BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Agenda

Health Consumer Council

Venue: CEO Meeting Room, Building 16
Date and Time: Tuesday 12 September 2018 at 11:00am – 2:00pm

Item No.	Item	Page
1	**Apologies**	
2	**Presentation** 2.1 System Level Measures Improvement Plan – Saray Davey and Sarah Nash – 11am	2
3	**Minutes of Meeting** - 8 August 2018	28
4	**Matters Arising**	30
5	**Papers for Decision** 5.1 Draft Terms of Reference	31
6	**For Discussion** 6.1 Draft BOPDHB Emergency Medicine Services 5 year Strategic Service Plan 2018-23	34
7	**Papers for Noting** 7.1 Correspondence for Noting - Nil	
8	**General Business**	
9	**Next Meeting** - Wednesday 10 October 2018	

System Level Measures Improvement Plan

2018-19

Bay of Plenty Alliance Leadership Team

BAY OF PLENTY DISTRICT HEALTH BOARD
HAUORA A TOI

WBOP PHO
Western Bay of Plenty Primary Health Organisation

Ngā Mataapuna Oranga
Mauri Ora, Mauri Tau - Whānau Prosperity & Wellbeing

Eastern Bay Primary Health Alliance
Healthy Whānau, Healthy Lives

This document outlines how the System Level Measures Improvement Plan 2018/19 will be applied across the Bay of Plenty region. It summarises how improvement will be measured for each SLM and identifies high-level activities that will be fundamental to this improvement. This plan has been collaboratively developed by the Bay of Plenty District Health Board and its three Primary Health Organisation partners.

Contents

Executive Summary

The Bay of Plenty Strategic Health Services Plan (SHSP) provides our local health system and the communities we service with clear direction for the next 10 years. The SHSP describes Bay of Plenty District Health Board's (BOPDHBs) priorities, key actions and intended outcomes, and the infrastructure required to deliver these outcomes. The SHSP recognises that strong partnerships with our communities and other agencies are required for BOPDHB to achieve our vision and mission and make a real difference to population health outcomes.

(Our fresh approach for the BOP Health System - BOP Strategic Health Services Plan 2017 - 2027)

The System Level Measures (SLM) Framework supports the achievement of SHSP objectives and enables improved health outcomes for our population by supporting DHBs to work collaboratively with health system partners (primary, community and hospital) using specific quality improvement measures.

This SLM Improvement Plan 2018/19 has been developed in partnership by the Bay of Plenty Alliance Leadership Team (BOPALT) through an established SLM structure. The planning process aligned SLM actions and measures to strategic health objectives[1] and utilised a health equity assessment tool to target actions to reduce inequities. The plan outlines areas of focus, reason for focus and outcomes within these areas. The plan summarises how improvement will be measured for each SLM (short/medium and long-term), and identifies the high-level activities fundamental to this improvement.

Draft versions of the plan were presented to a wide range of key stakeholders for discussion, consideration and input. The finalised plan reflects the themes that emerged from these discussions and remains focussed on using quality improvement methodology based on principles of:

- Health equity for Māori;
- Decisions based on evidence/data; and
- Prevention and early intervention approaches to health.

The district health board and primary health organisations included in this improvement plan are:

- Bay of Plenty District Health Board;
- Eastern Bay Primary Health Alliance;
- Nga Mataapuna Oranga, and
- Western Bay of Plenty Primary Health Organisation.

[1] **BOP Strategic Health Services Plan**, **DHB Māori Health: Good to Great** and the **BOPDHB Annual Plan**

System Enablers

BOPALT recognises that smartly applied health technologies and information systems are pivotal enablers in our transition to a 'one system' patient focused world. The Bay of Plenty Information Systems Group (BOPIS) established by BOPALT, provides information system governance, advice and support for Alliance projects focussed on whole of system information sharing. As part of their mandate, BOPIS supports and enables delivery of the SLM programme by ensuring systems are in place to share patient information safely, to assist clinical decision-making and make healthcare more co-ordinated and integrated. Current objectives of the BOPIS Group and projects within the Group's work programme can be found **here**.

2018/19 will see the establishment of the first Bay of Plenty Health Consumer Council (Council). The Council will provide a strong and informed voice for the community and consumers on health service planning and delivery. The Council will seek to enhance consumer experience and service integration across the sector, promote equity and ensure that health services meet needs of consumers.

Non-Government Organisations (NGOs) integral to the achievement of actions under Youth Health and ASH (0-4 years) are closely aligned to the work in these areas.

Overview of System Level Measures

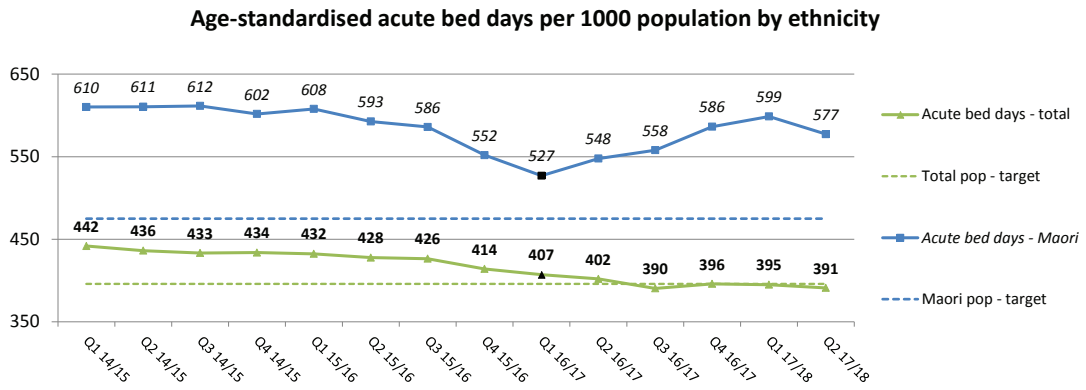
The table below shows an overview of the key focus areas for each of the system level measures.

Acute Hospital Bed Days

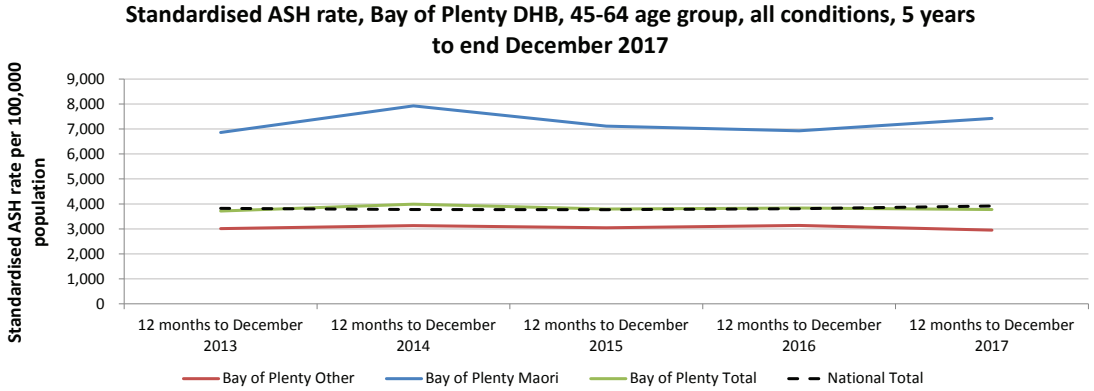
Using Health Resources Effectively - SLM Improvement Plan 2018-19

Where do we need to act?

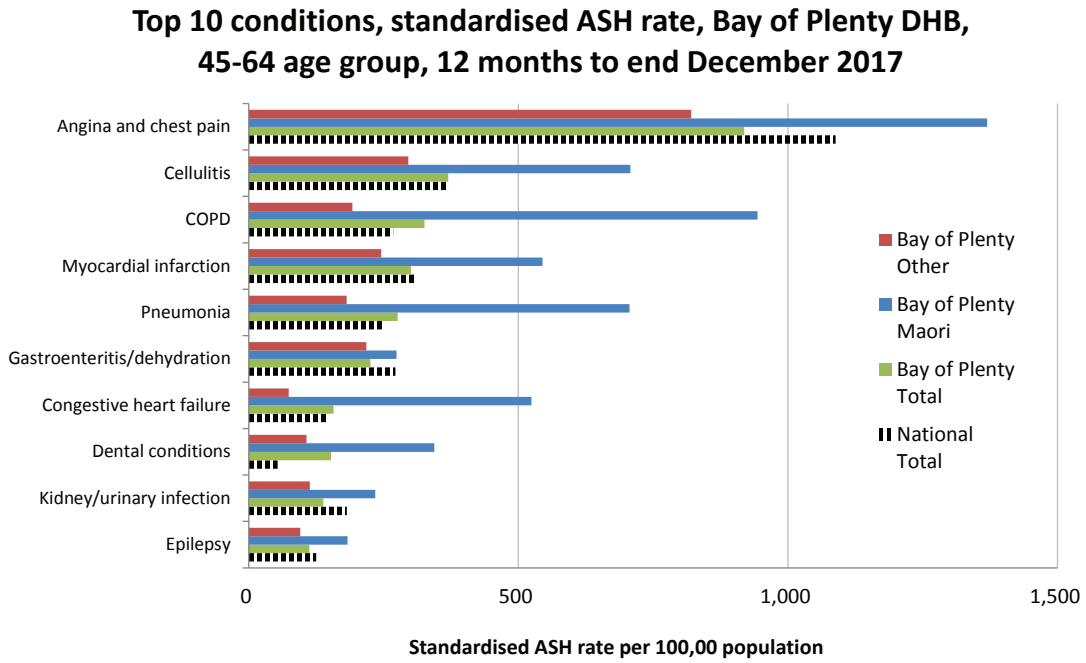
AcuteBed Day rates for Māori 48% higher than non-Māori



Māori 45-64 year olds are 2.5x more likely to be admitted for an ASH condition



Main reasons for preventative hospitalisation are; CVD, Respiratory & Cellulitis



Why do we need to act?

Acute admissions to hospital indicate increased risk of poor health outcomes, both as a result of the underlying condition(s) and from adverse events in hospital settings. Some of these admissions can be moderated by population health initiatives, early health care intervention and effective primary and community care and co-ordination with social services. BOP has higher rates of acute hospitalisation than the NZ rate. **(BOP Health and Service Profile 2016)**.

Our data tells us that:

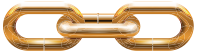
- Māori 45-64 year olds have a 48% higher rate of ASH admissions than non-Māori and that cardiovascular conditions, respiratory conditions and cellulitis are the main reason.

What are we trying to accomplish?

We are looking to reduce acute bed day rates by:

- proactively identifying patients at risk of admission to hospital in primary care;
- addressing chronic conditions through a self-management and early intervention approach in primary care;
- enabling efficient and effective flow through the hospital; and
- providing access to early advice for patients who are acutely unwell.

Linkages



BOP Strategic Health Services Plan: see Strategic Objective 2 & 3

BOPDHB Good to Great – Māori Health:

BOPDHB Annual Plan 17/18: see Section 2 & 5

Our Actions will be…

What changes/actions can we make that will result in an improvement?

- Collaboration between primary care and Emergency Departments to support referral back to, and promote patient engagement with, primary care, e.g. Cellulitis; Dehydration (Gastro); Pneumonia; COPD; Angina and Chest pain
- Collaboration with St John to increase transfers to primary care
- Proactive management of COPD and diabetes in primary care
- Analyse Māori acute admissions data and work with General Practices to explore population drivers and patient perspectives
- Implement a Risk Stratification tool in General Practice across the BOPDHB catchment
- Develop and implement a pilot group of GP Health Care Homes
- Reduce admissions to hospital from ARRC by supporting clinical knowledge/pathway development, and medicines reconciliation
- Undertake an Acute Flow Improvement Programme in Tauranga and Whakatane Hospitals, focused on the flow through ED, the deteriorating patient and frail/co-morbid patients.

Our Contributory Measures are…

How will we know a change/action is an improvement?

- 5% reduction in Māori **45-64 yrs Ambulatory Sensitive Hospitalisations**
- 90% of ED requests for transfer of care to primary care using care pathways (during the week) are accepted by primary care
- 5% reduction the proportion of Māori patients with a length of stay in excess of 7 days.

SLM Milestone…

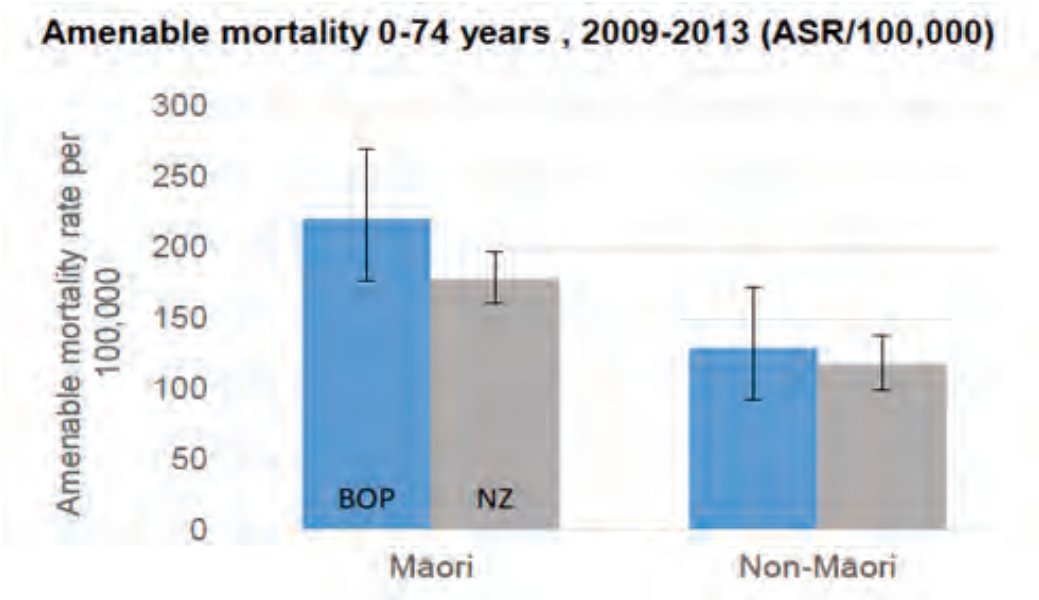
We will achieve a 5% reduction in Māori **Acute Hospital Bed Days** by 30 June 2019.

Amenable Mortality

Prevention and Early Detection - SLM Improvement Plan 2018-19

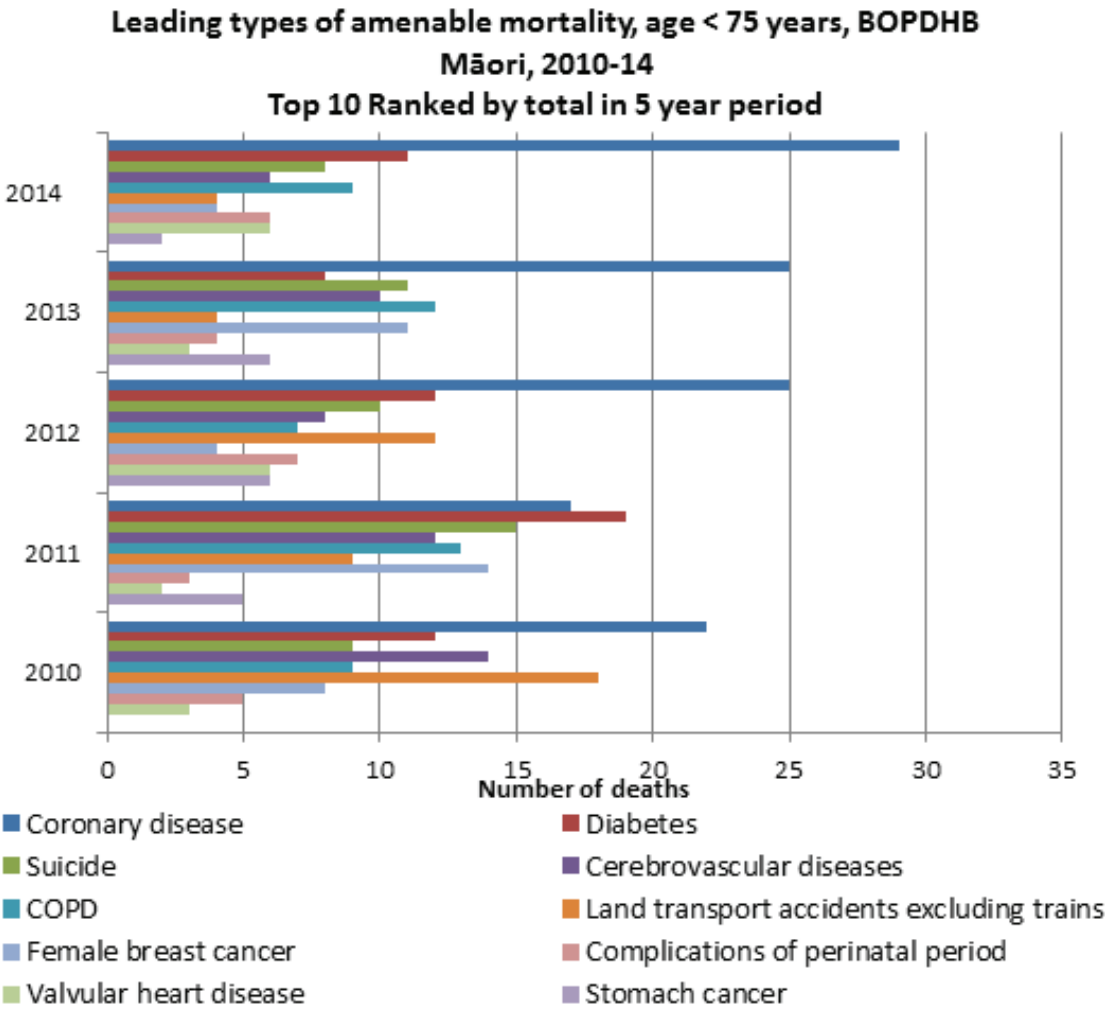
Where do we need to act?

Amenable mortality is 2x higher for Māori than non-Māori in BOP



Note: Data availability delayed due to New Zealand's coronial process.

Cardiovascular disease, Diabetes & COPD show highest rates for Māori



Smoking is a major risk factor for CVD and COPD

Why do we need to act?

Amenable Mortality refers to deaths that might have been prevented if:

- health promotion and/or health services had been more effective;
- people had accessed services earlier (either in primary care or in hospital); or
- there was equality in health determinants.

Amenable mortality is often used to portray the overall performance of health services in a region. **(BOP Health and Service Profile 2016)**.

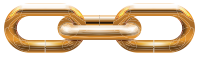
Our data tells us that:

- Standardised rates of amenable mortality are more than double for Māori compared to non-Māori in BOPDHB, and that coronary disease, diabetes, suicide and COPD are the main reasons for this.

What are we trying to accomplish?

We are looking to reduce standardised amenable mortality rates for Māori by reducing smoking rates – a contributor to most of our amenable mortality conditions. We also want to focus on current screening programmes (breast and cervical) to support prevention and early detection as well as engagement with primary care.

Linkages



BOP Strategic Health Services Plan: see Strategic Objective 1

BOPDHB Good to Great – Māori Health:

BOPDHB Annual Plan 17/18: see Section 2 & 5

Toi Te Ora Public Health Strategic Plan – 2013 - 2025

What changes/actions can we make that will result in an improvement?

Our Actions will be…

- Improve data capture and reporting on long term quit rates
- Support brief interventions in general practice and hospital settings
- Focus Stop Smoking services on vulnerable populations – Māori , mental health clients and Hapu Mama
- Work with general practice and screening services to perform tests of change to improve cervical and breast screening rates for Māori and priority women. Identify successful initiatives and implement these across the wider BOPDHB region.

How will we know a change/action is an improvement?

Our Contributory Measures are…

- 5% increase in the numbers of **PHO enrolled smokers who have been offered help to quit by a health care practitioner in the last 15 months** – Māori
- 5% reduction in smoking prevalence for Māori
- Achieve cervical screening coverage for Māori in excess of 75%
- Achieve breast screening coverage for Māori in excess of 65%

SLM Milestone…

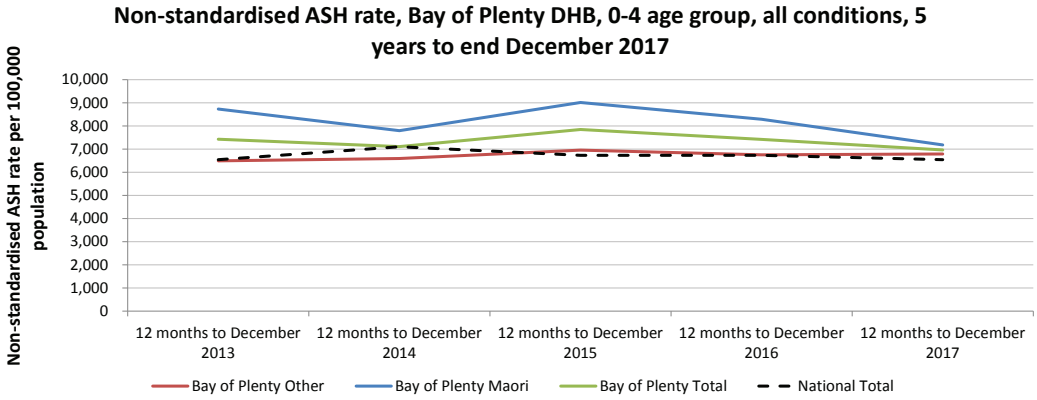
We will achieve a 30% reduction in standardised **amenable mortality** rates for Māori by 30 June 2023.

ASH 0-4 years

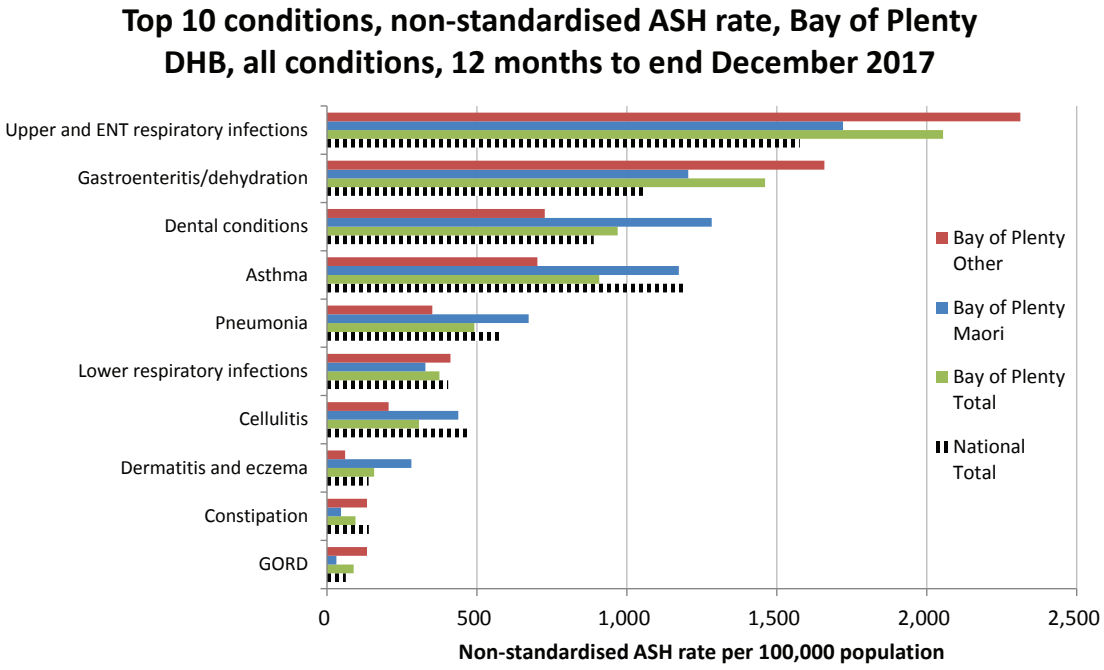
Keeping Children out of Hospital - SLM Improvement Plan 2018-19

Where do we need to act?

BOP Māori have a 6% higher rate of ASH (0-4) admissions than BOP non-Māori



The main conditions where there are disparities between Māori and non-Māori are: Respiratory and Dental Conditions



Why do we need to act?

0 – 4 year olds are vulnerable to higher risk of poor health outcomes and are reliant on caregivers to access services (e.g. because of cost, health, literacy, transport). Adverse health events during childhood and youth can be related to poor health and social outcomes later in life. Timely interventions can reduce risk of lasting harm and premature mortality. **(BOP Health and Service Profile 2016)**.

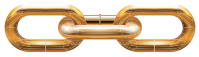
Our data tells us that:

- BOP Māori have a 6% higher rate of ASH admissions than BOP non-Māori and that Respiratory and Dental conditions are the main areas of disparity.

What are we trying to accomplish?

We want to eliminate the equity gap and reduce overall rate for ASH (0-4 years) conditions by enrolling children early into primary and dental care. Early engagement of children with health care providers will enable preventative options and promote early intervention when required.

Linkages



Well Child Tamariki Ora (WCTO) Quality Improvement Framework

BOP Strategic Health Services Plan: *see Strategic Objective 1*

BOPDHB Good to Great – Māori Health:

BOPDHB Annual Plan 17/18: *see Section 2 & 5*

Toi Te Ora Public Health Strategic Plan – 2013 - 2025

What changes/actions can we make that will result in an improvement?

Our Actions will be…

- Improve immunisation rates through early enrolment with General Practice, and following up and supporting enrolment for those that are vulnerable (i.e. missed or incomplete original enrolment form) with dedicated resource and reviewing the new Service support model for immunisation.
- Continue to focus on early enrolment with dental services
- Increase the use of fluoride varnish for disease prevention and investigate use of stainless steel crowns in pre-schoolers.
- Develop oral health programme for low income pregnant women (linked to first 1000 days focus)
- Develop and collect meaningful data around respiratory conditions and pathways of care to inform targeted actions for improvement in this area.
- Work with Well Child Tamariki Ora providers to improve data capture for the “Smokefree household at six weeks post-natal question”.

Our Contributory Measures are…

How will we know a change/action is an improvement?

- 5% reduction in Māori **Ambulatory Sensitive Hospitalisations Dental**
- 5 % reduction in asthma ASH (0-4 years) rates for Māori

SLM Milestone…

We will reduce the **childhood ASH rates** for Māori to 6545 (current National average for total population) by the 30 June 2019.

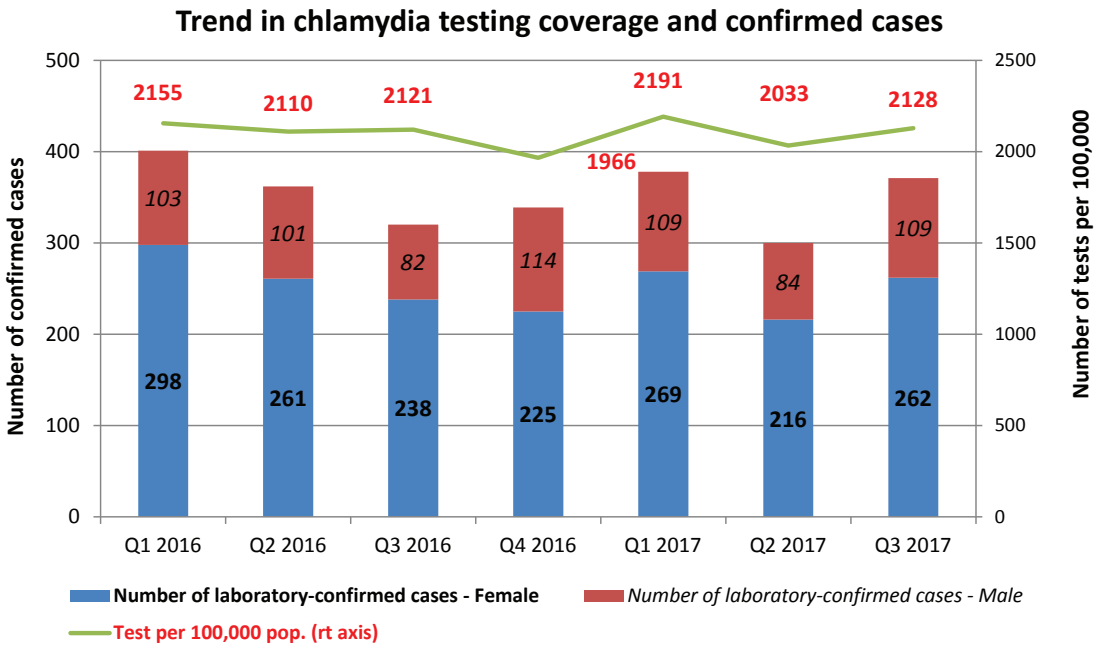
Youth Sexual Health

Youth are Healthy, Safe and Supported - SLM Improvement Plan 2018-19

Where do we need to act?

Chlamydia rates in BOP 5th highest in the NZ

Only 23-38% of at-risk females and <10% males are being tested



Note: Further work has been progressed to obtain chlamydia data by ethnicity.

Why do we need to act?

Youth have their own specific health needs as they transition to adulthood. Most youth in New Zealand successfully transition to adulthood, but some do not. This is mainly due to a complex interplay of individual, family and community stressors and circumstances, or 'risk factors'. Evidence shows that youth cope with illness with advice from friends and whānau, as opposed to engaging with health services or a registered health practitioner; attending a health clinic is often viewed as a last resort instead of a reasonable first choice. (Health Quality Measures NZ website).

Our data shows that:

- Chlamydia incidence is 629/100 000 nationally vs BOP 689/100 000 (Ranked 5th nationally)
- Our neighbours, Lakes and Tairawhiti DHBs consistently highest at 1143/100 000
- 83% of chlamydia cases are in 15-29 year olds, with cases twice as likely to be female than male
- Annual testing coverage rates in the at-risk age groups suggest that <10% of males and 23–38% of females are tested annually.

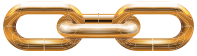
(BOP Sexual and Reproductive Health Service Presentation by Dr Lorna Claydon at Youth System Level Measures Working Group Meeting, Sept 2017)

What are we trying to accomplish?

We are looking to increase awareness, education, early identification and treatment for sexual health conditions. This will be achieved by making services more accessible to those at higher risk, e.g. Māori Youth, LGBQTI, rural youth, seasonal workers, gang members and alternative education attendees.

(BOP Sexual and Reproductive Health Service Presentation by Dr Lorna Claydon at Youth System Level Measures Working Group Meeting, Sept 2017).

Linkages



SLM: Youth access to and utilisation of youth appropriate health services

BOP Sexual and Reproductive Health Services Review 2016

BOPDHB Annual Plan 17/18: see Section 5

BOP Strategic Health Services Plan: see Section 4

What changes/actions can we make that will result in an improvement?

Our Actions will be…

Raising awareness and education by:

- developing accessible and accurate information online for youth;
- creating integrated multi-agency education packages involving Family Planning, Sexual Health, Mental Health and Iwi, with input from youth;
- building on the existing development of clinical pathways; and
- upskilling the clinical workforce through effective teaching, placements, study days and technology use to overcome barriers such as time, distance and funding.

Making services more accessible to those at higher risk by:

- providing transgender health services within sexual health;
- developing mobile rural health workers, particularly in the Eastern Bay to support existing clinical pathways;
- developing online testing for youth in remote communities; and
- develop ing outreach capacity (utilising Polymerase Chain Reaction (PCR) Rapid testing technology)

How will we know a change/action is an improvement?

Our Contributory Measures are…

- An increase in chlamydia testing coverage via “Quick Check” self-testing (this is a new initiative effective 1 July 2018).
- A 20% of all self-testing is carried out by youth who have not previously had an STI check.

SLM Milestone…

We will see a 5% increase in **chlamydia testing coverage for 15 – 24 year olds** by 30 June 2019.

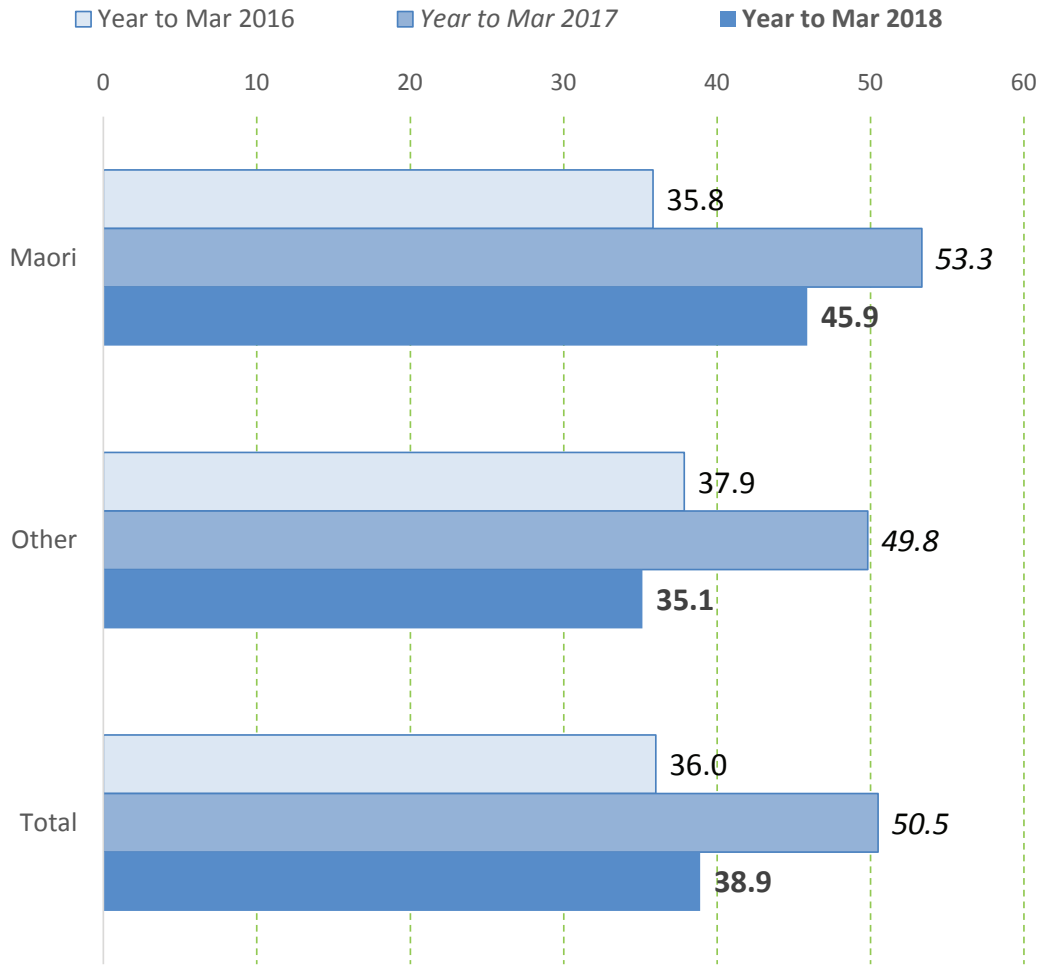
Youth Mental Health

Youth are Healthy, Safe and Supported - SLM Improvement Plan 2018-19

Where do we need to act?

BOP Māori youth have 31% higher rates of self- harm hospitalisations than other

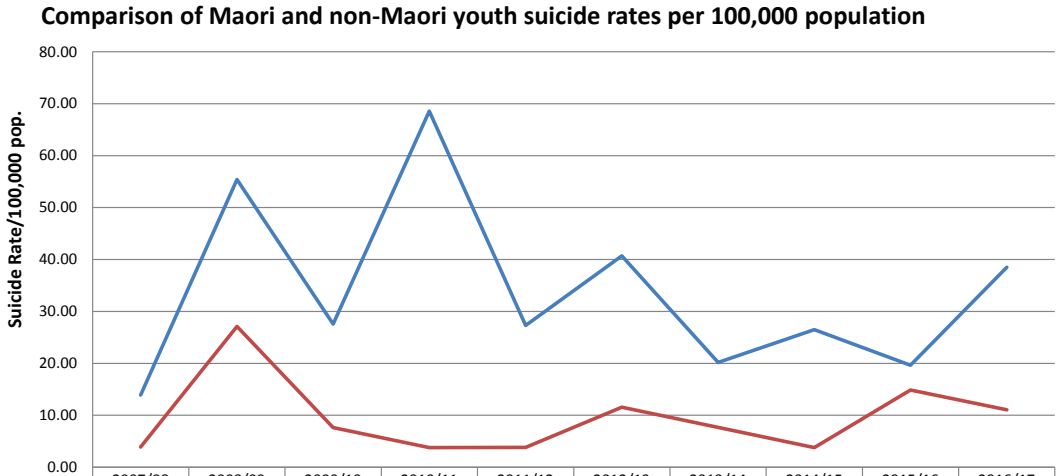
Age standardised youth self-harm hospitalisation rates per 10,000 population by ethnicity (2015 – 2017)



Note: Other refers to non-Māori, non-Pasifika. Pasifika have not been included in this graph as very low numbers make comparing the rates for this group difficult.

BOP Youth suicide rates per 100,000 population by ethnicity (2007/08 – 2016/17)

On average, over the last 10 years BOP Māori suicide rates were 3.5x higher than non-Māori



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
10-24 - Maori	13.92	55.40	27.59	68.59	27.29	40.71	20.17	26.51	19.63	38.51
10-24 - Non-Maori	3.91	27.11	7.63	3.79	3.82	11.57	7.65	3.76	14.88	11.05

Why do we need to act?

Many factors can influence a person's decision to attempt suicide. Suicide prevention initiatives generally aim to promote protective factors, reduce risk factors and improve services available for people in distress. A range of protective factors can enhance a person's wellbeing and resilience, and reduce their risk of suicide. These include: access to community and health resources, social connectedness, and the capacity to cope with life's difficulties. (Health Quality Measures NZ website). **Our data shows that:**

- Youth self-harm hospitalisations for Māori are 31% higher than for non-Māori.
- Māori youth suicide rates are higher than for non-Māori in all of the last ten years.
- Māori youth suicide rates were more than two times greater annually than for non-Māori over this period (with the exception of 2015/16).
- On average, over the last ten years Māori youth suicide rates per annum have been 3.55 times greater than non-Māori youth suicide rates

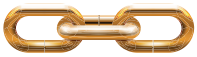
What are we trying to accomplish?

We are looking to improve the knowledge and skill of those working with vulnerable youth to:

- Identify mental health and addiction issues;
- Offer support and refer to appropriate Mental Health and/or Addiction Services as required; and
- Enable early detection of potential self-harming behaviour in youth.

This would involve workforce development for those working in schools, tertiary education, alternative education, kaupapa services and other agencies that work with youth. Knowledge and skills would be built through workforce training and developing a guideline for schools in the management of self-harm behaviour.

Linkages



BOPDHB Suicide Prevention Postvention Action Plan 2018 - 2021

SLM: Youth access to and utilisation of youth appropriate health services

BOPDHB Annual Plan 17/18: see Section 5

BOP Strategic Health Services Plan: see Section 4

What changes/actions can we make that will result in an improvement?

Our Actions will be…

- Finalise stocktake of Alternative Education providers in the Bay of Plenty
  - Identify students' access to Mental Health and AOD supports
  - Identify tutors access to consultation and workforce development regarding youth mental health and suicide prevention.
- Establish a Steering Group with appropriate youth sector representation to develop and prioritise interventions to address any gaps in service provision.
- Develop a workforce training package for the youth sector, which is evidence based and culturally appropriate.

Our Contributory Measures are…

How will we know a change/action is an improvement?

- 80% of Māori youth referred to mental health services are seen within three weeks.
- A 10% increase in the number of Māori youth seen in primary mental health services

SLM Milestone…

We will see a 5% reduction in **Age Standardised youth self-harm hospitalisation rates** for Māori by 30 June 2019.

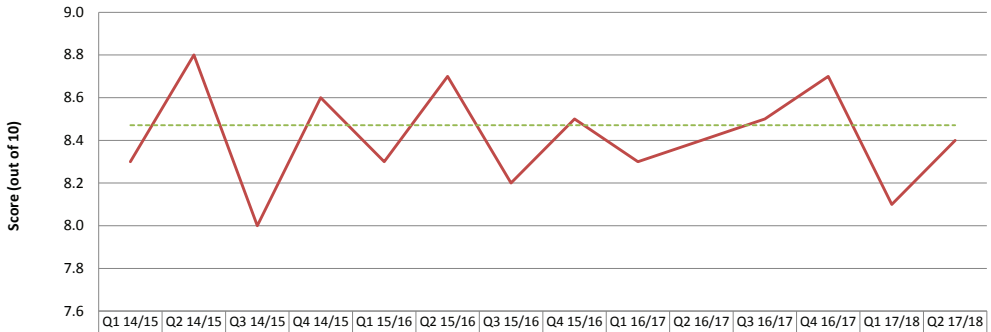
Patient Experience of Care

Person, Family/Whānau Centred Care - SLM Improvement Plan 2018-19

Where do we need to act?

Inpatient PEC survey overall results for BOP are similar to national results, though response rates are low

BOPDHB inpatient survey trends - overall score from 2014/15 onwards

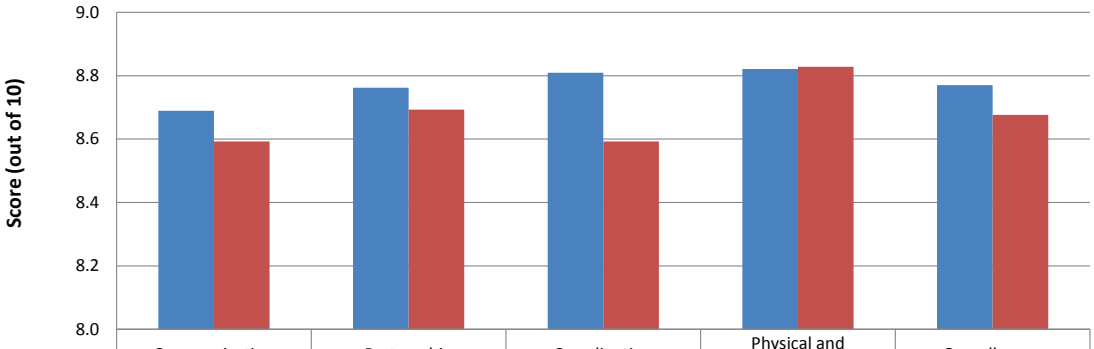


	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
BOPDHB inpatient score	8.3	8.8	8.0	8.6	8.3	8.7	8.2	8.5	8.3	8.4	8.5	8.7	8.1	8.4
Target (National average)	8.47	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5

Note: Further work has been progressed to obtain inpatient survey data by ethnicity.

BOP has higher scores than national averages across all 4 domains, based on fortnightly surveys. Māori scores are generally higher than for non-Māori

Weighted average fortnightly inpatient survey results by ethnicity for BOPDHB - From Aug-Oct 17, Nov 17-Jan 18, and Feb-Apr 18 periods

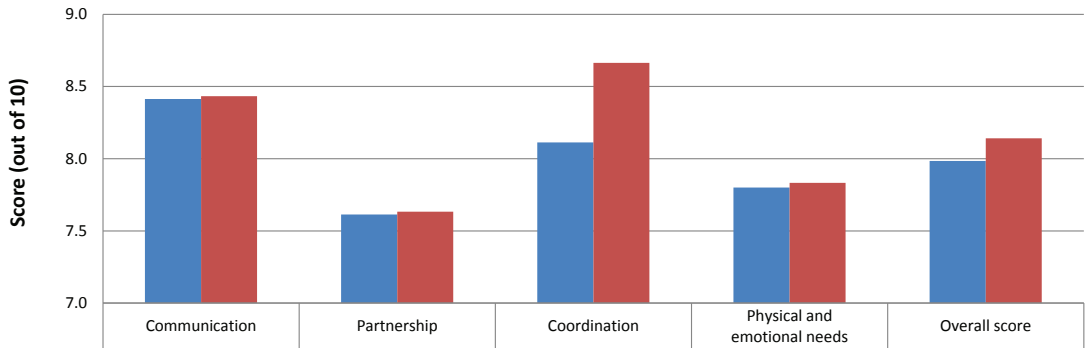


	Communication	Partnership	Coordination	Physical and emotional needs	Overall score
Maori	8.7	8.8	8.8	8.8	8.8
Non-Maori	8.6	8.7	8.6	8.8	8.7

Note: Further work has been progressed to obtain inpatient survey data by ethnicity.

The biggest area for improvement within the primary care survey is Partnership

Weighted average primary care patient experience survey results by ethnicity for BOPDHB - From Aug 17, Nov 17 and Feb 18 surveys



	Communication	Partnership	Coordination	Physical and emotional needs	Overall score
Maori	8.4	7.6	8.1	7.8	8.0
Non-Maori	8.4	7.6	8.7	7.8	8.1

Why do we need to act?

Patient experience is a vital but complex area. Growing evidence suggests patient experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers, and patient and family-centred care have been linked to improved outcomes across health, clinical, financial, service and satisfaction domains. (Health Quality Measures NZ website). **Our data shows that:**

- BOPDHB's overall inpatient survey score is broadly in line with what is observed nationally, based on quarterly survey data
- Māori typically score better than non-Māori in the fortnightly inpatient survey
- Primary care survey scores for Māori and non-Māori are broadly aligned in three of the four categories, though there is an equity gap in the Coordination space. However, the Partnership domain scores the lowest for both Māori and non-Māori respondents.
- Māori response rates are low for both inpatient and primary care patient experience surveys

What are we trying to accomplish?

The focus of 17/18 was principally to increase response rates for the primary care survey – these have steadily improved during the year. While improving response rates for Māori will remain a focus in the 2018/19 plan, the main intent of this plan is to improve performance in the partnership domain, and to identify opportunities to improve service delivery and integration (with a focus on Māori)through the analysis of survey comments.

Linkages

BOP Strategic Health Services Plan: see Strategic Objective 2 & 3 and Infrastructure

BOPDHB Good to Great – Māori Health:

BOPDHB Annual Plan 17/18: see Section 2 & 5

What changes/actions can we make that will result in an improvement?

Our Actions will be…

- Improve participation rates for Māori in both the primary care and inpatient Patient Experience Surveys (PES).
- Analyse results of the two surveys, particularly in the comments fields, to identify opportunities to improve service delivery and integration for Māori.
- Support other Working Groups by sharing patient experience data and working collaboratively to improve performance.
- Embed Future Care Planning as business as usual across the Bay of Plenty
- Partner with the BOPDHB Consumer Council where appropriate to support the design of improvement initiatives
- Increase uptake of Patient Portals in General Practice to support the partnership between patients and their General Practice.

Our Contributory Measures are…

How will we know a change/action is an improvement?

- Māori will provide over 15% of survey responses for **Patients completing the primary care patient experience survey**
- 15% of enrolled **Patients registered to use general practice portals across the BOPDHB region**

SLM Milestone…

We will increase our score in the partnership domain to 8.0 or more in the primary care **patient experience of care** survey by 30 June 2019 for both Māori and non-Māori.

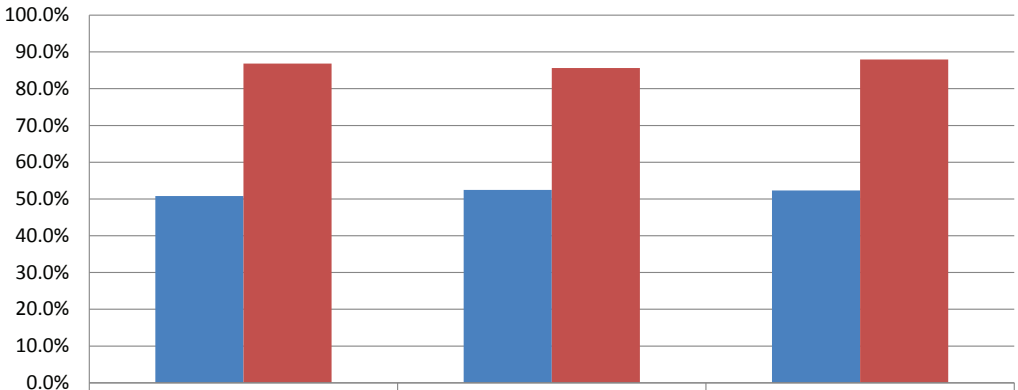
Babies Living in Smokefree Homes

A Healthy Start - SLM Improvement Plan 2018-19

Where do we need to act?

Māori infants are almost 4x more likely to reside in a household with a smoker present than for non-Māori.

BOPDHB babies living in smokefree households at six weeks by ethnicity



	Jul-Dec 2016	Jan-Jun 2017	Jul-Dec 2017
Maori	50.8%	52.5%	52.3%
Non-Maori	86.8%	85.6%	87.9%

Why do we need to act?

This measure is focused on the total reduction of infant exposure to cigarette smoke. The measure shifts attention beyond maternal smoking to also encompass the home and family/whānau environment, which requires an integrated approach between lead maternity carers, Well Child Tamariki Ora (WCTO) providers and primary care. The measure targets the collective environment an infant will be exposed to during pregnancy and in the early stages following birth, including the home environment where they are raised.

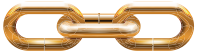
Our data shows that :

- Almost 50% of Māori infants in the BOPDHB region live in households where they are exposed to smoking
- Māori infants are almost four times more likely to live in a household where they are exposed to smoking than non-Māori infants
- Over 14% of responses have an unknown household smoking status in the 2017 calendar year, which increases to over 23% for Māori

What are we trying to accomplish?

We are looking to reduce the number of Māori children exposed to smoking in their home environment by targeting Stop Smoking services (Hāpainga) to Hapu Mama. We will also work with WCTO providers to improve data capture for the question used to measure performance against this SLM.

Linkages



Well Child Tamariki Ora (WCTO) Quality Improvement Framework

BOP Strategic Health Services Plan: see Strategic Objective 1

BOPDHB Good to Great – Māori Health:

BOPDHB Annual Plan 17/18: see Section 2 & 5

Our Actions will be...

What changes/actions can we make that will result in an improvement?

- Please see our ASH 0-4 years and Amenable Mortality plan

Our Contributory Measures are…

How will we know a change/action is an improvement?

- Over 70% of Māori **Mothers who are smokefree at two weeks post-natal** by 30 June 2019.
- We will reduce the proportion of Māori 'Unknown' responses to the household smoking status question to below 10% by 30 June 2019.

SLM Milestone…

We will improve the proportion of Māori **Babies Living in Smokefree Homes** to 60% or more by 30 June 2019.

Appendix 1: Additional Data Tables

Acute Bed Days

45-64 ASH admissions by year and ethnicity for all conditions

	12 months to Dec 2013	12 months to Dec 2014	12 months to Dec 2015	12 months to Dec 2016	12 months to Dec 2017
Māori	712	833	773	768	842
Non-Māori	1417	1473	1447	1537	1467
BOP Total	**2129**	**2306**	**2220**	**2305**	**2309**
National	43467	43403	43960	45357	47451

45-64 ASH admissions by top 10 condition and ethnicity for the 12 months to December 2017

	Angina	Cellulitis	COPD	Myocardial Infarction	Pneumonia	Gastro/ dehydration	Heart failure	Dental	Kidney/urinal	Epilepsy infection
Māori	154	81	106	62	80	31	60	39	27	21
Non-Māori	281	147	201	117	146	59	113	67	45	35
BOP Total	**435**	**228**	**307**	**179**	**226**	**90**	**173**	**106**	**72**	**56**
National	13172	4446	3285	3744	3021	3286	1750	640	2203	1507

ASH (0-4) years

0-4 ASH admissions by top 10 condition and ethnicity for the 12 months to December 2017

	Upper respiratory	Gastro/ dehydration	Dental	Asthma	Pneumonia	Lower respiratory	Cellulitis	Dermatitis and eczema	Constipation	GORD
Māori	191	137	60	58	29	34	17	5	11	11
Non-Māori	110	77	82	75	43	21	28	18	3	2
BOP Total	**301**	**214**	**142**	**133**	**72**	**55**	**45**	**23**	**14**	**13**
National	4807	3252	2712	3633	1769	1232	1438	423	425	192

Youth Mental Health

Self-Harm hospitalisations - Number of events and standardised rates for the last three years by age-group, ethnicity, gender and deprivation

	2015		2016		2017			
	Events - BOP	Standardised - BOP	Events - BOP	Standardised - BOP	Events - BOP	Standardised - BOP	Standardised - National	% diff BOP v Nat.
Total rate	**149**	**36.3**	**210**	**50.3**	**177**	**42.3**	**47.7**	**-11.3%**
10 to 14	15	10.0	28	18.6	18	11.6	16.3	-28.6%
15 to 19	93	64.8	123	84.3	103	70.3	76.3	-7.9%
20 to 24	41	32.7	59	46.4	56	43.4	48.8	-11.1%
Māori	52	35.7	76	51.2	69	47.3	59.8	-20.9%
Pasifika	1	9.1	6	59.3	5	46.5	28.9	**60.8%**
Other	96	37.9	128	50.0	103	40.0	46.1	-13.3%
Male	36	17.2	57	26.5	56	26.2	23.1	**13.7%**
Female	113	57.3	153	76.6	121	59.9	74.0	-19.0%
Q1	9	18.8	13	27.8	14	27.7	39.6	-30.0%
Q2	22	34.1	27	41.8	21	32.5	40.2	-19.3%
Q3	23	27.3	35	41.1	38	44.8	48.0	-6.7%
Q4	47	47.7	64	64.0	61	60.4	57.4	**5.2%**
Q5	48	39.9	71	57.8	43	35.4	51.2	-30.8%

Youth suicide numbers by ethnicity

	Māori - 10-24	Non-Māori 10-24
2007/08	2	1
2008/09	8	7
2009/10	4	2
2010/11	10	1
2011/12	4	1
2012/13	6	3
2013/14	3	2
2014/15	4	1
2015/16	3	4
2016/17	6	3

Babies Living in Smokefree Homes

Rolling 12 month number of non-smoking mothers and total mothers by ethnicity from LMC data

12 month period end	Māori mothers who don't smoke*	Māori mothers^	Non-Māori mothers who don't smoke*	Non-Māori mothers^
Q1 2014/15	609	1024	1562	1689
Q2 2014/15	660	1078	1591	1729
Q3 2014/15	649	1062	1617	1759
Q4 2014/15	656	1072	1663	1797
Q1 2015/16	635	1043	1676	1804
Q2 2015/16	622	1017	1681	1801
Q3 2015/16	622	1035	1679	1793
Q4 2015/16	655	1075	1660	1770
Q1 2016/17	690	1126	1645	1750
Q2 2016/17	722	1158	1670	1763
Q3 2016/17	743	1156	1693	1781
Q4 2016/17	744	1170	1780	1873
Q1 2017/18	746	1128	1870	1961

** Note: smoking status of N at two weeks post-natal, based on data from MOH provided LMC data set*
^ Note: this excludes mothers where no smoking status was recorded

Appendix 2: BOP System Level Measures Membership (2017/18)

SLM SLAT

Name	Position/Role	Organisation Representation
Dr Joe Bourne (Chair) and Innovation	Clinical Director of Improvement	Service Improvement Unit, BOPDHB
Andrea Baker	Portfolio Manager – Primary Care	Planning & Funding, BOPDHB
Carliza Patuawa	PHO Clinical Performance Manager	Nga Mataapuna Oranga Ltd
Marama Tauranga	Programme Manager – Health Equity	Māori Health Planning & Funding, BOPDHB
Jackie Davis	Portfolio Manager – Primary Care	Māori Health Planning & Funding, BOPDHB
Jeane Rossiter	Performance Manager	Eastern Bay Primary Health Alliance
Karen Smith	Business Leader	Regional Community Services, BOPDHB
Phil Back	General Practice Services Manager Organisation	Western Bay of Plenty Primary Health
Philippa Jones	Primary Care Nurse Leader	Māori Health Planning & Funding, BOPDHB
Sarah Davey	Service Development and Delivery	Planning & Funding, BOPDHB Manager
Steven Radford-Basher	Performance Analyst	Planning & Funding, BOPDHB

Acute Bed Days

Name	Role/Function	Organisation Representation
Philippa Jones	Manager/Operational Lead	BOPDHB/WBOPPHO
Dr Luke Bradford	Clinical Lead	WBOPPHO
Jen Boryer	Working Group Member	SIU, BOPDHB
Stephanie Watson	Working Group Member	ED, BOPDHB
Dr Kate Grimwade	Working Group Member	MEDICAL, BOPDHB
Chris Tofield	Working Group Member	SIU, BOPDHB
Sandra Feilding	Working Group Member	MEDICAL, BOPDHB
David Gilbert	Working Group Member	Accident & Medical
Rosemary Minto	Working Group Member	Te Manu Toroa General Practice Nurse Practitioner, NMO
Jeremy Gooders	Working Group Member	St Johns
Pauline McQuoid	Working Group Member	MEDWISE
Caroline Steens	Working Group Member	EBPHA
Andrea Baker	Working Group Member	Portfolio Manager, Planning & Funding, BOPDHB

Amenable Mortality

Name	Role/Function	Organisation Representation
Donna McArley	Operational Lead	Te Manu Toroa Business Practice Manager, NMO
Lizzie Spence	Clinical Lead	Smokefree Lead, EBPHA
Candy Blackwell	Working Group Member	Hapainga Stop Smoking Practitioner, NMO
Dr Geoff Esterman	Working Group Member	GP, Gate Pa Medical, WBOPPHO
Stephen Twitchen	Working Group Member	Public Health Analysis, Toi Te Ora, BOPDHB
Stewart Ngatai	Working Group Member	Māori Health Planning & Funding, BOPDHB
Roimata Timutimu	Working Group Member	Māori Health Planning & Funding, BOPDHB
Renee Wilton	Working Group Member	Suicide Prevention Coordinator, Māori Health Planning & Funding, BOPDHB

Patient Experience

Name	Role/Function	Organisation Representation
Jeane Rossiter	Operational Lead	EBPHA
Dr Marshall Hollister-Jones	Clinical Lead	Chadwick Medical Centre, WBOPPHO
Lilian Herrmann	Working Group Member	Clinical Lead Integrated Case Management, EBPHA
Jackie Davis	Working Group Member	Portfolio Manager, Primary Care, MHP&F, BOPDHB
Sarah Davey	Working Group Member	Service Development and Delivery Manager, P&F, BOP DHB
Averil Boon	Working Group Member	Programme Manager, Quality and Patient Safety, BOPDHB
Ros Jackson	Working Group Member	Programme Manager, BOPDHB
Carliza Patuawa	Working Group Member	PHO Clinical Performance Manager, NMO
Bronwyn Anstis	Working Group Member	Business Leader, Surgical Services, BOPDHB
Debbie Baillie	Working Group Member	Liaison, General Practice Services, WBOPPHO
Jewelz Taylor	Working Group Member	Equity Service Improvement and re-design Manager, BOPDHB
Ellen Fisher	Working Group Member	Future Care Planning Implementation Manager
Suzanne Board	Working Group Member	Change Manager, Service Improvement Unit, BOPDHB
Consumer Representation	Working Group Member	

ASH 0-4 years old

Name	Role/Function	Organisation Representation
Martin Steinmann	Operational Lead	Manager, CH4K, BOPDHB
Dr Alison James	Working Group Member	GP, WBOPPHO
Suzanne Thompson	Working Group Member	Childhood Immunisation Coordinator, EBPHA
Raewyn Lucas	Working Group Member	Child & Youth Mortality Coordinator, BOPDHB
Carliza Patuawa	Working Group Member	PHO Clinical Performance Manager, NMO
Jeane Rossiter	Working Group Member	Performance and Practice Relationship Manager, EBPHA
Connie Hui	Working Group Member	Portfolio Manager, Planning & Funding, BOPDHB
Tim Slow	Working Group Member	Portfolio Manager, Planning & Funding, BOPDHB

Youth Health

Name	Role/Function	Organisation Representation
Sarah Davey	Operational Lead	BOPDHB
Dr Lorna Claydon	Clinical Lead	Sexual Health Clinic, BOPDHB
Dr Claire McNally	Working Group member	GP, WBOPPHO
Julia De Silva	Working Group Member	Sexual Health Lead, EBPHA
Sue Matthews	Working Group Member	Community Health Team Lead, EBPHA
Rosemary Minto	Working Group Member	Te Manu Toroa General Practice, Nurse Practitioner, NMO
Irene Walker	Working Group Member	Kia Piki Te Ora, Te Ao Hou Trust
Anja Theron	Working Group Member	ICAMHS, BOPDHB
Caleb Putt	Working Group Member	Sorted, BOPDHB
Renee Wilton	Working Group Member	Suicide Prevention Coordinator, Māori Health Planning & Funding, BOPDHB
Becks Clarke (Watts)	Working Group Member	Tauranga Youth Development Team
Connie Hui	In attendance	Portfolio Manager, Child and Youth, MHP & F, BOPDHB
Roimata Timutimu	In attendance	Portfolio Manager, Public Health/Health Equity, P & F BOPDHB
Lesley Watkins	In attendance	Portfolio Manager, MH & A, P & F, BOPDHB
Tim Slow	In attendance	Portfolio Manager, Child and Youth, P & F BOPDHB

SLM Support: Sarah Nash - Project Coordinator, P & F, BOPDHB & Jen Boryer – Programme Manager, SIU, BOPDHB

Minutes of Health Consumer Council

Venue: Education Centre, Tawa Roon
Date: 8 August 2018 at 11:00am

Attendees: John Powell (Chair), Susan Horne, Julia Genet, Wol Hansen, Rosalie Liddle Crawford, Tessa Mackenzie, Susan Matthews, Maz McKevitt, Lisa Murphy, Florence Trout, Adrienne von Tunzelmann, Averil Boon and Cherie Martin

Item No.	Item	Action
	Meeting opened with a Karakia by Susan Horne	
1	**Apologies** No apologies were received	
2	**Presentation** 2.1 Health Services Plan Overview – Sarah Davey, Manager Service Delievery Send out presentation in PDF to team. Averil Boon will be the contact person if the committee needs to be put in touch with anyone from the BOPDHB. Averil will circulate references to local and NZ Healthcare resource documents	Cherie Averil
3	**Minutes of Meeting** Resolved that the committee receive the minutes of the meeting held on 11 July 2018 and confirm as a true and correct record. Moved: Florence Trout Seconded: Rosalie Liddle	
4	**Matters Arising** Add to list to share more information on ourselves. It would be nice for those available to have 10-15 minutes after the meeting for a catch up maybe for lunch/coffee.	
5	**Papers for Decision** 5.1 Draft Terms of Reference Update attached following today's discussion.	

Item No.	Item	Action
	Any further changes circulate through John.	
6	**Papers/Items for Discussion** 6.1 Consumer Engagement Framework Defer to October Agenda 6.2 Draft Contributions re "Patients" Terminology Document Defer to October Agenda	
7	**Papers for Noting** 7.1 Interests Register Any changes email Cherie. 7.2 Correspondence for Noting HQSC would like to present in October. The committee agreed.	Cherie to extend invitation
9	**General Business** Wol was to present other options for Karakia at next meeting	Wol
10	**Next Meeting** – Wednesday 12 September 2018	

The meeting closed at 1:04pm with a Karakia by Susan Horne

The minutes will be confirmed as a true and correct record at the next meeting.

Health Consumer Council

Matters Arising – September 2018

Meeting Date	Item	Action required	Action Taken
17.07.18	7.3	<u>Is there an alternative to the word patient</u> Adrienne write up a paper for submission to the Board	
08.08.18	2.1	<u>Health Services Plan Overview</u> Cherie send out presentation in PDF to team. Averil circulate references to local and NZ Healthcare resource documents	Completed Completed
08.08.18	7.2	Cherie to extend invitation to HQSC to present in October	Completed
08.08.18	9	Wol to present other options for Karakia at next meeting	

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

BOP Health Consumer Council
Terms of Reference - 2018

Purpose:	The BOPHCC will work collaboratively with the community and BOPDHB as an advisory and advocacy body to advance BOPDHB's vision of "Enabling communities to achieve good health, independence and access to quality services".
Functions:	The BOP Health Consumer Council will: • Promote meaningful consumer participation and maintain an overview of consumer engagement activity across the BOPDHB • Identify and advise on issues requiring consumer and community participation, including input into the development of health service priorities and strategic direction • Review and advise on reports, developments and initiatives relating to provision of health services • Promote communication and networking with the community and relevant consumer and special interest groups as required, for specific issues and/or problem solving • Challenge planned services for any omission or disadvantage to those in most need, should it occur For the avoidance of doubt, the BOPHCC will NOT: • Provide clinical evaluation of health services • Be involved in the BOPDHB's contracting processes • Be held accountable for decisions made by BOPDHB's management and/or governance whether compatible with BOPHCC's views or not • Discuss or review issues that are (or should be) processed as formal complaints, for which full and robust BOPDHB processes exist • Represent any specific consumer interest group or organisation nor enter into communication with a clear conflict of interest.
Level of Influence	The BOPHCC has the authority to give advice and make recommendations to the BOPDHB senior management and the Board according to the levels of impact shown in the BOPDHB Consumer Engagement Framework – 2016.
Secretariat	Secretariat support provided, in collaboration with the BOPDHB Programme Manager, Quality & Patient Safety will convene the BOPHCC
Membership:	The BOPHCC will comprise ten to twelve consumer representatives. Members will have diverse backgrounds, contacts, knowledge and skills, and must be passionate about consumers being able to access the best possible health care and services from the Bay of Plenty DHB. Members will be selected to cover a range of areas e.g. Maori health, women's health, child health, long term conditions, mental health, and disability. Although appointed to reflect the consumer voice in a particular area of interest, an individual member will not be regarded as a representative of any specific organisation or community, nor an "expert". One BOPHCC member will be appointed from the Consumer Health Liaison

	Group Membership composition will include the following principles: • Reflect the requirements of the Bay of Plenty Health Services Plan • Reflect the population that uses health services • Recognise the need to address inequalities and disparities in health outcomes • Act to recognise BOPDHB responsibilities under the Treaty of Waitangi When selecting members, consideration must be given to maintaining a demographic balance that reflects the population; Speciality, ethnic, rural/urban, east/west geography. The BOPHCC may co–opt other people from time to time for a specific purpose. Inaugural members will be appointed for a one or two year terms to stagger end of term dates, and thereafter appointments will be for a two year term commencing in June each year. Members may be reappointed for no more than three terms. Members will be provided with training and support by the BOPDHB to undertake their role successfully. All members will uphold BOPDHB's CARE values and adhere to BOPDHB's policies and protocols. Remuneration shall be paid based on the BOPDHB Consumer engagement payment and reimbursement of expenses guidelines. All Members who reasonably believe they may have an actual or potential conflict of interest is to disclose their interest to the chair immediately they become aware of it. Any conflict in interest will be recorded. Membership may be terminated or full dissolution of the BOPHCC may be undertaken by the Chief Executive Officer (CEO) of BOPDHB in consultation with the chair of BOPHCC. Termination will be requested within 3 months from when performance is found to be seriously unacceptable. Members who fail to attend three consecutive meetings without an apology will be asked by the chair to step down from the BOPHCC.
Chairperson	The inaugural chair will be appointed by the BOPDHB CEO (or delegate) for a term of one year. Thereafter the chair will be appointed by the CEO following consultation with BOPHCC members.
Meetings:	A minimum of ten meetings per year will be held February to November. Should more meeting time be required, this will be treated as an 'out-of-session' consultation. The Secretariat will provide administrative support. A quorum will be half the current membership, including the chair or delegate. Others may attend as Invited Persons to facilitate the business on hand by invitation of the chair.

	Minutes and agendas will be circulated at least a week prior to each meeting, with any reading material attached. Meetings will be up to two hours, held at an agreed time, to enable all members to participate. Meetings will be published on the BOPDHB website and be open to staff and the public. On occasion when there are issues of confidentiality or other risks, meetings may be closed in full or part at the discretion of the chair.
Reporting:	The BOPHCC will report and make recommendations to CEO quarterly or more often when requested. Relevant information is then reported to the Board by the CEO. Reports and minutes will be placed on the BOPDHB website once approved by members. Minutes of those parts of any meeting held in "public" shall be made available to any member of the public, consumer group, community etc. on request to the chair.
Terms of Reference Review:	Members will review the Terms of Reference (TOR) biannually and make any recommendations for change to the CEO. BOPHCC TOR will be reviewed and confirmed by CEO biannually.

Draft BOPDHB Emergency Medicine Service 5 Year Strategic Service Plan 2018-23

SUBMITTED TO:

Health Consumer Council	12 September 2018
Prepared by:	Derek Sage
Endorsed by:	Debbie Brown, Quality and Patient Safety Manager

RECOMMENDED RESOLUTION:
That the BOP Health Consumer Council provide any input on the draft document.

ATTACHMENTS:
Draft BOPDB Emergency Medicine Service 5 year Strategic Service Plan 2018-23.

BACKGROUND:
The BOPDHB Emergency Medicine Specialist has asked that the committee have input on the draft. It is not formatted or proof read at this stage so he doesn't require feedback on those aspects. Maori Health has also provided their feedback. A response from a consumer's perspective is requested within 15 days.

BOPDHB EMERGENCY MEDICINE SERVICE
5 YEAR STRATEGIC SERVICE PLAN 2018-23

FOREWORD:

Service planning balances the health and health-care needs of a community with the resources available to meet these needs in terms of human resources and technical resources, such as facility (capital planning), equipment, and health interventions.

Ideally the service plan should have clear requirements in terms of explicit links to the DHB's strategic plan and the allocation of resources, and in terms of clear and measurable objectives.

This document is not an operational guide but a guide to decisions yet to be made in terms of time and resource allocation across the EM service. Congruent with the ethos of the BOPDHB it has been developed through a values based consultative approach with the service membership because if it does not reflect the service membership culture no amount of strategic intent will prevail. After all it is the service membership who will deliver and live by the strategy it has adopted.

Congruent with our obligations to ensure consumer / patient partnership and participation in service governance and our obligations in addition to full consultation with our community partners and internal service membership we have consulted with our consumer council and Maori Health in order to guide and consolidate the strategic plan.

Notwithstanding the above we have to acknowledge that conventional business models do not fit well with a public health emergency service because generally more demand commands more income and resources. However we are resource constrained and most resource is procured by business arguments a relating to patient safety or compliance with adopted national and international standards.

DOCUMENT STRUCTURE

This document is structured such that our Goal Statement is presented first as a clear declaration of intent. This is followed by our aims, objectives and priorities and attempted to create objectives as meaningful and measureable as possible in alignment with SMART* principles
{ Specific, Measureable, Attainable, Relevant and Timely}*

TABLE OF CONTENTS

4. EM clinical governance and the NZ quality framework summary
5. Good to Great: Maori Health Summary
6. Health Workforce New Zealand Report 2015 Summary
7. BOPDHB Maori Health plan 2016/17 Summary
8. Summary of other informal feedback from various sources
9. Tauranga ED Workshop Summary
10. Whakatane ED Workshop Summary

EXECUTIVE SUMMARY

Over the last 12 months we have had the opportunity as a service to undertake quality improvement initiatives. These opportunities have explored our services ability to adapt our models of care to encompass partnerships with other providers. In doing this we have explored our own internal capacity to deliver patient centred services.

As a service we have elevated the BOPDHB on the National League tables for the SSED target. Although at times that has been difficult to maintain consistently as a service we have continued to seek performance improvement to achieve a sustainable long term outcome.

ED Service challenges:
Demand and patient flow to specialty services remains the significant challenge for the ED Service at both sites. At Tauranga we have seen increases in our critically unwell patients and our volumes of trauma case in addition to our high volume elderly care cohort. This is compounded with the continued demand for afterhours low acuity medical care traditionally managed by GP services. The lack of after-hours alternatives which are affordable to patients as well as the lack of after-hours service has seen an ongoing demand for medical care from 8.00pm at night to 8.00am in the morning and the weekend hours still see high presentation rates for conditions generally serviced by General Practice.

In the Whakatane area, the option for patients to gain access to care alternatives to the Emergency Department is even more reduced as there is no after-hours service at all in the community apart from the GP service being offered in the Whakatane Emergency Department.

Sustainability for staff is an issue with the increased demand that we are facing. This poses a significant health and safety issue of burn out for all of our clinician groups. Creating a sustainable service that offers work life balance in the long run will reduce the costs of recruiting and training. The loss of staff from attrition is particularly felt after periods of high demand and more notable in Whakatane.

ED Service approach:
We have focused our delivery of care around the concept of how we add value to the patient journey. We are engaging in partnerships with our Specialty Colleagues in order to remove barriers for our patients and we are creating diversified models of care which involve Nurse Practitioners in Tauranga and Clinical Nurse Specialist in Whakatane to ensure that we have a responsive service to both our patients and to our staff.
Key drivers for the Service:

- CARE Values
- Fiscal responsibility, only spending on what we need to be able to sustain our service.
- Looking at all opportunities to spend wisely and to maintain the patient centred focus

as a measure of value about what we purchase
- Partnering both Internal Specialities and External Providers to increase the opportunities of care for our patients
- Focuses on delivering care to two groups who are have high presentation rates and complex care concerns (Frail Elderly and Paediatric Care).
- Continuing to utilise Best Practice to ensure that the care we deliver is timely and conforms to current practice innovation and research
- That we respond to the needs of the patients who present to us without bias and that they are offered access to care.
- That patient equity is a key value the service holds and delivery of care must acknowledge inequity as a key determinate of patient health outcomes

Trends/Opportunities:
- Stronger relationships with Iwi providers to establish CPO pathways that have a cultural focus in the provision of care
- Stronger relationships between General Practice and ED Services so that patient can be shown alternative options for care.
- Partnership for admission processes such as the SMART process to expedite the right patient to the right service at the right time
- Increased use and the number of Best Care Bundle pathways of care to reduce patients waiting times
- Increasing the nursing potential to work to top of scope and assist in preparing the patient for an outcome decision
- Creating the Emergency Service as a magnet employment opportunity for Training and Development of the Emergency Medicine Specialty
- Creating cutting edge services in delivery care to critically Injured Trauma patients and stabilisation and transfer of those patients to tertiary centres
- Creating a central hub for the Whakatane community where help can be sought and delivered sustainably

Five year Financial Plan:
- Year 1, sustainability for the Whakatane Emergency Department. Investment in the Nurse Practitioners diversification from Streaming to the whole model of ED care. Creation of a supporting CNS model to retain the gains we have made from the streaming Minor Injury and Minor Ailments. Exploring NP roles across floor, services and into the community. Moving towards top of scope for professional groups. Releasing time to use specialist clinician expertise by improved administrative support of developing service/clinical governance structures. Reaching into community partnerships and pathways.
- Year 2, resolving the SMO/RMO difficulty gap in the weekends to create a sustainable model of care over the weekend periods. With a view to investing in more medical cover at both sites. Increasing distributive leadership responsibilities supported by clinical director oversight across both sites.
- Year 3, looking at diversification of decision maker. Utilisation of Allied Health as decision makers, such as physiotherapy and Pharmacy
- Year 4, increasing the Nurse Practitioner capacity on both sites to retain sustainability and to manage the demand for service.
- Year 5, review of the SMO FTE to focus on growth and how to meet the community needs with the subspecialisation of our service such as a designated Emergency Medicine Geriatrician and a transport and retrieval and primary care interest Emergency Medicine specialist.

EMERGENCY DEPARTMENT GOAL STATEMENT:

The Bay of Plenty Emergency District Health Board Medicine Service [BOPDHB EMS] undertakes to administer to all who attend the BOPDHB's emergency departments [EDs] with compassion and understanding, respecting their reasons for choosing our service to provide them with their perceived acute or urgent care needs by aligning the patients' needs with the most appropriate service internally or externally to the DHB secondary service.

The BOPDHB EMS will navigate their care without unnecessary delays and in accordance with best technical and consumer care / Pae ora principles, minimising their time spent in the emergency department whether they are ultimately admitted or discharged.

The EMS will, where possible, attempt to convert an 'admission trajectory' into a safe and appropriate discharge pathway or transfer of care, only undertaking investigations and procedures that add value to the patient's journey and recognising the whole healthcare team as providers of care.

The EMS will provide expert input into the care of the critically ill patient, coordinating the early involvement of other specialist teams, transferring care to those teams and to the most appropriate site / area within 2hrs of arrival.

The EMS will develop staff and service processes through positive inter-professional learning models that promote self-efficacy and teamwork.

The EMS will build valued partner relationships with other healthcare providers / services and agencies at all levels in order to facilitate the integrated care of our patients in the community and secondary/tertiary care services.

BACKGROUND

COMMUNITY SERVED (CONSUMER)	• 9,666 square kilometres stretches from Waihi Beach in the North West to Whangaparaoa on the East Cape and inland to Te Urewera, Kaimai and Mamaku ranges. • BOPDHB serves a population of 214,910. 77% of our population resides in the Western Bay of Plenty. Eastern BOP predicted to have a population decline. • The Bay of Plenty District Health Board serves 18 iwi. 23% of BOPDHB's population identified as Māori (47,277 people). Of all New Zealand's Māori population, 11.5% usually live in the Bay of

	Plenty Region. • Bay of Plenty Region has 6.3 percent of New Zealand's population and the second fastest growth rate of all New Zealand's DHBs. • 2006 to 2026 growth forecast to be 23.5%, higher than that for New Zealand as a whole.

Total Bay of Plenty Population 2013/14-2025/2026

	Total BOP Population Forecast 2013/14		Total BOP Population Forecast 2025/26		% growth
Age Group	Number	%	Number	%	%
0-14	43,845	20.4%	45,055	18.8%	2.8%
15-24	26,330	12.3%	24,195	10.1%	8.1%
25-44	48,380	22.5%	56,705	23.7%	17.2%
45-64	56,730	26.4%	56,230	23.5%	0.9%
65-74	21,765	10.1%	29,805	12.5%	36.9%
75+	17,860	8.3%	27,240	11.4%	52.5%
Total	214,910	100.0%	239,230	100.0%	11.3%

Māori BOP Population Change 2013/14-2025/2026

	Total BOP Population Forecast 2013/14		Total BOP Population Forecast 2025/26		% growth
Age Group	Number	%	Number	%	%
0-14	18,045	8.4%	18,935	7.9%	4.9%
15-24	9,775	4.5%	10,095	4.2%	3.3%
25-44	12,280	5.7%	14,690	6.1%	19.6%
45-64	10,125	4.7%	10,980	4.6%	8.4%
65-74	2,235	1.0%	3,685	1.5%	64.9%
75+	1,045	0.5%	1,920	0.8%	83.7%
Total	53,505	24.9%	60,305	25.2%	12.7%

BOPDHB VISION:	*Healthy, thriving communities*, Kia Momoho Te Hāpori ōranga.
BOPDHB MISSION	Enabling communities to achieve good health, independence and access to quality services
BOPDHB VALUES: • HE POU ORANGA TANGATA WHENUA VALUES	Manaakitanga, CARE Values: Mana Atua, Compassion, Mana Tupuna, All one team, Mana Whenua, Responsive Mana Tangata, Excellence. **Wairuatanga**: Understanding and engaging in a spiritual existence. **Rangatiratanga**: Positive leadership. **Manaakitanga**: Show of respect or kindness and support. **Kotahitanga**: Maintaining unity of purpose and direction. **Ukaipotanga**: Place of belonging, purpose and importance. **Kaitiakitanga**: Guardianship and stewardship over people, land and resources.

	Whanaungatanga: Being part of and contributing collectively. **Pukengatanga**: Teaching, preserving and creating knowledge.
• BOPDHB STRATEGIC DIRECTION	BOPDHB's four key strategic population priorities for the coming year: (i) Child and youth; (ii) Health of older people; (iii) Māori health – Achieving equity; and (iv) Long-term conditions.
• BOPDHB STRATEGIC ISSUES / TARGETS RELEVANT TO THEM (Source DHB Annual plan 2016-17 and NZ Health Strategy)	• Aging population • Smoking especially in Pregnancy and especially Maori • Avoidable hospitalisations Shorter stays in emergency departments: 95% of patients will be admitted, discharged, or transferred from an emergency department within six hours. Better help for smokers to quit: 95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking Living within our means **Overlapping with NZ Health Strategy: (Building capability and workforce and HIS implementation):** • More integrated health services, including better connection with wider public services • The transparent use of information • An outcome-based approach • Strong performance measurement and a culture of improvement • An integrated operating model providing clarity of roles • Operating as a team in a high-trust system • The best and flexible use of our health and disability workforce • Leadership and management training • The increased use of analytics and systems to improve management reporting, planning and service delivery and clinical audit • The health system as a learning system, that continuously monitors and evaluates what it is doing, and shares that information. Strengthening our workforce by : - Increased participation of Māori and Pacific peoples in the health workforce - Establishment of specialist roles, such as educators, nurse practitioners, clinical nurse specialists
• KINGS FUND STAFF ENGAGEMENT (CEO News Letter April 2016)	Develop a compelling, shared strategic direction Build collective and distributed leadership Adopt supportive and inclusive leadership styles – need to support following Give staff the tools to lead service transformation – also tools to be

	followers Establish a culture based on integrity and trust – absolutely necessary
• ADDITIONAL REFERENCE SOURCES	1. Service planning Day October 2017: Focus on outside relationships 2. Tauranga and Whakatane: Focus on departmental level issues 3. Various unsolicited informal and historical feedback comments. 4. Review by consumer council 5. Review by Maori Health Service 6. The following documents: a. What are the healthcare experiences of the Emergency Department among adult Māori patients in Tauranga Hospital, New Zealand? How may these experiences be improved? **Needs a date and Author** b. Clinical Governance – guidance for health and disability providers: Health Quality and Safety Commission New Zealand Feb 2017 Wellington: Accessed May 12th 2018 https://www.hqsc.govt.nz/assets/Capability-Leadership/PR/HQS-ClinicalGovernance.pdf c. Future intentions of the New Zealand DHB-based senior medical workforce: Health Dialogue Issue 13 July 2017 Chambers, C., Frampton, C. ASMS Wellington d. Bay of Plenty Strategic Health Services Plan 2017-2027: BOPDHB e. New Zealand Health Strategy: Future direction: Ministry of Health, Wellington. Accessed 12th May 2018 https://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-futuredirection-2016-apr16.pdf f. New Zealand Health Strategy: Roadmap of actions 2016; Ministry of Health, Wellington. Accessed 12th May 2018 https://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-roadmapofactions-2016-apr16.pdf g. Health Equity Assessment Tool: A user's guide. 2008 Signal, L., Martin, J., Cram, F., and Robson, B.,Ministry of Health, Wellington accessed 12th May 2018 https://www.health.govt.nz/system/files/documents/publications/health-equity-assessment-tool-guide.pdf h. Non medical practitioners in the Emergency Department: The College of Emergency Medicine, Service and Design Committee Feb 2015 i. Medical Practitioner Staffing in Emergency Departments: The College of Emergency Medicine, Service and Design Committee Feb 2015 j. Guidelines on constructing and retaining a senior emergency medicine workforce Australasian college for emergency medicine G23 Nov 2015 Version O2 k. Shift Work, Scheduling and risk factors: ASMS

	Research Brief Issue 2 June 2016; ASMS l. Demographic and attitudinal change in the New Zealand specialist workforce: ASMS Research Brief ASMS 5: 2016 m. Minimum Requirements: Accreditation of Adult and Mixed emergency departments; Australasian college for emergency medicine AC01 July 2014 Version v8 n. "The Times" Effective committees book – Need to find book and reference o. Emergency Department Workforce Analysis Tool 2nd Edition Workforce Development and Innovation Branch NSW HEALTH 2010 p. Te Ekenga Hou Summary: BOPDHB q. Maori Health Plan 2016-2017 BOPDHB r. Good to Great - Maori Health BOPDHB s. Geriatric Emergency Department Guidelines ACEP 2013 t. Policy on a quality framework for emergency departments policy P28 version 3 July 2016 ACEM u. National Emergency Departments Advisory Group. 2014. A Quality Framework and Suite of Quality Measures for the Emergency Department Phase of Acute Patient Care in New Zealand. Wellington: Ministry of Health. Published in March 2014 by the Ministry of Health: v. Staff engagement: Six building blocks for harnessing the creativity and enthusiasm of NHS staff: website accessed 2018 May 12th https://www.kingsfund.org.uk/publications/staff-engagement w. Creating our culture: Manager's guidebook BOPDHB June 2018 x. New Zealand District Health Boards Senior Medical and Dental Officers collective agreement 1 July 2017 – 31 March 2020 y. Introduction to the Health and Safety at Work Act 2015 SPECIAL GUIDE March 2018 WorkSafe New Zealand z. Health & Safety at work act health and safety at work: quick reference guide Worksafe New Zealand December 2016 aa. CEO News Letter April 2016- http://docman/comms/CEONews/CEO%20Newsletter%2022042016.pdf#search=Kings%20Fund
HIGHLIGHTS OF THE PAST 12 MONTHS: ACHIEVEMENTS / SUCCESSES	• Attainment of the shorter stays target • Improved smoking cessation target – trending upwards • National representation of the BOPDHB Emergency Medicine service on ACEM committees • Development of THE ACNM positions in Tauranga ED • New Supervisory appointments (UoA/MCNZ) in Tauranga/Whakatane • Implementation of ENP pathway pilot and utilisation to cover weekends in Whakatane • Strong representation in the frail elderly project work • Demonstration of the utility of the ENP in supporting flows in

	front of House activities. • Improved recognition of individuals' efforts through recognition certificates improving team ethos. • Increased FTE nursing at Whakatane ED • Attainment of 12 months registrar training accreditation from ACEM • EMS 0ne Place webpage launch
HIGHLIGHTS OF THE PAST 12 MONTHS: PROBLEMS / ISSUES	• Increased attendance in both Whakatane and Tauranga Emergency Departments (NEED AN EXACT VALUE % PER SITE) **JEN (Neil would like year on year and month on month).** • Difficulty in having a sustainable back fill for the ENP interns in Whakatane • Sustained RN recruitment and retention in ED Whakatane • Sustaining the clinical governance model across the service and maintenance of reporting structures • Inefficiency in committee activity which has resulted in experimentation of different meeting models. • Lack of role clarity and delegations / decision making authority in the distributive leadership model • Issues meeting demand with current resource model in relation to growth and ED service demand and lack of after-hours provision of care in the community. • Awareness of Senior Medical Teams, feeling that there is a lack of transparency and participation by staff. Also a demonstrated lack of clarity around delegated responsibilities and accountabilities and reporting lines • Disparity of view in relation to Models of Care between Medical and Nursing paradigms which has led to conflict between both leadership teams. • Multiple demands, KPI's and competing directions (nationally and within DHB) – all confuse and distract • Lack of reporting of activities and ability to coordinate reporting efficiently

KEY PRIORITIES FOR THE COMING YEAR from SWOT analysis below	Linkages and/or actions	Timing and/or Explanation
Streaming based on the likely hood of admission, discharge and fast track opportunities to manage the demand for care in ED.	• ENP/ CNS and the RMO FTE considerations already mentioned • Links to Excellence in the Care Values • Patient satisfaction and experience • Reduction of Waste as	Establish the frame work by 2019

	a time cost to the overall service • Reduction of ASH conditions so they are managed within the 3 hour time threshold • Meeting the Service Level Measures for the DHB with MOH.	
Acute Flow	Continue to develop partnership agreements with Secondary Services that reduces patient waiting times and reduces the cost of waiting as inefficiency in the costs of patient care. Specific partnership: • SMART Process with the Medical Specialty • #NOF pathway with Orthopaedic Surgeons • Exploration of extending SMART to Surgical Specialties. • Community Primary Options pathways back to General Practice • Expansion of Best Care Bundle pathways to enhance early delivery of care to ED patients Relates to all of prior longterm strategic goals EM to concentrate on clinical care that only EM can do and add value by converting admissions to discharges and not delaying admissions.	Currently underway
Weekend cover	Exploration with Funding and Planning the weekend resource in the community with a first line review of weekend GP Clinic capacity to see their own patient cohort across both sites. Increased community demand for ED care creates a need for increase FTE capacity. Utilisation of alternative providers such as Allied Health. Substitution to nursing roles such as ENP and CNS.	This will cost shift back to General Practice and to the patient who may still present due to financial circumstance. Will also have an FTE cost and a lack of clarity of who would own that budget cost. Will also have an FTE costs to obtain an effective and efficient

		model However, money can be save through efficient management of waste areas such as patient time waiting for next steps in care to occur.
Ring fence existing or employ an additional 0.5 FTE admin support to execute the requirements of a service governance structure to support Central Roster business case and Administration to service over both sites.	Service Governance	Establish by January 2019
The introduction of Appraisals for senior Nursing and Medical staff	Education	Established by March 2019 Completed by November 30th 2019. Strong signalling from SMO for this to occur and to be a stakeholder in its development. PDRP core for nurses and career progression. To be consolidated for ENPs
Good to Great and meeting our treaty obligations	EMS staff will conform to DHB Good to Great objectives by attend "Engaging Effectively with Māori" workshops by December 2019 New EMS staff will attend "Engaging Effectively with Māori" workshops within 6 months of appointment as per the Good to Great objectives. The service will investigate an appropriate Te Reo Maori programme to assist in Maori word pronunciation.	Established by November 30th 2019

WORKFORCE PROCUREMENT PRIORITIES TO SUPPORT THE STRATEGIC PLAN
Workforce order of priority in procuring FTE (background data will be supplied for business case or in the appendices of this document in relation to growth and demand management):

The results of all these inputs were taken into consideration and added to both a SWOT and PESTEL analysis to arrive develop a goal statement for the service, a set of strategic broad aims and then measureable objectives.

Data, information and analyses that informed the strategic plan are included in the appendices and references list	
STRATEGIC AIM	**OBJECTIVES:**
There is currently a National awareness on the following high user health groups. The EMS workforce needs the skill mix to meet the needs of the Elderly, Maori, Mental Health, Paediatric and adolescent groups to differing extents across the Bay of Plenty as they are determined as high health care resource users and have an equity exposure. The facilities and processes should be designed to reflect those needs. The workforce demographic must ultimately move towards the demographic of the population served. Our clinical skills are expanding to recognise the variables in delivery of care related to the diversity of our population. The sub classification of frail elderly and gerontology of the adult population is an example. One size no longer fits all. Therefore our clinical leadership needs to be able to tailor clinical care to the diversity of our demographic. This requires an increasing degree of sub specialisation to support service and development and governance.	Future employment of senior medical and nursing staff will include a commitment to actively encouraging applicants from a representative demographic cross section. Preference will be made for the development of a Kaupapa SMO position for the service preferentially but not exclusively primarily based in Whakatane but also a cultural advisor to the service. The recruitment of development of EM specialists in Geriatric emergency medicine with allied health linkages and associated nursing subspecialisation within the team is required on both sites and should begin with developing these roles from January 2019 onwards with strategic recruitment thereafter as required. Development of this 'talent' within the service is preferred. If this is unable to be resourced then an educational programme to address equity gap will be undertaken. A mental health lead SMO at both or across sites will be developed from October 2019 supported by EM nurses upskilled in this subspecialised area. The consult liaison/crisis team at the earliest opportunity is to be offered space to operate out of in the ED in Tauranga. We recognise the cross service benefits of partnering with the Mental Health service in delivery of care to our community. Any future facility expansion opportunities requires consideration of acute mental health presence in ED
Whakatane ED must get itself out of the chronic cyclical shortage of registered nursing staff due to its staff turnover.	Ensure staff exit interviews/survey is offered by HR at every resignation to capture what is occuring at both sites for all professions effective immediately. By June 2019 develop joint appointments of nursing staff across the ED/ACU/HDU interface to support the HOT floor concept established at Whakatane. Exploration of initiatives to create attractive employment opportunities at Whakatane ED such as: • Supported Core ED Nursing skill advancement programme • Grow our own with placement of Whakatane Whanaunga nursing students and Net P placement in the ED setting

	• Development of relationship with nurse tutors to support the educational opportunity in Whakatane ED for nursing students. • Development of a course that capitalises on the interface between Primary Care and Whakatane ED as a Rural/ED Care facility pathway for nurses and advertise this through the PHA.
The BOPDHB EMS must explore the resources existing in the community and create an comprehensive reference resource of navigational pathways and lists of useful agencies in order to facilitate transfer of patient care back to the primary healthcare sector [assisting the patient to engage in the right service at the right time] and avoid unnecessary admissions. [and therefore staff awareness of such resources]The EMS must engage with the external agencies, including other emergency services and local government agencies, to foster resilient responsive relationships and build patient pathways.	The development of a resource that defines the community resource that we can engage with in relation to other Primary and NGO services by June 2019. Develop a relationship with Funding and Planning portfolios to identify the strategic development of the Primary Care contracts within our community November 2018 for both service sites. Develop relationship and partnerships with all external providers whom engage with our patient community to reach memorandums of understanding that enhance the patient's journey of care by August 2018. Regular PHA/PHO meetings with ED both sites will be in place by June 2019 Regular Meetings between P&F and ED will be in place by June 2019 Regular meetings between 2nd Av Tauranga (A&M) will be in place by March 2019
The BOPDHB EMS must develop a service governance model that is supported by a dedicated co ordinating administrator. The role would retain a close relationship with service quality and service improvement personnel, involving and integrating the consumer/patient at every level underpinned by Pae ora and good governance principles. This requires a distributive leadership model that is inclusive of all professional and non-professional groups in the service and provides participants with training in how to be effective committee members and how to run effective meetings. The governance models must reflect shared learning and understanding.	A service working group will be established under the service leadership steering function to deliver a service governance structure proposal by December 2018. Its role will be to deliver it through subcommittees of: • Patient and Staff experience (Project Comms plan). • Patient and Staff Safety (- including M&M) • Clinical Effectiveness • Audit • Research and Quality Improvement • Education and Training Adhering to good governance principles with patient participation and engagement with Maori. The Clinical Governance structure will generate quarterly reports [satisfying the NZ ED quality framework] by June 2020 The service working group established under the service leadership steering function is to deliver a service governance structure proposal by December 2018, will be responsible for ensuring that the service governance structure also includes a strategy for communication. It is envisaged that committee membership would be 2 year tenures renewable but offer opportunity to rotate and gain

	managerial experience across the spectrum of responsibilities All committees will have consumer (patient) participation and Maori health consultation.
Good governance enables good communication and the service must develop and invest in an effective communication strategy / plan that allows for all paradigm views and enhances the All One Team values	The service working group established under the service leadership steering function to deliver a service governance structure proposal by December 2018, will be responsible for ensuring that the service governance structure also includes a strategy for communication. A working group will be formed to create a communication strategy for the service which reflects all methods of communication as well as provides a clear pathway for management of complaints and compliments whereby we can achieve a learning value to the service by August 2019.
We must cultivate the social support and team cohesiveness but not at the expense of the problem solving tasks that we face. The BOPDHB EMS will need to practice converting our espoused values into consistent congruent values in practice and that will require a collective supportive team approach.	The subcommittees (as outlined above) will be responsible for ensuring that social support and team cohesiveness are two strong pillars for each subcommittee – and those pillars will be linked with the espoused values and the intended means of putting those values into practice. The patient and staff safety committee will own the Health and safety at work responsibility. Team building and support in building and maintaining healthy interpersonal professional relationships within the service will benefit at least from a short to medium fixed term appointment of an occupational psychologist and there is exploration oh how this can be achieved. The skill set should also include ability to debrief teams post traumatic or emotionally challenging situations and support personal professional development.
The BOPDHB EMS value highlighting and focusing on the positives and celebrating success, openly recognising each other's achievements and leaning from excellence. Work must continue to cultivate this as culture and habit. The BOPDHBEMS must apply the BOPDHB CARE values so that the Service is both culturally and spiritually safe for patients and staff and these behaviours become a service habit.	Attendance at Orientation, CARE Values presentations, customer service training, and any other staff training course that helps the EMS meet its espoused values will be considered mandatory for all current staff within 24 months of the sign off for this plan and for all new staff within six months of commencing employment. A working group will be set up and a service communications strategy will be developed by 2020 supporting news highlights and positive achievements being distributed to the service membership and the continuation of the staff appreciation awards. Monthly update will be provided of positive highlights and celebrations this will feed into the monthly executive highlight report July 2018.
BOPDHB EMS Staff feel most invested in and valued when they are recognised as being valued and then offered opportunity for professional education and training. Staff especially value positive feedback and appraisals. The appraisals process must value positively supporting health	A standardised senior medical appraisal with compulsory MSF component at least every three years will be piloted by March 2019 Protected administrative FTE will be apportioned to the clinical governance requirement of staff portfolio development and appraisal All SMO/MO in the service will have completed an annual appraisal within 18 months of adoption of this strategic

professionals. Staff place high value on practical collaborative learning including simulation education that is inter-professional and focusses on human factors.	document.
The service (clinical) governance system must oversee the Quality Framework and Suite of Quality Measures for the BOPDHB EMS supporting, monitoring and reporting on the service compliance. This reporting must reflect on the Service Dashboard and the Key Performance Indicators that have been determined. It must also be the key to determining any further KPI measures or changes to KPI measures as the service continues to develop and grow	The various individual governance (sub) committees will develop meaningful key indicators for the service dashboard completing this work by October 2019 and review these on a continuous basis reporting back on them to the service leadership. The key measures will be approved by service leadership and inline wit Organisational and National targets and objectives.
The population of Bay of Plenty requires focussed attention on Maori health equity and movement to a service that is matched in terms of cultural appropriateness to its population In order to ensure that we meet our Treaty of Waitangi obligations we must adhere to the principles of: Partnership, participation and Protection and for our Maori population to gain equity in health outcomes	EMS staff will conform to DHB Good to Great objectives by attend “Engaging Effectively with Māori" workshops by December 2019 New EMS staff will attend “Engaging Effectively with Māori” workshops within 6 months of appointment as per the Good to Great objectives. The service will investigate an appropriate Te Reo Maori programme to assist in Maori word pronunciation. Current EMS staff will be offered training in the pronunciation of Te Reo Māori (in order to correctly pronounce the names of patients attending the department) by December 2019 New EMS staff will be offered training in the pronunciation of Te Reo Māori (in order to correctly pronounce the names of patients attending the department) within 6 months of appointment
Participation, transparency and high trust are key desires of the staff delivering the EM service especially the use of distributive leadership. However this is not just applicable to the leadership but also to that of the followers.	All Emergency Medicine Service committees and meetings membership will be open to all professional groups in the EM service, and roles therein will involve a cross section of the various professional sections. At least 25% of chairpersons at any one time should be from nursing cohort with administration and clerical staff encouraged attending the meetings and then report back to their colleagues. This will be attained by June 2019.
Communication is an issue that the service membership has highlighted as requiring improvement and there is therefore an imperative to	The ED One place site will be developed and fully utilised as the central communications platform with the ability to work through it on committee work and project development. A working group will be set up across the 2 sites and this will be

enable up and downward and sideward communication that is transparent, trustworthy and timely. Staff wished to be informed but not overloaded and wishes to have a consistent way of communicating. This includes the ability to communicating in working groups to achieve project aims.	fully developed for the service by Jan 2020. If IT support is required to develop the functionality the service will investigate and present options for extra application arrangements within or with outside of our IT resource.
Appreciation. The service membership has clearly indicated a desire for more positive communication and interactions in the form of open appreciation and recognition for efforts, achievements and especially excellence. Although individually the membership prefer as variety of ways of recognition especially the appreciation certificates.	A project working group will be set up and a service communications strategy will be developed by 2019 supporting news highlights and positive achievements being distributed to the service membership and the continuation of the staff appreciation awards The group is free to suggest other means of recognition within budget constraints and as approved by service leadership. Capturing the appreciation awards and certificates will be reflected in the highlight report to the executive on a monthly basis August 2018.
Education: the service membership feel valued when there is an investment in their professional development and the time, space and opportunities exist for such activities especially practical activities such as simulation and inter-professional team working activities.	ED NZ core instructors will provide and the service will make available the candidates to run 2 service specific NZCore courses per annum to meet the needs across both sites. The service will continue to run, evaluate and focus on continuously developing a simulation educational curriculum developing in house inter-professional instructor expertise to run the simulations as its priority. The simulation curriculum will be reviewed quarterly commencing January 2019 Resus room training course will be developed and delivered along the lines of NZCore format focusing on EM nurse requirements and supplementing RMO training. EM service seeks registrar training accreditation for Tauranga for 12 months by January 2019 and Whakatane 6 months (linked) by December 2019. EM simulation programme to benchmark itself against national and international standards and comply with good governance principles. Ensure ED simulation subcommittee meets at least quarterly.
The EM service values its workforce ensuring the health and wellbeing of our workforce through Health and Safety Measures	ASMS DHB MECA Clause 13.6 will be attained by March 31st 2020 All senior medical and nursing staff will through appraisal and ad hoc review be expected to not regularly exceed their hours or undertake unreasonable workloads / responsibilities that pose a threat to their wellbeing and therefore the continuity of service There is a key role for a Health and Safety representative at both sites for the ED service which is currently in place and they will also be part of the Patient and Staff safety committee under the Clinical Governance framework.

There is recognition of the scopes of practice of professions other than doctors and that this should be used to complement the skill mix requirements in the ED and across the 'acute hot floor interface' and community.	Based on business case development over the next 5 years the following items will be presented. Exploration of attaining a Clinical pharmacist as an integrated member of the ED service team by 2020. By December 2018 the ED service will have a centralised roster administration that allows for skill mix to be consistently matched demand across the weeks and not dependent on professional groups across both sites. Expansion of the CNS group to 16 hours per day to cover the increased demand for ambulatory presentations will be a key focus for further business case funding with expected achievement by 2020. The EM service will enter into ENP/PCNP/ACNP development in conjunction with other services and Primary care such that a training program is developed based on predicted direction of services. This model will be based on the UK ACP model using the NZ ENP frameworks. FTE for SMO to extend to weekend coverage in Tauranga and supporting DEMT/DEMR roles across the service will be required by 2022 Have professional groups operating at top of scope with individuals providing input and expertise only they can provide and having others substitute for their other 'lower level' skill sets. Additionally develop SMO subspecialty interests to meet expanded and new development areas.
Improved IT support for ED processes	To have the patient journey supported by IT processes from triage and advanced warning to discharge from ED by December 2019
Order of priorities	1. Administrative support for the service governance activities / roster support (which has a business case currently with executive) 2. Nursing FTE matched demand CCDM 3. Cross unit nursing FTE for senior ED nurse development in Whakatane 4. Increase CNS/ENP numbers linking with other services/providers in partnership with a focus on timely patient care 5. Increase RMO numbers and blend ENP mix on rosters for both sites (Assist in achieving both weekend coverage improvements and better roster pattern for RMOs) 6. Rationalisation of FTE requirements to complete SMO leadership of medical workforce and service provision at weekends – Plus rationalisation of DEMR/DEMT and funding model which protects the service delivery (Consider using part time roles supporting weekends and have covered reflecting our service view on equity for Maori/Geriatric/Mental health. As well as considering the needs for transport/transfer and retrieval and primary care interests/needs as a Level 4 secondary care ED) 7. (Consider the use of clinical fellows or senior registrars to satisfy 6])

	8. Trial of occupational psychologist support for the service (this could be a shared FTE with other services or the development of occupational psychologist support through existing EAP service to specifically meet the needs of the psychological safety of the ED team) 9. Clinical Pharmacologist is a partner relationship that has been developed as a business case by Pharmacy. 10. Potentiation of the Model of Care through exploration of partnerships with Allied Health to increase the substitute decision makers available in the ED setting during the weekend hours.

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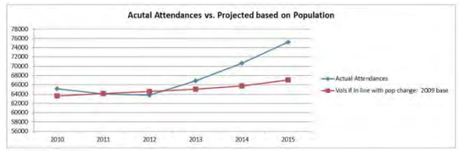
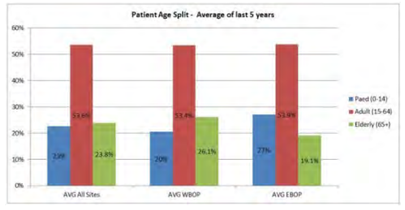
The following SWOT and PESTEL analyses were undertaken using the information from the workshops, feedback submissions and reference documents and underpin th strategic plan decisions:

ENVIRONMENTAL SCAN	**SWOT ANALYSIS** **INTERNAL = Within the Emergency Medicine Service** **EXTERNAL = Outside the EMS, within or outside of the DHB**	
STRENGTHS: **INTERNAL CHARACTERISTICS** qualities, and capacities that are doing well and are part of the reason for the service's accomplishments.	• Multi FACEM service on both sites • Nurse Practitioners within the EM service • Strong nursing leadership through ACNM's • Strong educational presence in service and BOPDHB to meet all professional groups' educational needs. • Additional education qualifications in some staff with commitment to simulation training and inter-professional education. • Experience in trauma, critical care and transport/retrieval increased with new appointments • Strong paediatric links with vocationally registered Paeds EM specialist • EM specialist with nurse practitioner experience and training programme development experience • CNM Tauranga with MBA / experience beyond nursing	

	• Currently have SMO interest in leading on Geriatric EM	
WEAKNESSES: INTERNAL QUALITIES that need to be improved (What are their implications for the service?)	• SMO talent split inequitably across two sites, eg sub specialty expertise such as Geriatric/Paediatric medicine. • Resistance (passive greater than active) to Kotahitanga with cross-site working at service development level. • No formal geriatric EM equivalent to Paeds EM despite heavy Geriatric population loadings. • No naturally passionate primary care lead /liaison within the service: • Physical facilities that do not reflect the community of Māori across both sites despite serving 18 iwi as reflected from workshops • A workforce that demographically does not reflect the population demographics served as per workshop feedback • Tauranga ED facility not 'fit for purpose' as reflected from workshop feedback. • No coordination of rosters across profession and sites to anticipate and backfill for critical gaps. Nor a One Service culture to support shared FTE resource • High trainee/student loadings for supervisory commitments. There is a competition between the needs of the trainee and the needs of the patients with training being elevated above patient's needs for service • The ED environment and interactions with Healthcare professionals (HCPs) can influence Māori health experiences. The Kaumātua face additional challenges in ED. Educating HCPs and making the ED environment more pleasant for Māori people may improve their experiences. • SMOs compelled to work excessive hours (especially antisocial due to demand/supervision requirements) which is not congruent with Health and Safety	

	at work principles and does not meet mitigation requirement under the Health and Safety act. • Whakatane ED is chronically short of staff of RN's due to the turnover and difficulty recruiting suitable staff as per workshop feedback and reporting through Op Centre and evidenced via VRM reporting. • Lack of sustained and committed IT support to development of the electronic whiteboard and associated IT platforms for patient care processes and service communication	
OPPORTUNITIES: refer to **EXTERNAL ACTIVITIES OR TRENDS** that the service may benefit from, connect with or take advantage of to grow or enhance its performance.	• Part FTE funding from University of Auckland and Medical Council for supervision purposes. • Shared relationship with Maori Health in co-creating or services to meet Maori patient needs and equity of care • Increasing development of and / or utilisation of CNS and ENPs in EDs • Increased medical school intake • Short to intermediate term an expansion of EM specialist workforce that is young, lessening the impact of older workers and antisocial roster issues. • No barrier to entering community and promoting education and training opportunities for Māori especially starting at secondary school level • BOPDHB era of supporting innovation • Primary care liaison / acute demand primary – secondary priority for DHB • Increased liaison with University of Auckland through medical student placements • Capitalise on future Mental Health team presence in ED to improve process, ED staff education and support creating new synergies. (mental health strategic direction) • Mental health requires further improvement with linkages EBOPPHA	

	• Managing frequent flyers EBOPPHA • Better workforce utilisation advised. EBOPPHA which would look at partnership between primary and secondary care such as the CPO pathways for Whakatane communities • Acute demand nurse initiative WBOPPHO • Supporting Nursing homes and evidence already reducing referrals to ED WBOPPHO • Increasing the role of pharmacists in reducing admissions and supporting ED WBOPPHO • Primary care options and pathways to reduce ASH WBOPPHO • GPs seek opportunity to participate in pathways to avoid Admissions • PARIS and utilisation of allied health skill mixes including pharmacy • Utilisation of the whole Allied Healthcare provider team in helping to meet the demand for care and to reduce the demand on Medical Services.	
THREATS: EXTERNAL ACTIVITIES OR TRENDS that threaten the current and future success of the organization. (What are their implications for the service?)	• Population growth resulting in greater out-of-hours care. Possible hidden local immigration or change of health seeking behaviour increasing demand? • A change to FTE being split to more part time workers. This could also be an opportunity. • Increased locum requirement • Increased requirement to take medical and nursing trainees and the entry level and increased regulatory supervision requirements at all levels including for senior staff. (Increase the workload), which for both clinical paradigms changes the priority of service. • Progressively dwindling GP provision due GP workforce choices especially in the eastern bay • Change to the medical workforce male female ratio creates a funding change for the service (ASMS Research brief) [EM medical workforce now reaching 50% female who are far more often part time and have 'career breaks' more often] *	**Whilst the literature paints this as a problem – it is proper to have the 50% as a rough demographic*

	There is an impact on delivery of service particularly in relation to school holidays which are now a premium time for annual leave and increased locum engagement to cover family development. • Increasing choice of lifestyle and mobility over traditional work commitment • Increasing ED attendances in excess of that expected from population change  • In 2015 the increase in the Paediatric groups was centred on the 0-5 age group which had a significant increase of 14% (in particular 14% in the Eastern Bay) • Population profiles differ between Eastern and Western Bay of Plenty. Eastern Bay of Plenty has a higher ration of paediatric to elderly patients whereas Western Bay of Plenty has a higher ratio of elderly to paediatric patients.  • Children 0-5yrs feature heavily in winter months but adults under 65 more so in the summer months. • Children feature highly in consumer group in the Eastern bay • In Eastern Bay we see there is a distinct rise in the volume of 0-5yr olds seen in comparison with 65+ in Western Bay. • Maori feature highly in consumer group in the Eastern bay Elderly (over 65yrs) feature heavily in the Admitted group but not in the ED only group • For the past 5 years the volume of non-BOPDHB Patients has been increasing at a steady rate – an overall increase of 11% over 5 years, with most of the significant increases occuring in 2013 and 2015. The proportion is significantly higher during	*representation. Part timer workers can create advantages and more a reflection that men are not offered necessarily the same options as women and this may change.*

	the summer months. • GP Registration: Overall the number of Patients entering ED with a known BOP GP is stable at approximately 85-86% whereas the unknown GP is stable at 8-9%. • 2-3% of Patients who are domiciled in the BOP have GP Practices based out of BOP – these could be recent migrants, or those who travel into the region for work or recreation. • There appears to be an understandable tendency for oversubscribed GP practices to have higher ED attendances. • The ratio of patients referred by GPs (15%) compared to self-presentations (85%) has remained the same. • Approximately 40% of what we see in the ED we admit regardless of GP or self-presentation to ED service (not GP referrals to other teams) • The top coded condition in the ED is 'unknown' • The top 20 presentations outside of this, account for 22% of all presentations to ED regardless of admitted or not. • In particular, there have been notable increases in 2015 (volume share) for the following conditions 1. Chest Pain 2. Viral Infection unspecified 3. Acute URTI unspecified 4. Urinary Tract infection 5. Other and unspecified abdominal pain • The volumes in these conditions alone equate to almost 8000 events in 2015, which represents 10% of total volumes. • The top 20 ED-only events equate to between 15-23% of ED-only Demand Events and 9-14% of all Acute Events in the last 3 years. • There are some very significant increases in specific conditions ie, 40-50% increase from the previous year which boosted overall volumes increases: 1. Acute URTI Unspecified 2. Viral Infection Unspecified 3. Other and unspecified Abdominal Pain 4. Sprain and Strain of Ankle part	

	unspecified 5. Urinary Tract Infection Site unspecified 6. Other Chest Pain & Chest Pain unspecified 7. Open wounds of ankle and foot 8. Acute Obstructive Laryngitis (Croup) • The volumes of the top 5 conditions alone equate to almost 4500 events in 2015 and represent 10% of total ED-Only volumes in that year (and 6% of total volumes). For ED presentations that get admitted: • There have been notable increases in volume in the following conditions in the last 3 years - Urinary Tract infection - Viral Infection - Unspecified Acute Lower Respiratory Infection However not unsurprisingly the top presentations are • Chest pains, Pneumonia, Urinary infections, viral infections, COPD/Asthma, Heart failure, Syncope/Collapse, • Gastroenteritis, Abdominal pain and cellulitis. • Who are we seeing for the top conditions? • A number of the significant figures are in the 0-5 and 65+ age groups: • The 0-5yrs group comprise almost all (91%) of 'Acute Bronchiolitis' events – this is our 17th highest reason for acute events in the BOP over the last 3 years • The 0-5yrs group comprise almost half of 'Viral Infection unspecified and over half of 'Acute URTI'. These conditions are 1&2 on our conditions list. As we know from previous seasonal data most of these diagnoses are seen in the winter months. • The 0-5yrs group comprise almost half of 'Viral intestinal infection Unspecified' • The 65+ group comprise over half of 'Pneumonia' and 'Syncope and Collapse' conditions and almost half of 'Chest Pain' and 'Acute Lower Respiratory Tract' Infections' • Maori 0-5yrs comprise 58% of 'Acute Bronchiolitis' events • Non-Maori 65+ comprise a significant proportion of 'Pneumonia', 'Syncope and	

	Collapse' and 'Chest Pain' • Mental Health Peak presentations 5pm to 10pm • Significant comorbidities due to the psych illness and social deprivation often associated with it blocking access to healthcare • Police will be bringing more acute cases to the ED • Need to have better working relationships across the sector to reduce ED attendance and rapid management of these cases including linking back to primary healthcare to improve their general health statistics. • In-patient team capacity, willingness to change to meet the political and operational requirements to meet acute demand (stuck in old ways of thinking and doing) • From our planning days we anticipated certain high demand groups likely to emerge: o Maori o Older Adult (Frail elderly, Complex co morbid and palliative care) o Children (Whakatane) o Bariatric o Mental Health o The most needy, deprived and homeless including the working poor. o Recreational drug and alcohol abuse/use o International visitors, cruise ships (Tauranga) o Students (Tauranga) o High Risk industry	

PESTEL ANALYSIS: (Political, Economic, Social, Technological, Environmental & Legal)			
	PLANT	**PEOPLE**	**PROCESSES**
	• Size	• Government, college	• Interdepartmental

POLITICAL	configuration of EDs • Does 'our space' mirror our community population served in character? • Streaming: can we reconfigure what we have • Are we large enough? Can we enlarge eg into chapel space if there is a purpose built chapel elsewhere on the Tga site? • Are rooms appropriately fitted / fit for purpose • Our emergency departments should feel like home and belong to the community and so should be 'decorated so' eg Auckland Airport feels like we are back home and is not like all other airports McDonalds are the same all over the world and so are EDs. We should have plants etc. • No new	and BOPDHB drive to increase Maori recruitment into the workforce. **(BOPDHB Maori Workforce Development 2008)** • Treaty obligations • Government /MOH targets • 'Worksafe-NZ' implications. (Safe staffing / anti-bullying) • Resident Doctors' Association limitations on shift patterns • Primary – secondary partnership • Developing a workforce should be based on skill sets and mixes not on professional groups • 'Innovation' latest favoured direction of DHB efforts • Association of Salaried Medical Specialists and antisocial working hours • One service two sites and intra-service interdepartmental support: When it came to this philosophy the values set did not	transfer / orthopaedics • Tertiary transfers • Pathways • Triage: How and when and is it needed? • Triage 2 interruptions • Streaming • Greater knowledge and linkages with other community, secondary and tertiary services were felt needed. • IT support for clinical activities offers potential • Tauranga described new models of care to include enhanced fast track and use of streaming. 'Front of House initiatives' • Improving communication to enable more people to be involved in service development and contribute to the service direction. • Regular team catch ups, • The use of E mail, ED one place and a communication strategy was felt necessary. • Staff feel valued and are invigorated by training and feel safer and more

	building of facility will occur at Tauranga or Whakatane EDs • Consider purpose built satellite NP run A&M clinics	support this both on the planning days and general feedback sessions, though examples of good cross service activity exist that contradict this. • Police – mental health policy as above • We have poor knowledge of services and resources in the community both volunteer and also funded by P&F contractually: the planning day highlighted this and the need to explore and compile integrated systems. • The need for patient/consumer involvement at all appropriate levels and activities / developments • We value our current workforce skills, attributes and other professional groups that can add value and can be used in innovative ways. • All staff working to top of scope maximises and releases the potential in the workforce. • Exploring the ENP	confident to deal with the breadth and depth of problems coming to ED. They especially value the mini courses and simulation opportunities but feel that there is little time and space afforded for these opportunities. • Staff value positive feedback and appraisals and prefer to focus on what has gone well and why (bright spots) rather than always analysing what went wrong. • They appreciate the recognition for their efforts and cited the certificates as a useful but not only way of doing this. • Staff taking an interest in and supporting each other for example when domestic issues are affecting them is highly valued. • Positive attitudes and welcoming smiles and offering to help without being asked is valued. • Social activities outside the workplace and soup days etc at work are felt to assist bonding in the wider team. • It is also recognised that we are not an island and that both

		and CNS roles and seeking ways to improve nursing recruitment and retention • The DHB values distributive leadership. This is not confined to doctors. It means across all the staff at various levels and professional groupings as part of all one team. • The clinical director should spend more time in Whakatane supporting the team on that site because its service is becoming more complex and the growth both in work and services is creating a more competing system between departments. • Current out of hours model works well for EBOPPHA • Need for better coordination and building of relationships with external emergency and local government agencies to reduce harm and encourage healthy living	the professional training and social events are important in building teams. • We are in an era of values based leadership, but with it still remains a requirement for followership and legitimate authority / leadership in order for accountability to be assigned to roles. Responsibility (innate to post or delegated) cannot be assigned without authority to execute the necessary actions to fulfil role. • There is inefficiency in the coordination of the non-clinical activities in Whakatane emergency MO/SMO • Tauranga SMOs desire appraisals • Governance and especially clinical governance is recognised by all the service membership as being core and is valued • The current (clinical) governance structure is fragmented and requires revitalising / rebooting • The governance model will need to be a service governance model to truly enable the principle of shared

			learning - But should reflect site specific needs • Service (Clinical) Governance cannot survive without administrative support. • Service (clinical) governance must involve patient/consumer participation. • Service governance must be based on the 8 principles of good governance and clinical governance based on internationally recognised frameworks. • Staff need to be comfortable with the skills of running and participating in meetings and committees. • Value in ED is in converting 'potential admissions' to discharges: • Reduced ambulatory sensitive hospitalisation (ASH) for 0-4 and 45-65 age groups is a target for (BOPDHB Maori Health Plan) • Sustainable service provision needs to be built • Stop wasting patient's time • Rapid transit through acute

			services / improving patient flows • Transfer of care to GPs • Smart integrated systems across the health sector: strengthening relationships across the sector • Looking for strategic thinking in the services • Need for ED to know what is out there to join up with. • Evolve excellence across all hospital services • Care coordination and strengthening relationships involved in reducing demand • Highlights working as one team •
ECONOMIC		• Funding of EM service and DHB funding • Skill shortages • Glut of Fellows of the Australasian College of Emergency Medicine due out of the training system. • Restricted entry to EM training by ACEM • Staffing to weekends both sites	• Plenty of free options that ED could utilise during office hours and encourage use of GPs in Eastern bay

		• Geographical distances and social determinants were felt to have a much greater impact on the Eastern Bay presentations and likelihood of admission to Whakatane • Strong feeling of being under resourced (staffing level wise) to meet current and certainly future demand.	
SOCIAL		• Changing demographics of workforce, aging, increased female workforce affecting working patterns, part time work and social attitudes to work choosing to work casual as opposed to contract which has a cost implication to our funding model • Employer-employee trust and integrity. • Perceptions of use of clinical support time for Doctors and nurses • Judgments about use of SMO CME / Sabbatical and secondments • The planning days indicated that we are a very values driven service at both sites and that we appreciate	

		regular positive feedback
		
		• Although 'values driven' it was acknowledged that our espoused values are not necessarily reflected our values in action and this needed exploration and corrective actions
		
		• Great value was placed on two areas that were at face value staff centric:
		  • Professional development
		  • Social relationships	

TECHNICOLOGICAL	• Rooms equipped for Tele-medicine and Tele-education • Inadequate numbers of clinical workstations in Tauranga		• Telemedicine enabling support in satellite areas such as - • Tele education / E learning • Clinical decision making support • Electronic white board • Health records access • Bar coding • Telehealth consultations • Better discharge communication with GPs required EBOPPHA

ENVIRONMENTAL	• Physical environment and resources
	  - Space
	  - Equipment to fit space
	  - Clean facilities
	  - Culturally appropriate environment
			• Use of separated paeds and elderly areas and also separating out minor and moderate illness areas

		• Patient Rights	• Credentialling

LEGAL		• Recovery time for SMOs, post on call	• Heath Practitioners Competency Assurance Act • Health & Disability Sector Standards • Appraisal / PDPR ASMS DHB MECA MECA Clause 36.7(a) & (b) and 48.2(c) • Scope of practice for each cohort of staff

APPENDIX 1

Summary from workshops:

- **FROM SERVICE PLANNING DAY ONE**
  - **COO :-**No more real estate / building money needs to go to service provision and need new ways of doing things
- **STRATEGIC HEALTH SERVICES PLAN (P&F)**Sustainable service provision needs to be built Stop wasting patients' time Rapid transit through acute services / improving patient flows Transfer of care to GPs, Smart integrated systems across the health sector: strengthening relationships across the sector. Looking for strategic thinking in the services. Need for ED to know what is out there to join up with. Evolve excellence across all hospital services. Care coordination and strengthening relationships involved in reducing demand. Highlights working as one team. Highlights Obesity and Dementia as growing issues.

- **EBOPPHA**
  Current out of hour's model works well
  Options for telehealth are being explored
  Plenty of free options that ED could utilise during office hours and encourage use of GPs
  Mental health requires further improvement with linkages
  Better discharge communication with GPs required
  Managing frequent flyers
  Better workforce utilisation advised.

- **WBOPPHO**
  Acute demand nurse initiative
  Supporting Nursing homes and evidence already reducing referrals to ED
  Increasing the role of pharmacists in reducing admissions and supporting ED
  Primary care options and pathways to reduce ASH

- **General Practice**
  Have been challenged to change the way they do things and have done so.

What can ED to change
Seek participation in information sharing for pathways and management of complex patients to proactively prevent acute presentations

- **Mental Health**
  Peak presentations 5pm to 10pm
  Significant comorbidities due to the psych illness and social deprivation often associated with it blocking access to healthcare
  Police will be bringing more acute cases to the ED
  Need to have better working relationships across the sector to reduce ED attendance and rapid management of these cases including linking back to primary healthcare to improve their general health statistics.

- **Medical Workforce training**
  The demands of medical training are ever increasing without increase in resource to meet these needs for supervision. What little funding is available has no strategic implementation in terms of fte buy back by a service. It becomes practitioner purchased not service purchased. Training future workforce is valued as a way to sustainable services and it demands that staffs are on top of their own practice.

- **Nursing Workforce**
  The route to being an ENP is thorough and intensive. The potential scope allows a crossover with primary care and urgent care provision and options on having NP delivered urgent care through satellite units. How this model would look and how it would be funded has not been determined. ENPs feel that they can increase both their depth and breadth of scope to meet a community demand in the urgent and emergency care.

- **Allied Health**
  Sees opportunity to keep people at home and reduce complications leading to deterioration and hospital attendance. Additionally PARIS involvement to reduce length of stays.

APPENDIX 2

What are the healthcare experiences of emergency department among the adult Maori patients in Tauranga hospital, New Zealand? How may these experiences be improved? 2017 Student elective needs references. Recommendations

1 Making more wholesome introductions in ED including a handshake.
2 Acknowledge long wait times and encourage patients to wait in a compassionate manner.
3 Ask a patient's preference with regards to whānau being present in decision-making.
4 Offer the service of a Māori cultural support person, especially for kaumātua.
5 Make the public and private space more distinct and respect the privacy of individuals.
6 Appreciate Māori intuition about their own body and health and encourage shared decision-making.
7 Introduce compulsory Māori health training for HCPs with annual refreshers.
8 Continue to incorporate Māori words in the medical setting and strive to pronounce Māori names correctly and check pronunciation in a sensitive manner.

APPENDIX 3

Summary: Geriatric Emergency Department Guidelines ACEP 2013

Older person friendly is available baseline of geriatric care. There are 8 distinct model characteristics

- Evidence based practice model
- Nursing clinical delivery involvement or leadership.
- High risk screening
- Focussed geriatric assessment
- Initiation of care and disposition planning in the ED
- Inter-professional and capacity building work practices

- Post ED discharge follow up with patients
- Establishment of evaluation and monitoring processes

Increased demand by this demographic of patient means that an integrated inter professional approach is required

Geriatric emergency department goal is to recognise the patients who will benefit from in-patient care and to effectively implement outpatient care to that not needing in patient care by:

- Effective and expedient outpatient arrangements preferred to acute inpatient events are often accompanied by functional decline increasing dependency and decreased mobility
- Staffing need to be multidisciplinary model focused on the geriatric population
- Staffing need to be well trained in with educational awareness of :
    - Atypical presentation of disease
    - Trauma
    - Cognitive Behaviour disorders
    - Modification for older patient emergency intervention
    - Medication management
    - Transition to care
    - Plan management /Palliative care
    - Effect of comorbid conditions
    - Functional impairment disorder
    - Groups pf disease management eg abdominal pain
    - Iatrogenic injuries
    - Cross cultural issues related to older patients in the emergency setting
    - Elder abuse and neglect
    - Ethical issues

Quality improvement programme:

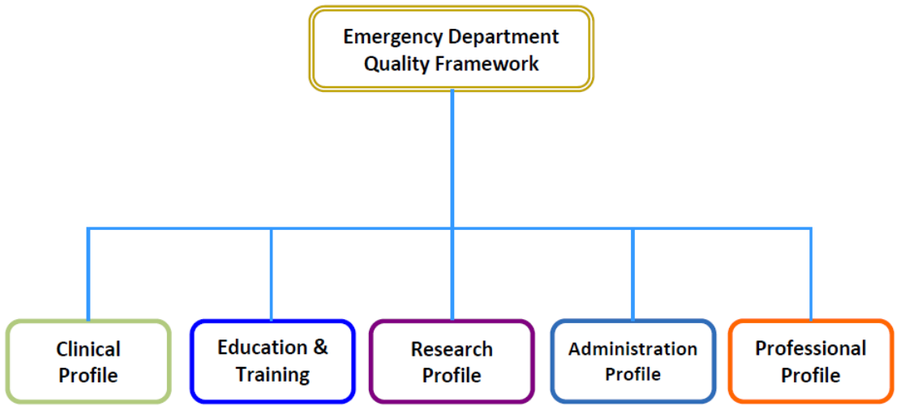
- Geriatric volume
- Admission rates
- Readmission rates
- Deaths
- Suspected neglect/abuse
- Transfer to another facility for higher level care
- Admission requiring upgrading of level of care to ICU within 24hrs of admission
- Completion of at risk tools
- Return to ED within 72hrs
- Completion of follow up re-evaluation for discharged patients

Remainder of document is guidelines

APPENDIX 4

EM CLINICAL GOVERNANCE AND THE NZ QUALITY FRAMEWORK:

1. **POLICY ON A QUALITY FRAMEWORK FOR EMERGENCY DEPARTMENTS policy P28 version 3 July 2016 ACEM**



2. **National Emergency Departments Advisory Group. 2014. A Quality Framework and Suite of Quality Measures for the Emergency Department Phase of Acute Patient Care in New Zealand. Wellington: Ministry of Health. Published in March 2014 by the Ministry of Health:**

This document defines that the quality outcomes depend also on services or departments outside of the ED. It has 59 quality measures based on 3 audit criteria

- Continuously measured
- Regularly measured
- Occasionally measured

3. **Clinical governance | Guidance for health and disability providers** Health Quality & Safety Commission 2017 Published in February 2017 by the Health Quality & Safety Commission, PO Box 25496, Wellington 6146, New Zealand

- **People-centred** is the extent to which a service involves people, including consumers, their families and whānau, and is receptive and responsive to their needs and values. (H&DC codes)
- **Access and equity** is the extent to which people are able to receive a service on the basis of need and likely benefit, irrespective of factors such as ethnicity, age, impairment or gender.
- **Safety** is the extent to which harm is kept to a minimum.
- **Effectiveness** is the extent to which a service achieves an expected and measurable benefit.
- **Efficiency** is the extent to which a service gives the greatest possible benefit for the resources used.

What are the key principles of clinical governance?: The key principles for clinical governance to be effective are:

- consumer-/patient-centred care
- open and transparent culture
- all staff actively participate (and partner) in clinical governance
- continuous quality improvement focus.

4. **Governing for quality | A quality & safety guide for district health boards:** Health Quality & Safety Commission 2017 Published in February 2017 by the Health Quality & Safety Commission, PO Box 25496, Wellington 6146, New Zealand

- Lead and set clear goals
- Gather information and seek out patient stories
- Establish system-wide measures and monitor them
- Put a high quality and safety culture in place
- Ensure the right mix of people and encourage discussion
- Commit to ongoing learning at all levels
- Define roles and establish clear accountability at all levels

5. **Emergency service clinical governance: Initial review findings and recommendations**

Moving beyond merely clinical governance and understanding good governance and what it takes to support service (clinical governance)

It requires

- Clear purpose
- Well informed leaders
- Dedicated members
- Administrative support

What is governance?

- Governance means to “steer or guide”
- It involves strategy development
- It involves well informed best possible decision making
- It involves ensuring implementation of the decision
- It also involves monitoring the implementation of the decisions
- It involves monitoring outcomes of the decisions
- It is not a day to day ‘operational’ activity

Governance is "the process of decision-making and the process by which decisions are implemented (or not implemented)".

The 8 guiding principles of good governance are:

1. Participation.
2. Rule of law.
3. Transparency.
4. Responsiveness.
5. Consensus orientation.
6. Equity.
7. Effectiveness and efficiency.
8. Accountability.

Clinical governance is often cited as *“a framework through which….organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."* Modified from G. Scally and L. J. Donaldson, Clinical governance and the drive for quality improvement in the new NHS in England BMJ (4 July 1998): 61-65

In researching the literature and soliciting local feedback, In implementing the service (clinical) Governance the following is required:

- All one team needs to apply as much as possible: Breaking down siloes
    - One service two sites
    - Across secondary services
    - Across Primary-secondary-tertiary levels
- New structure is needed
- Effective committees / Meetings / Working groups
- Specific administrative support to the structure (referred to in DHB templates on meetings/committees as ‘secretariat’)

An indicative new structure is:

- Patient and Staff experience committee
- Patient Safety Committee
- Clinical Effectiveness Committee
- Audit Committee
- Research and Quality Improvement
- Education and Training Committee

With feeding

- Subcommittees
- Liaison roles
- Lead roles
- Professional groups
- Site

Each committee will be responsible for reporting on specific aspects of the NZ ED quality indicators

APPENDIX 5

Good to Great: Maori Health Summary

- Improving Maori Health is good for all
- Improving Maori Health is everyone's responsibility
- We will operate from a strengths based philosophy and build on the positive achievements in Maori Health strategy and plan
- There will be a deliberate focus on accelerating the achievement of equity for Maori by focussing on mainstream responsiveness
- Our mainstream responsiveness approach will prioritise the implementation of the Maori Health Plan priorities as these are evidenced based and this is where we will get the greatest health gain
- We have set explicit gals which are:
    - There will be no MHP indicators in the red by 18 months
    - All the indicators will be yellow or green in 3 years
- Leadership and oversight of this will be through the Maori Health Plan Steering group which comprises primary care, NGO, clinical and BOPDHB executive representatives
- We will have a much stronger focus on delivering on the Maori Health plan through consistent application of Institute of Health Innovation and PDSA quality improvement methodology
- In line with our commitment to Pae Ora we recognise the importance of the broader determinants and the need to work with other agencies and stakeholders however we will leverage the MHP priorities to undertake this intersectorial work.
- We are promoting an ownership rather than an accountability leadership culture. Our experience shows us the most effective champions/change agents are those individuals who step up to take ownership rather than wait for it to be imposed or assigned

We acknowledge there are also other important measures for Maori Health such as Mauri Ora, Whanau Ora and Wai Ora. We know that implementing the MHP will contribute to the achievement of the broader Pae Ora measures

APPENDIX 6

Health Workforce New Zealand Report 2015 Summary

Interested in planning, recruitment, retention, workforce fit for purpose, equitable workforce distribution, Focus on meeting the government healthcare priorities.

Whakatane recognised as an area hard to staff and especially for primary care (General practice)

Additionally the aging medical and nursing workforce is also an issue. There is an increased burden in hospitals to take training grades that do not add significantly to service provision and require supervision. This has meant more medical students and PGY1 grades.

There is significant demographic mismatch between Maori and general population in the nurse workforce [and also this was noted by ACEM in EM workforce REDS conference Taupo 2016].

APPENDIX 7

BOPDHB Maori Health plan 2016/17 Summary

Aim is to reduce disparities and improve health outcomes for Maori
Our demographics:
>65yrs Maori is greater than the national average at 17.5% of BOP Population (14.35 % is the national average)
BOP Maori population skewed toward 1/3rd of Maori being under 15yrs age (7% of Maori are >65yrs age)
Growth Projection is that 25% of DHB population to 2033 is the median age of this demographic group will continue to be significantly younger than the total BOPDHB
Over 50% of Maori in BOPDHB are in the most deprived 9-10 decile. Only 4% have 1-2 decile attainment
PHO/PHA
EBPHA = 47% Maori in the population

WBOP PHO have 12% Maori in their population
NMO have 71% Maori in their population
Key outcomes for improvement over the healthcare system:

- Greater accuracy of ethnicity data in the PHO enrolment database
- Increased access for Maori population to primary care services
- Reduced ambulatory sensitive hospitalisation (ASH) for 0-4 and 45-65 age groups
- Higher rates of breast feeding for Maori infants 6 weeks and 6 months
- Lower rates of breast cancer morbidity and mortality among Maori women through better utilisation of the national breast screening programme for women age 50-69yrs
- Lower cervical cancer morbidity and mortality among Maori women through better utilisation of the national cervical screening programme for women aged 25-69 years.
- More Maori women who are smoke free at 2 weeks post natal
- Reduced immunisation preventable morbidity and mortality
- Reducing influenza morbidity through increased seasonal flu vaccination rates in the eligible population 65yrs and over
- Reduced rates of acute rheumatic fever
- Improved oral health outcomes for Maori children
- Appropriate rates of use of Section 29 of the mental health act (community treatment orders)
- Lower rates of SUDI among Maori infants
- Lower did not attend DNA rates at Maori at outpatient clinics.

APPENDIX 8

Other informal feedback from various sources:

- The DHB values distributive leadership. This is not confined to doctors. It means across all the staff at various levels and professional groupings as part of all one team.
- We are in an era of values based leadership, but with it still remains a requirement for followership and legitimate authority/leadership in order for accountability to be assigned to roles. Responsibility (innate to post or delegated) cannot be assigned without authority to execute the necessary actions to fulfil role.
- The clinical Director should spend more time in Whakatane supporting the team on that site because service is becoming busier and the growth both in work and services is creating a more complex system.
- There is inefficiency in the coordination of the non-clinical activities in Whakatane emergency MO/SMO
- Tauranga SMOs desire appraisals
- Our emergency departments should feel like home and belong to the community and so should be ‘decorated so’ eg Auckland Airport feels like we are back home and is not like all other airports McDonalds are the same all over the world and so are EDs. We should have plants etc.

APPENDIX 9

Tauranga ED Workshop Summary

Tauranga Emergency Medicine Planning Day

Tuesday 10th April 2018

These are our Values

Manaakitanga

Mana Atua

Mana Tupuna

Mana Whenua

Mana Tangata

What we're Proud of in our Emergency Department

- Soup for the soul
- Whanau philosophy
- Focus on patients
- Support we give to individual team members when they are having a difficult time in their home life
- Humour
- Moving through bias – the ones who go in and keep an open mind to CARE – Manaakitanga
- Our clinical team – got each other's backs
- Welcome people – open heart with nothing behind it – just "How can I help you?"
- People/patients can be comfortable to respond = Open faces
- Welcoming staff – showing respect
- Aroha – giving and enhancing

- Our clinical leader and opportunities to be involved in service development
- Cohesive team approach (e.g. trauma calls)
- Team building which builds relationships out of work
- Being able to work across sites
- Accepting Change
- Looking after staff in time of need
- Helping each other and sharing the load
- Including all members of the team as equals
- Accommodating rostering/staffing
- Our Admin Team
- Sense of Humour
- Working together to support the serso, their needs
- Teamwork – trust and understand each role
- Teamwork
-

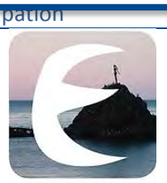
- Continue to try to make it a better place
- Meeting the needs of our patients
- Simple philosophy if we ask patient what their needs are, then work to meet their needs
- Awhi
- Ability to improvise
- Responsive to feedback
- Work best under pressure
- Share resource and skills
- 2 staff Mana Whenua on the team
- Adaptable – willing to embrace change – trial new ideas and reflect on them
-

- Investment into personal development
- Being able to develop a senior nursing structure
- The never-ending abilities of Kellie M – nothing is ever a problem and always has a smile
- Acknowledgement Certificates
- Nursing education
- Staff professional development
- Years of experience
- Growing and improving our relationships with other services in the hospital
- PARIS team work
- Highly skilled team
- Team resilience
- Honest communication
- Hard working
- Leaps and strides in education – nursing and medical, under and post graduate (Medical)
- Amazing dedication of Nurse Educator
- Acknowledging the work is often difficult and resources are tight but staff don't give up and keep coming back together and trying again
- Willingness to share extended knowledge and learning – non-judgmental. Continuous improvement and self-motivation
- Collegial support
- Growth since the beginning of ED at every level and occupation

Mana Atua

Mana Tupuna

Mana Whenua



Mana Tangata

What Staff behaviours in the Emergency Department would demonstrate our organisational CARE values?

- Pou Oranga roles in ED
- Spiritual/Holistic models of care
- Power of love that is available through belonging and belief in higher power
- Weave together holistic care for Maori
- "Hello my name is ……." and include a smile
- Use non-verbal cues

- Purposeful Maori Workforce Plan
- Manaakitanga Team – operates like PARIS Team – Pou Oranga/Social Work/staff trained in Manaakitanga
- Connected through Whakapapa – collective
- Sharing knowledge and skills to benefit others – grow your team

- Pronunciation of Te Reo Maori kupe/names – Hauora a Toi App (more to come)
- Responsiveness to the whenua and from the whenua (reciprocity)
- Staff trained in Manaakitanga – ED staff actively participate in Manaakitanga care
- Debrief after shifts

- Manifesting potential as human
- Recognised nationally for excellence in care of Maori
- Consistent measurement monitoring of Maori in ED
- Celebrate (birthdays, events, social, soup, outings, TEAM)

Manaakitanga

- Social Club (Flowers for bereavement, new baby etc)
- Use the Whanau room
- Greeting on coming staff members
- Encourage whanau to be present with patients
- Take the time to ask :Are you ok?" if someone is in difficulty or appears so
- Listening, debriefs and humour
- Help patient solve problems – taxis, PARIS Team, Refer back to GP, Social worker etc.
- Be more honest with patients when we are not the right service for them
- Ask the hard questions about why we are losing so many senior nursing staff
- Treat everyone with respect
- Ask "How can I help you?"
- Recognise people's time is precious – work hard to minimise waiting times and be as efficient as possible
- "Are you ok?"
-

- Welcome new staff to the team
- Call huddles – respond, plan, act and assess
- Understanding – staffing model, skill mix, resource, experience, behaviour changes depending on situation needs – recognise it
- Help create a sense of Whanau and team by sharing food – admin lollies, soup for the soul, night shift snacks, home baking, fruit and veges
- Listen to our colleagues and act on concerns
- Role of delineation – uniforms, identity
- Development of care groups including PARIS
- 110% communication and "Agreeing to Disagree"
- Respect for team, patient and other teams
- Flexibility and adaptability with roster changes – sickness/leave
- Open communication between nurses and doctors
- Listen and attempt to accommodate pressures on wards/specialties i.e. negotiate transfer times
- Consider staff needs (out of work) and do the best to accommodate roster to meet needs
-

- Psychologically safe workplace
- Response to staff fatigue – rotate areas, educate/coach/mentor new staff into roles
- "How can I help?" attitude
- Reach out to other services – understand barriers to response – move to partnerships,
- Appreciation certificates whole team
- We aim to keep patients at home in their own environments when sae and possible
- Online walk through the department
- Listening to others experiences. Sharing across and between services
- Signage that meets the people's needs not the staff (language and content)
- Acknowledging failures
- We listen to patients and their families/caregivers incl. feedback
- Aim to be elderly friendly – need further development PARIS links – the elderly experts
- Need to develop a culture where feedback is listened to no matter what role you play
- Introduce ourselves to patients and use first name to reduce and "hierarchy"
- Admin attitude "What can I do to help the clinical team?"
- Need to plan for Winter workload
- Need to capture more data on "DNWs"
- Patient centred solution focused
- Adapt our care according to best practice – ever changing policies
- Turn up the work rate in a higher VRM – respond to increased work pressures

- Great Blue Wall inviting
- Bike rack – healthy living and organised
- SIM session development as a team
- Introduce ourselves and smile
- We train – share knowledge, joint training, meet with individualised assess needs and expectations
- Tailor care to individual – everyone's needs are different
- Knowing the system and resources available to benefits the patient
- What does the patient need – don't waste (time, resource) What value do we add
- Letting patient know plan of care
- 6 weeks of nursing preceptorship for new staff
- Reflect on performance
- Evaluate complaints and work to promote best practice
- Need more listening to understand
- Safe environment to learn
- Seize the moment education opportunities
- Show appreciation of excellent work i.e. frogs, coffee, certificates
- Call poor behaviours – make this our norm
- Developing a united senior team
- ACNM group – working hard to engage with nursing team through appraisals
- Open to change – channel feedback appropriately rather than corridor conversation
- We inform people of what is happening

These are our Goals

Goals

- Pae ora – healthy Whanau futures
- Whanau Ora self-assessment tool
- Community Network growth
- Effective and appropriate
- Space for people
- Right staff (Capacity and competence)
- Right stuff
- Right place
- Futurist
- Future planning
- Culture – learning, growing, reflective of the community and safe in all aspects
- Resources matching demand
- ED not an isolated island
- **Capturing patient feedback and focusing in on how we make positive changes with it**
- **Reflective system for improvement – bright spots, learning from excellence, Appreciative Inquiry. Comprehensive learning from the floor**

Value we add

- Enabling patients to go home instead of being admitted
- Navigation to best pathway of care
- Disrupting Maori illness trajectory – igniting wellness and promoting holistic care
- Experts in the first 2 hours for critically unwell patients
- Treatment for those that don't "fit" anywhere else
- Management of the undifferentiated patients
- Whanau to help keep patients well
- Place of safety

Measures

- Staff factors – sickness, recruitment
- Mortality
- Morbidity
- KPIs e.g. time to thrombolysis/analgesia/ antibiotics
- Equity for Pae ora
- Need to be meaningful for staff and utilised frequently
- Ensure we have quantitative and qualitative measures

WHO will we be providing care for?

Maori

Older Adult (Palliative, frail, co-morbid)

Bariatric patients

Youth

Mental Health

Recreational alcohol/drug use

International visitors and students

Cruise Ships/ Tourists

High risk industry

Homeless families

High deprivation

"Working Poor"

Most needy

Most acute

HOW and WHAT care will we be providing?

Enhanced Fast track/Streaming

Risk stratification – work with primary care

IT Development????

Greater knowledge and linkages with other services (Community and secondary/tertiary)

Separate paeds area (and separate elderly area?)

Separate minors/moderate illness (ambulatory) area

WHAT workforce considerations are there?

Need to look at top of scope in context of overall workforce needs – HCAs, RNs, CNS, NP

HR Support (recruitment, workforce development etc)

Offer secondments? Or rotations?

Need to reflect on benefits – perceived vs real and balancing measures

Nursing retention challenges – progression of career, $/travel, lifestyle, drivers for individuals

Explore NPs in Ambulatory Care – explore and define (or CNS?)

Valuing the workforce – in innovative ways

Valuing the workforce – skills, attributes, needs (aging workforce)

Valuing the workforce – all professions….

This is how we can develop our communication

What is the key message?

What are you interested in?

How do you want to get involved?

What do you want to contribute?

Structures Handover – What's new?, What's good?, What's the focus?

ACNMs now having regular catch ups with their "teams", promoting huddles and reflective practice

ED OnePlace Page – could be used to better effect

E-mail – look to develop smaller groups and potentially targetted groups.

Need to work on regular communication and ensuring that when feedback is sought, that the results of this are communicated clearly

APPENDIX 10

Whakatane ED Workshop Summary

Whakatane Emergency Medicine Planning Day
These are our Values

Tuesday 27th March 2018 Manaakitanga

	Mana Atua	Mana Tupuna	Mana Whenua	Mana Tangata
What we're Proud of in our Emergency Department	☐ Welcoming/inclusive ☐ Patients saying "thank you" - appreciation ☐ Patient connection ☐ Focus on the patient ☐ Rapport with patients and family/Whanau	☐ Teamwork resilience ☐ HCA's new role inclusive ☐ CNS and team support ☐ Stable SMO workforce ☐ Team relationships ☐ Work above and beyond ☐ Respectful pulling the team in ☐ Huddles could be developed further ☐ Team work ☐ Resilience ☐ Reassurance	☐ Flexing - managing demand, strategies, lateral thinking ☐ Service Improvement - willingness to change and try new things ☐ Ability to flex ☐ Willingness to help out ☐ Random hug ☐ Adaptability and approachability ☐ Nurturing the new staff	☐ ED Dept physical space ☐ Relationship with Maori Health ☐ Sharing knowledge base team = good care ☐ Social quality baking - themed nights ☐ Nursing Leadership - Colleen ☐ Equipment ☐ Quality above and beyond ☐ Patient diversity = team diversity ☐ Skilled team members
What Staff behaviours in the Emergency Department would demonstrate our organisational CARE values?	☐ We don't own it ☐ Do other staff feel part of the WHK ED team? ☐ What is worrying you? How can we help? ☐ Continuous communication to hold expectations to service capability ☐ Voicing that we are available to assist with their care ☐ Introduction of self and position to patient and family or friends, patient supporters ☐ Common understanding and why people present to ED ☐ We are here to help others	☐ Responding with full teams to complete efficient evidence based effective patient care ☐ Setting the context at the beginning ☐ Advising the patient of waiting times so they can make decisions ☐ How may I be of assistance? ☐ Is the patient the true focus? ☐ What are the barriers for being one team?	☐ Patient Expectations ☐ How can I help? ☐ Communicating with the team and patients ☐ How do our CARE values fit with patient groups ☐ Resus treatment, minors, palliative, community ☐ ?Community, ?ED patient groups enquiry ☐ Lack of resources for our patients - show understanding ☐ Plan for discharge, understanding needs ☐ Helping our patients have realistic expectations of what we provide ☐ Education, cultural safety, cultural practice, developing relationships with patients	☐ Learn from excellence ☐ Ability to give and take from others and other TEAMS ☐ How can I (we) do better?

REFERENCES

Since I have already referred to this list I am unsure if it is needed and since it is not a scientific document and it would be a mammoth task to read through and reference everything many times over I am unsure if it is rally required