quality and Safety Programme: Primary Birthing facilities	4	3	7	Balance birthing and postnatal bed footprint across the maternity sector, strengthening clinical governance in Waikato Primary Birthing services to continue the confidence of health professionals and women in these services.
Maternity Quality and Safety Programme: Priority Women	4	4	8	Improving outcomes for priority women: • Improve service and outcomes for Maori and Pacific Island women, rural isolated women, women living in low socio economic areas and families experiencing pregnancy loss and neonatal loss • Increase early registration with a midwife for groups were the access rate is much later in pregnancy – this will increase early screening to pick up problems early ensure health care through pregnancy • Access to pregnancy and parenting education improve woman's knowledge about caring for herself and her baby • Reducing maternal smoking – Waikato has a high rate, decreased rates of smoking will show improvements in poor outcomes for women and infants • Promoting safe sleep – reduce the SUDI rate in Waikato • Increasing breastfeeding – consistently lower rates for Maori babies • Improving bereavement services.
Maternity Quality	2	2	4	Focus on national maternity clinical indicators and areas including monitoring Neonatal

PPP 1.4 - Identified activities (Project or BAU)	PPP helps activity 1= Hinders 2=no significance 3= helpful 4= very helpful	Activity helps PPP 1= Hinders 2=no significance 3= helpful 4= very helpful	Total A score of 4 or higher is a positive correlation	Notes
and Safety Programme: Secondary / Tertiary Services				Encephalopathy rates, implementing the national guideline on gestational diabetes. Investigate and where necessary make improvement changes to where Waikato is an outlier against the national clinical indicators: Instrumental delivery, Perineal care, induction of labour, GA caesarean section.
Primary / Secondary Interface Integrated Care Pathways (map of medicine)	4	4	8	Integration of primary/ secondary and community services in a manner that moves services closer to home where appropriate. Defining the scope of primary care and secondary care and how the interfaces are managed. Embedding standardised best practice integrated care pathways across the Midlands region
Discharge Enablement Project	4	4	8	SAFER Patient Flow Bundle (from NHS) Camplex and long stay discharges work Criteria based discharges Weekend discharges
Workforce credentialling to work in Virtual Health environment	4	4	8	Create professional standards to deliver virtual care ensuring consistency of practice
Nursing Documentation Project	4	4	8	4 year improvement project that has dramatically reduced the number of forms nurses use for assessing patients, and instead refocuses them on patient care and what really matters to each patient. The most intangible result is the breakdown of nursing 'silos' and changes in nursing practice. Implementation is due in mid-May 2017.

Appendix E: A Successful Priority

A Successful Priority		
Priority Programme Plan 1.4: Enable a workforce to deliver culturally appropriate services… We will equip those who partner in health care now and in the future with skills and knowledge to provide care and services that meet the diverse values, beliefs, and cultural needs of our People.		
Enablers	**Themes for a successful priority**	**Theme narrative**
People	***Give and earn respect*** *Accept differences and diversity*	We need to have a holistic view of the diverse needs of our population
	Give and earn respect *Own what you do*	We must understand our accountabilities, power position, responsibility, authority so we can ensure culturally appropriate interactions, services, and care
	Give and earn respect *Put yourself in the shoes of others*	We must have a healthy relationship to diversity
	Give and earn respect *Value everyone's contribution*	To get an empowered population we need to change, including attitudes, behaviours, approach
Process	***Growing the good*** *Provide experiences to maximise potential*	We need our organisational culture to be output to outcome
	Stronger together *Foster a supportive safe work place*	We must support each other to ensure cultural safety
	Listen to me; talk to me *Listen to and hear others*	Focusing on relationships we must adhere to the 3 Principles of Te Tiriti o Waitangi (Partnership, Participation, Protection)
	Fair play *Clear and transparent processes*	HOW not what we do – it's the how not the what
Environment	***Fair play*** *Create opportunities for inclusive decision-making*	We need a workforce that reflects diversity of our population
	Listen to me; talk to me *Open and safe sharing*	We must accept not knowing so we can learn, grow, develop, and engage
	Stronger together *Collaborate to achieve known outcomes*	We want empowered population – They need to feel structurally empowered before and after they are using our services

Appendix F: Activity Gap Analysis

Activity Gap Analysis			
Priority Programme Plan 1.4: Enable a workforce to deliver culturally appropriate services… "*We will equip those who partner in health care now and in the future with skills and knowledge to provide care and services that meet the diverse values, beliefs, and cultural needs of our people*".			
Enablers	**People**	**Process**	**Environment**
Themes for a successful priority	• Give and earn respect - Accept differences and diversity • Give and earn respect - Own what you do • Give and earn respect - Put yourself in the shoes of others • Give and earn respect - Value everyone's contribution	• Growing the good - Provide experiences to maximise potential • Stronger together - Foster a supportive safe work place • Listen to me; talk to me - Listen to and hear others • Fair play - Clear and transparent processes	• Fair play - Create opportunities for inclusive decision-making • Listen to me; talk to me - Open and safe sharing • Stronger together - Collaborate to achieve known outcomes
CURRENT Activity	How do we rank (1 to 5: 1 very poor; 2 poor; 3 average; 4 good; 5 very good) **[TO BE DEVELOPED DURING IMPLEMENTATION]**		
Quest for new Medical School			
eSPACE Programme			
Priority Programme Plan process			
Cultural Safety work plan			
Health Integrity Line			
Rural Health			
Patient flow improvements			
Production planning			
Women's Health Model of Care			
Mental Health & Addictions Models of Care			
CBD Offices and Facilities Consolidation			
Sterile Services Unit (Project Alloy)			
National Patient Flow (NPF)			
Maternity Quality and Safety Programme: Primary Care and Maternity Services Alliancing			

Maternity Quality and Safety Programme: Increasing Consumer Engagement			
Maternity Quality and Safety Programme: Primary Birthing facilities			
Maternity Quality and Safety Programme: Priority Women			
Maternity Quality and Safety Programme: Secondary / Tertiary Services			
Primary / Secondary Interface Integrated Care Pathways (map of medicine)			
Discharge Enablement Project			
Workforce credentialing to work in Virtual Health environment			
Nursing Documentation Project			

Appendix G: Objectives

Objectives			
Priority Programme Plan 1.4: Enable a workforce to deliver culturally appropriate services… "*We will equip those who partner in health care now and in the future with skills and knowledge to provide care and services that meet the diverse values, beliefs, and cultural needs of our people*".			
Enablers	**People**	**Process**	**Environment**
Themes/outcomes for a successful priority	• Give and earn respect - Accept differences and diversity • Give and earn respect - Own what you do • Give and earn respect - Put yourself in the shoes of others • Give and earn respect - Value everyone's contribution	• Growing the good - Provide experiences to maximise potential • Stronger together - Foster a supportive safe work place • Listen to me; talk to me - Listen to and hear others • Fair play - Clear and transparent processes	• Fair play - Create opportunities for inclusive decision-making • Listen to me; talk to me - Open and safe sharing • Stronger together - Collaborate to achieve known outcomes

Proposed Activity	**What will need to occur in order for this proposed activity to be successful?**	**Who are the people (and agencies) responsible for delivering on the priorities?** **[TO BE DEVELOPED DURING IMPLEMENTATION]**	**What are the organisation-wide activities that need to occur?** **[TO BE DEVELOPED DURING IMPLEMENTATION]**	**What are the timeframes for the activities?** **[TO BE DEVELOPED DURING IMPLEMENTATION]**	**How will progress and performance be reported?** **[TO BE DEVELOPED DURING IMPLEMENTATION]**
Customer service training for all staff, not just frontline	Waikato Host Training (Kiwi Host): The Waikato Way We have internal and external 'customers'				
Cultural Competency training to be part of orientation	• E Learning • Working through Scenarios				
Comms plan to deliver the priorities message	• For staff • For hospital visitors/patients e.g. foyer design: "your				

	whanau/family are cared for here" • Future employees				
Cultural arrest team	I need help with a cultural critical incident with another staff member /patient /stakeholder				
Physical spaces that reflects our bi-culture	• Bilingual signage • Area in front of ED (Waikato hospital) can show who we are • Enquiries desk at ED is made more welcoming • Our physical spaces needs to reflect who we are, who our population are, and the needs they have of our facilities				
Population demographic hiring	We are explicit in hiring staff whose culture is reflective of our population. We are explicit in DHB expectations and values when recruiting.				
Celebrations	• What does your team do to celebrate diversity • What does your team do to celebrate each other • What does your team do to celebrate you • Patient stories • Staff stories				

Staff WOF	Performance reviews that do a warrant of fitness for cultural competency and safety.				
Service and Team WOF	Stocktake cultural state of services and assess need for culture change. Modifying or implementing recommended changes to service delivery.				
Values workshops	Mandatory – if not already For EG For Board				
Staff journey of self-development and discovery	Sharing stories of staff's reflection on situations, learnings etc. TED Talk style?				

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
14 JUNE 2017

AGENDA ITEM 10.2

PRIORITY PROGRAMME PLAN PROJECT RECAP AND UPDATE

Purpose	1) For information

Introduction
This paper presents a re-cap and an update on the Priority Programme Plan Project. A PowerPoint presentation will be delivered to guide the discussion at the Health Strategy Committee. The slides will be spoken to by the PPP Project Team: Esmae McKenzie-Norton (Planning and Integration Manager) and Nicola Parker (Change Manager).

Background
A part of the development phase of the Waikato DHB Strategy Refresh Project a clear problem was identified. That problem was:

> *"…..that the main concern is our strategic priorities do not link to or drive how the organisation operates on a day-to-day basis. Staff identified a need to have a strategic direction that supports the parts of the organisation to work as a collective whole for a common purpose. Staff indicated they feel their day-to-day work occurs in a vacuum and that it is not linked directly enough to a clear sense of the DHB's overall priorities….."*

In the Waikato DHB Strategy Refresh Project Brief that was presented to Board in September 2015 the need for a strategy implementation mechanism was highlighted and the priority programme plan concept was born. A programme plan in this context is defined as: a set of related projects and activities to deliver outcomes and benefits that contribute towards achieving our strategic imperatives. A programme is likely to have a relatively long lifespan, with a project usually of shorter duration. A programme must:

- Meet a strategic need
- Communicate a compelling visualisation of a better future
- Enable and manage the realisation of benefits
- Lead change
- Have high level leadership and direction
- Learn from experience
- Add value

While the strategy refresh process had its' complexities, a lot of thinking and work had occurred to shape up the priority programme plan approach as a strategy implementation vehicle. Aside from the overarching focus of improving the health of

our population and eliminating inequities, the priority programme planning approach is part of the solution to the initial problems around:

- Linking the strategy to day-today activity
- Having a strategic direction that drives the organisation to work as a collective on a common purpose
- Providing a clear sense our priorities

Objectives of the Priority Programme Plan Project

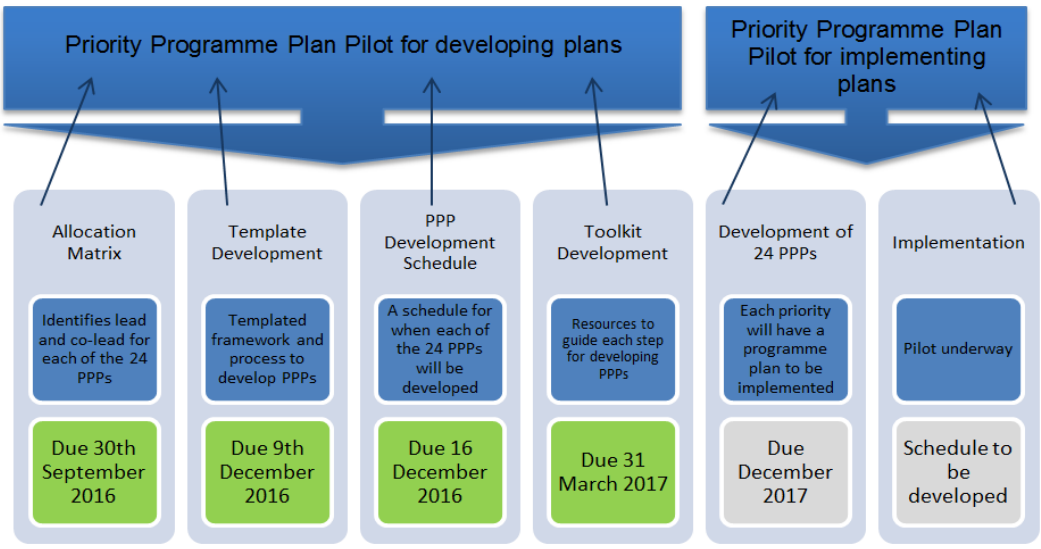
At the 8 July 2016 meeting of the Executive Group, a paper was presented around priority programme planning. The conversation at the meeting identified a number of points that have been used to develop the overall objectives for the Priority Programme Plan Project as one of the mechanisms for implementing the strategy. Achieving the Priority Programme Plan Project requires the following objectives to be realised:

- Identification of projects and activities at a National, Regional, and Local level (with the aim to reduce duplication)
- Organise work currently being carried out and scheduled to be carried out by the Waikato DHB
- Identify gaps and plan activities to fill the gaps in the long and short term
- Identify ways to work more proactively where possible
- Strengthen processes to identify and respond to priority areas
- Work more collaboratively with each other / stop silos (where possible and/or required)
- Ensure accountability and responsibility is clear
- Ensure robust information for decision making is available
- Develop a process that responds to the diversity of the organisation's business and activities

Approach

The overarching Priority Programme Plan Project is responsible for designing the process for the development of all Priority Programme Plans. Priority Programme Plan methodology and approach have been developed using a scalable and templated process to ensure consistency and robustness of approach. Tested templates support the process and tools to optimise delivery of the objectives.

The Priority Programme Plan Project approach is summarised in the diagram below.



Update on progress

Below is a status table for the activities and process for developing the plans:

Activity	Detail of activity	Status
Allocation of priorities to Executive Group members	An allocation matrix has been developed and signed off by the Executive Group. This matrix identifies one or more lead/s (Alpha) and one or more co-lead/s (Bravo). The Alpha and Bravo roles are made up of the Executive Group. The working groups that will be developed for each priority will include staff and non-staff (consumers, providers etc.) where appropriate.	Completed 30 September 2016
Priority Programme Plan Template	A priority programme plan template has been developed to guide executives and working groups in the development of priority programme plans. The Pilot and Executive Group feedback was key to developing the template.	Completed 9 December 2016
Development Schedule	The development schedule identifies the timing of when each priority programme plan will be developed. The rationale used for the scheduling was due to the nature of the priorities and the different requirements of each. Phase One was identified as expected to take longer due to the size and requirement for relationship building. Phase two include the priorities that are more foundational priorities. Phase Three include the priorities that focus on building the activity listed in the priority. Phase Four include priorities that take more of a delivery approach. Using a phased approach will also allow following phases to leverage off the work developed in earlier phases.	Completed 16 December 2016
Pilot Priority Programme Plan	A pilot for developing the priority programme plans was completed in February 2017 and the Health Strategy Committee gave approval for implementation on 8th March 2017. The priority piloted is 4.4: Enable a culture of innovation to achieve excellence in health and care services. A pilot was undertaken so staff could utilise the momentum of the new strategy while developing a robust process for developing priority programme plans.	Completed 28 February 2017
Toolkit for developing Priority Programme Plans	A toolkit for developing priority programme plans is being developed with the majority of the collateral for the toolkit developed through the Pilot process. The development of the toolkit will increase the sustainability of current and future priority programme plans and is a key deliverable for succession planning.	Completed 1 May 2017
Reporting mechanism to be developed for updates to the Health Strategy Committee	At the Health Strategy Committee on 12th April 2017 there was a request for a clear reporting mechanism to keep the Committee updated and informed on Strategy Implementation, especially the Priority Programme Plans.	Draft to be presented at the Health Strategy Committee on 14 June 2017

Recommendation
THAT
The Committee notes the content of the report

ESMAE MCKENZIE-NORTON
PLANNING AND INTEGRATION MANAGER
STRATEGY AND FUNDING

NICOLA PARKER
CHANGE MANAGER
CHANGE TEAM

Waikato District Health Board

General Business

Waikato District Health Board

Date of next meeting
9 August 2017