Māori Relationship Board Meeting

Date:	**Wednesday, 9 November 2016**
Meeting:	**9.00am to 12.00pm**
Venue:	**Te Waiora Meeting Room, District Health Board Corporate Office, Cnr Omahu Road & McLeod Street, Hastings**

Board Members:

Ngahiwi Tomoana (Chair)
Heather Skipworth (Deputy Chair)
George Mackey
Na Raihania
Des Ratima
Kerri Nuku
Ana Apatu
Lynlee Aitcheson-Johnson
Diana Kirton
Helen Francis
Trish Giddens
Denise Eaglesome
Tatiana Cowan-Greening

Apologies: Ngahiwi Tomoana

In Attendance:
Member of the Hawke's Bay District Health Board (HBDHB) Board
Members of the Executive Management Team
Member of Hawke's Bay (HB) Consumer Council
Member of HB Clinical Council
Member of Ngāti Kahungunu Iwi Inc.
Member of Health Hawke's Bay Public Health Organisation (HHB PHO)
Members of the Māori Health Service
Members of the Public

Our vision

HEALTHY HAWKE'S BAY

TE HAUORA O TE MATAU-Ā-MĀUI

Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community.

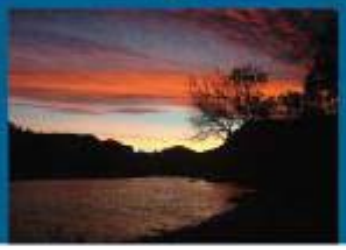
Our values

Tauwhiro – delivering high quality care to patients and consumers

Rāranga te tira – working together in partnership across the community

He kauanuanu – showing respect for each other, our staff, patients and consumers

Ākina – continuously improving everything we do



PUBLIC MEETING

Item	Section 1 : Routine	Time
1.	Karakia	**9.00am**
2.	Whakawhanaungatanga	
3.	Apologies	
4.	Interests Register	
5.	Minutes of Previous Meeting	
6.	Matters Arising - Review of Actions	
7.	MRB Workplan 2016	
8.	MRB Chair's Report	
9.	General Manager Māori Health Report	
	Section 2: Presentation	**9.20am**
10.	Fluoridation the Key Facts (Dr Robin Whyman, Dr Jones and Dr Robertshaw)	30-mins
	Section 3: For Discussion / Decisions	**10.00am**
11.	Transform and Sustain Refresh (Tracee Te Huia / Kate Rawstron)	20-mins
12.	13-17 Year Old Primary Care Zero Rated Subsidy Project (Patrick LeGeyt)	20-mins
13.	Alcohol Harm Reduction Position Statement (Caroline McElnay / Rachel Eyre)	20-mins
14.	Palliative Care in Hawke's Bay (Tim Evans / Mary Wills)	20-mins
	Section 4 – For Information / no presenters Please provide any feedback to lana.bartlett@hbdhb.govt.nz by email.	
15.	Travel Plan Update	-
16.	Orthopaedic Review – Closure of Phase 1	-
17.	Regional Tobacco Strategy for HB (2015-2020) Update	-
18.	Te Ara Whakawaiora: Smoke Free	-
19.	Annual Māori Plan Q1 Jul-Sept 2016 Dashboard Report – late paper	-
20.	Draft System Level Measures	-
	Section 5: General Business	**11.40am**
	Light Lunch	**12.00pm**

Māori Relationship Board Interest Register - 26 October 2016

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict (if any)	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Declared
Ngahiwi Tomoana (Chair)	Active	Chair, Ngati Kahungunu Iwi Incorporated (NKII)	Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The HBDHB Chair	01.05.08
	Active	Brother of Waiariki Davis	Perceived Conflict of Interest. Non-Pecuniary interest. Waiariki Davis is employed by HBDHB and is the Health Records Manager.	Will not take part in any decisions in relation to Health Records management. All employment matters in relation to Waiariki Davis are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Uncle of Tiwai Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Tiwai Tomoana is employed by HBDHB and is a Kitchen Assistant in the Food and Nutrition Department at Hawke's Bay Hospital.	All employment matters in relation to Tiwai Tomoana are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Uncle of Iralee Tomoana	Iralee Tomoana is employed by HBDHB and works in the Radiology Department as a clerical assistant.	All employment matters in relation to Iralee Tomoana are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Brother of Numia Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital.	Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital.	The HBDHB Chair	01.05.08
Helen Francis	Active	Alzheimer's Napier previously a Committee member Patron and Lifetime Member	Alzheimer's Society holds a contract with the HBDHB to provide dementia specific daycare and community services.	Will not take part in any decisions or discussion in relation to HBDHB contract with Alzheimer's Society	The Chair	08.06.10 21.06.14
	Active	Employee of Hastings Health Centre	Actual Conflict of Interest. Pecuniary Interest.	Will not take part in any decisions or discussions in relation to Hastings Health Centre.	The Chair	18.02.09
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.11
	Active	HB Medical Research Foundation	Trustee	Declare this interest prior to any discussion in relation to the Foundation, and an appropirate mitigation action is decided on.	The Chair	20.08.14
Diana Kirton	Active	Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB.	Perceived Conflict of Interest. Non-Pecuniary interest.	Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO	The Chair	18.02.09
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on.	The Chair	16.01.14
	Active	Son, Chris Kirton, GP in Wairoa employed by HBDHB	Non-pecuniary interest: Will not take part in discussions around employment of GP's in Wairoa	All employment matters are the responsibility of the CEO.	The Chair	26.02.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
Denise Eaglesome	Active	Deputy Mayor of Wairoa District Council	Advocate as Deputy Mayor for Wairoa District, whereas HBDHB covers whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	28.02.11
	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussions in relation to the Trust.	The Chair	05.03.14
	Active	Coordinator for Health Contract for Rugby Academy in Wairoa	Health Contract with Wairoa Rugby Academy	Will not take part in any decisions or discussions in relation to this contract.	The Chair	25.05.15
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract	Will not take part in any discussions or decisions relating to the Contract with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15
	Active	Director of Kahungunu Asset Holding Company Ltd	The asset portfolio of the company in no way relates to health, therefore there is no perceived conflict of interest.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	26.10.16
Tatiana Cowan-Greening	Active	Husband, Parris Greening, Service Manager of Te Kupenga Hauora (TKH)	Contracted health provider of HBDHB	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.03.14

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict (if any)	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Declared
	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussions in relation to the Trust.	The Chair	19.03.14
Kerri Nuku	Active	Kaiwhakahaere of New Zealand Nurses Organisation	Nursing Professional / Industrial Advocate	Will not take part in any discussions relating to industrial issues	The Chair	19.03.14
	Active	Trustee of Maunga HaruruTangitu Trust	Nursing Services - Clinical and non-Clinical issues	Will not take part in any discussions relating to the Trust	The Chair	19.03.14
George Mackey	Active	Wife, Annette Mackey is an employee of Te Timatanga Ararau Trust (a Trust aligned to Iron Maori Limited)	The Trust Holds several contracts with the HBDHB	Will not take part in any discussions relating to the Trust	The Chair	19.03.14
	Active	Wife Annette is a Director and Shareholder of Iron Maori Limited (since 2009)	The company is aligned to a Trust holding contracts with HBDHB	Will not take part in any discussions relating to Iron Maori Limited	The Chair	04.08.16
	Active	Trustee of Te Timatanga Ararau Trust (a Trust aligned to Iron Maori Limited)	The Trust Holds several contracts with the HBDHB	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.06.14
	Active	Director and Shareholder of Iron Maori Limited (since 2009)	The company is aligned to a Trust holding contracts with HBDHB	Will not take part in any discussions or decisions relating to the Contract aligned to Iron Maori Limited).	The Chair	04.08.16
	Active	Employee of Te Puni Kokiri (TPK)	Working with DHB staff and other forums	No conflict	The Chair	19.03.14
Lynlee Aitcheson [married 12 May 2016] now Lynlee Aitcheson-Johnson	Active	Chair, Maori Party Heretaunga Branch	Political role	Will not engage in political discussions or debate	The Chair	19.03.14
	Active	Chair of Te Whare Whanau Purotu Inc.	Maori Womens Refuge	No conflict	The Chair	22.12.15
	Active	Trustee, Kahuranaki Marae		No conflict	The Chair	14.07.16
	Active	wahine co-Chair for Ikaroa Rawhiti Electorate for the Maori Party	Political role	No conflict	The Chair	14.07.16
Na Raihania	Active	Wife employed by Te Taiwhenua o Heretaunga	Manager of administration support services.	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.03.14
	Active	Member of Tairawhiti DHB Maori Relationship Board		No conflict	The Chair	19.03.14
	Active	Employeed as a Corrections Officer		No conflict	The Chair	19.03.14
Trish Giddens	Active	Trustee, HB Air Ambulance Trust	Management of funds in support of HB Air Ambulance Services	Will not take part in discussions or decisions relating to contracts with HB Air Ambulance Service.	The Chair	19.03.14
	Active	Manager, Taruna College		No conflict	The Chair	15.04.15
	Active	Assistant Director Governor, Rotary District 9930		No conflict	The Chair	15.04.15
	Active	Member of the Lotteries Board		No conflict	The Chair	15.04.15
Des Ratima	Active	Chair Takitumu Maori District Council	Maori Community Development Act 192	No conflict	The Chair	Dec 13
	Active	Chair Ahuriri District Heatlh Trust	Maori health post settlement equity group	Potential Conflict if contractural arrangements in place	The Chair	Dec 13
	Active	Chair Whakatu Kohanga Reo	Early Childhood	No conflict	The Chair	Dec 13
	Active	Chair Wanautahi Charitable Trust	Community Trust	No conflict	The Chair	Dec 13
	Active	Deputy Chair Maori Wardens NZ Maori Council	Maori Community issues	No conflict	The Chair	Dec 13
	Active	Chair of the Kaupapa Maori Comittee	Maori Community Issues	No conflict	The Chair	Dec 13
Ana Apatu	Active	CEO of U-Turn Trust (U Turn is a member of Takitimu Ora Whanau Collective)	Relationship and and may be contractural from time to time	No conflict	The Chair	12.08.15
	Active	Chair of Directions	Relationship and contractual	Potential Conflict as this group has a DHB Contract	The Chair	12.08.15
	Active	Chair, Health Promotion Forum (previously Deputy Chair from 12.08.15)	Relationship	No conflict	The Chair	12.08.15 04.08.16

MINUTES OF THE MĀORI RELATIONSHIP BOARD (MRB) MEETING HELD ON WEDNESDAY, 12 OCTOBER 2016 IN TE WAIORA MEETING ROOM, DISTRICT HEALTH BOARD (DHB) ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS COMMENCING AT 9.00AM

Members:
Ngahiwi Tomoana (Chair)
Heather Skipworth (Deputy Chair)
Kerri Nuku
Denise Eaglesome (video conference)
Ana Apatu
Tatiana Cowan-Greening (teleconference)
Lynlee Aitcheson-Johnson
Trish Giddens
Diana Kirton
Helen Francis
Des Ratima
George Mackey
Na Raihania (teleconference)

Apologies:
George Mackey
Helen Francis
Denise Eaglesome

Diana Kirton (late)
Kerri Nuku (late)

Tracee Te Huia (General Manager, Māori Health HBDHB)
Matiu Eru (Pouahurea, Māori Health HBDHB)
Dr Adele Whyte (CEO Ngāti Kahungunu Iwi Incorporated)
Nicola Ehau (Acting CEO, Health Hawke's Bay PHO)

In Attendance:
Kevin Atkinson (Chair HBDHB Board)
Graeme Norton (Chair, HB Consumer Council HBDHB)
Peter Dunkerley (HBDHB Board Member)
Dr Kevin Snee (CEO HBDHB)
Caroline McElnay (Director Population Health, Health Equity Champion HBDHB)
Dr Russell Wills (Community Paediatrician HBDHB)
Andrew Phillips (Chief Allied Health Professions Officer HBDHB))
Anne McLeod (Allied Health Educator HBDHB)
Chrissy Hape (Iwi/CYF Partnership Advisor, Ngāti Kahungunu Iwi Incorporated)
Traci Tuimaseve (Project Manager, Ngāti Kahungunu Iwi Incorporated)
Deborah Baird (Acting for Nicola Ehau, Health Hawke's Bay PHO)

Minute Taker: Lana Bartlett (MRB Administrator and Executive Assistant GM Māori Health Service)

SECTION 1: ROUTINE

1. KARAKIA

N Tomoana opened the meeting with karakia followed by an acknowledgement of those members re-elected and commiserations to those who were not re-elected.

2. WHAKAWHĀNAUNGATANGA

H Skipworth (Acting Chair) welcomed everyone to the meeting.

3. APOLOGIES

Apologies were received from G Mackey and H Francis. Additional apologies were received from D Kirton and K Nuku who were running late.

4. INTERESTS REGISTER

There was one amendment for the Interest Register from H Skipworth, recently appointed as a Director of the Kahungunu Asset Holding Company.

No MRB Board members declared a conflict of interest with today's agenda items.

5. MINUTES OF THE PREVIOUS MEETING

The minutes of the MRB Board meeting held 14 September 2016 were taken as read and confirmed as a correct record, pending the following amendments:

- Typo 'N Raihaia' on page 6 (1 of 5), item 3. Apologies
- Health and Social Care Networks diagram on page 9 (4 of 5) to be corrected

Moved: T Giddens
Seconded: A Apatu
CARRIED

6. MATTERS ARISING FROM THE PREVIOUS MINUTES – REVIEW OF ACTIONS

The following matters from the September minutes were discussed:

REVIEW OF ACTIONS

The Action and Progress List as at September 2016 was taken as read. The following actions were discussed:

September MRB Meeting

MRB hosting the next DHB Māori Caucus

Dates for Te Whiti ki te Uru are 17 February 2017 Hutt Valley DHB; 4 April 2016 Whanganui DHB and 2 October 2017 HB DHB. Email dates to MRB. **ACTION: MRB Administrator**

August MRB Meeting

Wānanga between MRB and Mental Health Services

Wānanga date for 21 November 2016 noted. MRB have requested to be included in the development of the agenda. Also, for the information to be received before the workshop. Liaise with Mental Health Services to circulate the information for feedback via email to merge information before the Wānanga on 21 November 2016. **ACTION Programme Manager Māori Health**

D Kirton joined the meeting at 9.22am.

June MRB Meeting

Health Equity Update 2016 – NZ Territorial Authorities Statistics Gap in Years between Māori and non-Māori Life Expectancy by Gender and Region 2012-14

Caroline McElnay (Director Population Health, Health Equity Champion HBDHB) apologised because she was not able to provide an update. Caroline had been on holiday for two months and on her return was pre-occupied with water contamination issues in Havelock North. However, Caroline has been in contact with Professor Tony Blakely, Health Inequalities Department of the University of Otago, Christchurch (UOC) and is awaiting a response. Caroline will update MRB once the information is received. N Tomoana suggested contacting Dr Suzanne Pitama, Associate Professor and Director of Māori/ Indigenous Health Institute of the UOC.

May MRB Meeting

Review form and function of MRB and Youth Representative

Ken Foote (Company Secretary), Tracee Te Huia (GM Māori Health) and Adele Whyte (CEO Ngāti Kahungunu and There was a brief discussion about youth representation. Graeme Norton (Chair Consumer Council) advised The Consumer Council are looking at appointing two youth representatives from a collective group being formed as part of the Youth Strategy. This should happen in the next month or so. H Skipworth (Acting Chair) suggested a male and female representative for consideration.

7. MRB WORKPLAN 2016

The MRB Workplan as at September 2016 was taken as read. It was noted the number of papers deferred to the November meeting i.e. Orthopedic Review, HB Integrated Palliative Care DRAFT, 13-17 Year Old Primary Care Zero Rated Subsidy Project; and Bariatric Surgery Investigation Paper.

As result, the number of agenda items for November's meeting exceeded MRBs requirement of six papers. Therefore, MRB confirmed the following papers for next month's agenda:

1. 13-17 Year Old Primary Care Zero Rated Subsidy Project DISCUSSION
2. Integrated Palliative Care DISCUSSION
3. Transform and Sustain Refresh DISCUSSION
4. Fluoridation the Key Facts PRESENTATION
5. Bariatric Surgery Investigation Paper
6. Orthopaedic Review – closure of phase 1

MRB noted the following two papers are 'For Noting' and 'Information Only':

1. Tobacco Annual Update FOR NOTING
2. Long Term Conditions FOR INFORMATION

It was stressed that MRB look at pieces of work that need to be tidied up or completed before the new MRB Board is elected and the review of the MRB.

8. MRB CHAIR'S REPORT

The Chair's Report for October 2016 was taken as read and the contents noted.

Moved: D Ratima
Seconded: A Apatu
CARRIED

9. GENERAL MANAGER (GM) MĀORI HEALTH REPORT

The GM Māori Health report for October 2016 was taken as read and the contents noted.

Moved: D Ratima
Seconded: T Giddens
CARRIED

SECTION 2: PRESENTATIONS

10. MAHI TAHI: WORKING TOGETHER FOR TAMARIKI IN HAWKE'S BAY

Dr Russell Wills (Community Paediatrician HBDHB) was in attendance to speak to Terms of Reference (ToR) for Oranga Tamariki – Investing in Hawke's Bay Children, Mahi Tahi mo ngā Tamariki – One Workforce for Children. Dr Wills provided a brief overview and the purpose of today's presentation was to get MRBs feedback on which agencies should be involved from the onset and outset, assistance to write the TOR and guidance to progress further.

While the paper needs a lot of work, MRB acknowledged Dr Wills for his efforts to date and the work achieved whilst the Child Commissioner. Moreover, his desire and passion to help our Tamariki and the courage to start the ball rolling.

MRB provided the following feedback for consideration:

- In relation to the sentence 'Tamariki of parents with mental illness, addictions and in violent relationships ("vulnerable children"), violence is the issue not the relationship. There is a tone of victim blaming and stigmatisation of Māori instead of aspiring them. The Māori Women's Welfare League (MWWL) have a crisis intervention team and Dr Wills offered to meet with the group

- 'Vulnerable children' should be defined first before we can decide on how to address the issues and determine what the outcomes will look like
- Whānau and community involvement throughout the entire project was echoed by the MRB members. The issues are in the communities and this is also where you will find the solutions. It is for these reasons that communities need to be involved in the development and implementation stages but also to provide advice to the clinicians. Gangs and solo parents should also be included in the development. To be able to respond appropriately to these issues, Dr Wills was encouraged to engage with these communities.
- The proposal is too clinically focused and driven. Māori need to be involved in the scoping and development. Also, having Māori lead as opposed to clinicians telling Māori what works for them as well as to advocate for our most vulnerable children and whānau. Consumer Council, Māori and community representation should be included on the governance group, management team structure and stakeholder map
- Strategically placing Māori in key lead roles will be imperative to the implementation and effectiveness of this project. To understand the complexities and make-up of our vulnerable children and whānau, you have to be understanding of an indigenous world view
- Perform a Peer Review of the TOR and a HEAT to identify gaps, triggers and evaluate the effectiveness of the project
- Examine the current problematic system and identify the areas that are discriminative instead of looking at Māori being the issue in the system
- Clearly demonstrate the connectivity between training that staff will receive and what the outcome of this training will be for the target group. Also, with the training at least three years away, identify the activities over this period
- Recognise and include what Māori are currently doing in the sector that are contributing in some way to vulnerable whānau - i.e. marae, Te Kōhanga Reo, MWWL and Kura Kaupapa
- Consider the Pae Ora methodology and the relativity of this approach
- Ensure this work is connected to Social Inclusion and other projects

The feedback received via email from N Raihania was tabled and a copy given to Dr Wills.

It was agreed for a workshop to be held to discuss the project further. MRB will shoulder tap people within their networks and in the community who could contribute to the development of the project. Connect with Dr Wills to organise a date and time **ACTION: Programme Manager and MRB Administrator**

11. CO-DESIGNING RELATIONSHIP CENTRED PRACTICE PRESENTATION

Dr Andy Phillips and Anne McLeod was in attendance to present the Co-Designing Relationship Centred Practice (RCP) framework and obtain MRBs feedback.

MRB provided the following feedback:

- Consider what experiences whānau have had with the health services in the past.
- Again, involve the whānau and community in the design of the framework
- Concern that the DHB will start to tell Māori how the Mihimihi Process works whereas Māori should be instructing the DHB. A key element will be the person running the process
- Consider using a whānau member to manage the cultural aspect so the clinician can focus on the clinical aspect
- Look at the system which is problematic.
- Look at what activities are happening before the patient is admitted in the system and what is being done after they have been discharged.
- Look at other projects and if they connect or overlap
- Share data for discussion in a meaningful way. Data is not just for clinicians. Good starting point.

- For future reference, although the framework has 7 steps, in Māoridom there may be 700 steps and the starting point may not necessarily be at one. Māori are a revolutionary people so it is difficult to set a framework on Māori.
- The approach could be implemented across the long term conditions and disability sectors and then across the entire health sector.

The Co-Designing Relationship Centred Practice framework contained a lot of great information that overlapped with the above paper and could be incorporated. With this in mind, I suggested Dr Phillips also attend the meeting with Dr Wills (Community Paediatrician) and Patrick LeGeyt (Programme Manager Māori Health) **ACTION**

The presentation will be emailed to MRB to feedback directly to the MRB Administrator. Deadline in two weeks. **ACTION**

12. TE MATATINI 2016 PRESENTATION

Traci Tuimaseve (Project Manager, Ngāti Kahungunu Iwi Inc.) was in attendance to provide a brief progress update on Te Matatini 22 – 26 February 2016 as follows:

- 35,000 visitors to participate in or witness Te Matatini 2016 are expected
- The largest cultural event in HB to date that won't happen for another 30 years
- 48 Kapa Haka teams consisting of 2000 performers from New Zealand and Australia. More teams than ever before
- Working closely with the Hauora Team of Shari Tidswell (Team Leader/ Population Health Advisor), Maree Rohleder (Team Leader/ Health Protection Officer) and Tracee Te Huia (GM Māori Health). The Hauora Team will provide health messages and a one on one interactive stall to engage with the audience to promote health. The team are also working with different marae to develop health and safety plans. Maree is also putting in place a contingency plans
- Also working with the three councils and HB Tourism. There is also opportunity for the wider community to participate
- Everything is on track. Accommodation is all booked out and tickets are already on sale. The marketing communication is starting next week
- Ngāti Kahungunu Iwi Incorporated purchased tickets to encourage all of HB to attend the event. Traci is meeting with the Taiwhenua to discuss plan
- Narelle Huata of Ngāti Kahungunu Rūnanga Arts and Culture Board is coordinating the 'Haka Fit' project who already has four HB teams registered for the project. Narelle is looking at opening the project to other teams.
- Iwi are working with John Bostock and the Fisheries to supply raw food to distribute to local marae
- The event will be free of sugar, deep fried food, waste, smokefree, drug and alcohol.
- Live streamed via Māori TV.

Traci's update was impressive and MRB were heartened by the collaboration across the sector. The innovative approach by the Hauora Team was acknowledged. Te Matatini 2017 sounds out of this world.

At the recent Iron Māori Women's Duathlon, a mass warm-up class was held and N Raihania asked this activity also be considered for Te Matatini.

SECTION 3: FOR DISCUSSION

13. COMPLEMENTARY THERAPIES POLICY

Dr Andy Phillips (Chief Allied Health Professions Officer HBDHB) also presented the Complementary Therapies Policy for discussion and to obtain MRB's feedback.

MRB provided the following feedback for consideration:

- The registration process is great but would like consideration for registration to be reviewed on an annual basis

- A lot of maintenance work will be required and this extra work could potentially fall onto the manager of that facility. This is where there is a risk around some people getting through before others.
- Ensure the process remains flexible and informed
- Look at patient feedback on complementary therapies
- There are some very strong Māori organisations who would disagree with Rongoa defined as Complementary and Alternative Medicines. Fitting Rongoa inside the policy would have wider ramifications so thinking needs to be more laterally around Māori concepts of Rongoa in a Tikanga sense. In addition, Rongoa has its own standard of practice and is dealt with separately.
- The term 'Practitioner' has a specific meaning in the medical world. Consider removing practitioner and using just 'Therapist'.

D Ratima commented the information presented by Dr Andy Phillips today has given Māori a sense of confidence to outcomes for Māori.

SECTION 4: GENERAL BUSINESS

There were no items for General Business.

SECTION 5: Recommendation to Exclude

That MRB

Exclude the public from the following item:

15. Confirmation of Minutes of the MRB Meeting

- Public Excluded

Moved: A Apatu
Seconded: L Aitcheson-Johnson

H Skipworth, Acting Chair closed the public section of the meeting at 11.45am with members taking a brief break.

Signed: _____
Chair

Date: _____

Date of next meeting: 9.00am Wednesday 9 November 2016
Te Waiora (Boardroom), HBDHB Corporate Administration Building

MĀORI RELATIONSHIP BOARD
Matters Arising – Review of Actions

6

Oct MRB Meeting

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at October 2016
12/10/16	**1. Mahi Tahi: Working Together For Tamariki in Hawke's Bay Workshop** Hold a workshop to discuss the project further. Connect with Dr Wills to organise a date and time. MRB to shoulder tap people within their networks and in the community who could contribute to the development of the project.	**Programme Manager Māori Health**	Nov 2016	**COMPLETE** Workshop scheduled for 07/11/16
	2. Co-Designing Relationship Centred Practice Framework The framework contained a lot of great information that overlapped with the above paper and could be incorporated. It was suggested Dr Phillips also attend the meeting with Dr Wills (Community Paediatrician) and Patrick LeGeyt (Programme Manager Māori Health).	**Programme Manager Māori Health**	Nov 2016	**COMPLETE**
	2.1 Presentation Email MRB presentation to provide feedback directly to the MRB Administrator. Deadline in two weeks.	**MRB Administrator**	Nov 2016	**COMPLETE** Presentation emailed to MRB 17/10/16. There was no feedback received.

Sept MRB Meeting

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at October 2016
14/09/16	**1. MRB hosting the next Te Whiti ki te Uru:** a) Send dates to MRB Administrator. b) Develop the agenda and discussions c) Consider future MRB representation to the Māori Caucus.	T Cowan-Greening MRB	Nov 2016	**COMPLETE -** Email dates to MRB, **MRB Administrator**. Dates were emailed to MRB 17/10/16.
	2. Future Direction of MRB Develop a draft for MRB to discuss at the October Meeting.	**GM Māori Health/ Company Secretary HBDHB/ CEO NKII**	Nov 2016	**IN PROGRESS** Rescheduled to the 11/11/16.

Aug MRB Meeting

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at October 2016
10/08/16	**1. Fluoridation Presentation in November** MRB requested the most up-to-date information about 'Neurotoxin and for this subject to be discussed. Also the possibility for a neurologist presenting this information in conjunction with Dr Whyman. Circulate Neurotoxin information to MRB members.	Clinical Director Oral Health L Aitcheson-Johnson	Nov 2016	Agenda item for today's meeting.
	2. Wānanga between MRB and Mental Health Services Allison Stevenson and Dr Shaw to formulate a clear purpose, agenda, response(s) and outcomes for the wānanga.	Service Manager Mental Health and Addiction Services/ Clinical Director & DAMHS	Sept 2016	**IN PROGRESS** Liaise with Mental Health Services to circulate the information for feedback via email to merge information before the Wānanga on 21 November 2016. **ACTION Programme Manager Māori Health**

June MRB Meeting

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at October 2016
08/06/16	**1. Health Equity Update 2016** ***NZ Territorial Authorities Statistics Gap in Years between Māori and non-Māori Life Expectancy by Gender and Region 2012-14*** MRB were interested in the reasons for the longer life expectancy of Māori in the Canterbury region and requested that Dr McElnay conduct further research to provide an update on the findings	DPH/ HE	Oct 2016	Dr McElnay was unable to provide MRB an update. Caroline has been in contact with Professor Tony Blakely, Health Inequalities Department of the University of Otago, Christchurch (UOC). Once information received Caroline will update MRB.

May MRB Meeting

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at October 2016
12/05/16	**1. Review form and function of MRB and Youth Representative** NKII and MRB are reviewing MRB including the composition and consideration of a Youth Representative.	GM Māori Health/ CEO NKII	Sept 2016	**IN PROGRESS** Review of MRB underway led by NKII
	2. Bariatric Surgery Investigation Request for an investigation of the evidence to rationalise the increase of surgeries per annum.	Head of Strategic Services	Oct 2016	Deferred to December.

20

HAWKE'S BAY District Health Board Whakawāteatia

MĀORI RELATIONSHIP BOARD WORKPLAN 2016/17

7

Meetings	Papers and Topics	Lead(s)
5 Dec **Dec 16**	*New Board comes into office.* **No Meeting in December** The following papers will be emailed to MRB: Health and Social Care Networks Update Orthopedic Review Phase 2 DRAFT Long Term Conditions Evidence Base for Adults at Risk of Obesity (Bariatric paper) Update on RFP (for screening)	 Tracee Te Huia Andrew Phillips Tim Evans Mary Wills Jenny Cawston
JAN 17	**No Meeting in January**	
8 Feb 17	Orthopedic Review Phase 3 DRAFT Palliative Care in HB FINAL **Monitoring – for information - no presenters:** Annual Māori Health Plan Q2 Oct-Dec 2016 Te Ara Whakawaiora: *Access* (local indicator) Ambulatory Sensitive Hospitalisations (ASH) tbc	Andrew Phillips Tim Evans
8 Mar 17	Travel Plan Update (Verbal) Health and Social Care Networks Update **Monitoring – for information - no presenters:** Annual Māori Health Plan Q2 Oct-Dec 2016 tbc Te Ara Whakawaiora: *Breastfeeding* (national indicator) tbc Travel Plan Update	Sharon Mason Tracee Te Huia
15 March 17	**HB Health Sector Leadership Meeting** – venue and time TBA	
12 APR	**No Meeting in April** – email papers to MRB for feedback Health Equity Update Draft Youth Health Strategy Draft Suicide Prevention Postvention Update against 2016 Plan **Monitoring – for information - no presenters:** Te Ara Whakawaiora: *Cardiovascular* (national indicator) tbc	 Caroline McElnay Caroline McElnay Caroline McElnay
10 May	Best Start Health Eating Plan Yearly Review Te Ara Whakawaiora Priorities and Reporting Schedule 2017-2018 **Monitoring – for information - no presenters:** Annual Māori Health Plan Q3 Jan-Mar 2017 tbc	Caroline McElnay Patrick LeGeyt
14 Jun	Orthopedic Review Closure of Phase 2 Orthopedic Review Closure of Phase 3 Health Equity Update Youth Health Strategy Update Suicide Prevention Postvention Update against 2016 Plan **Monitoring – for information - no presenters:** Te Ara Whakawaiora: *Oral Health* (national indicator) tbc	Andrew Phillips Andrew Phillips Caroline McElnay Caroline McElnay Caroline McElnay

Note: The 2017 HBDHB Workplan is a work in progress. HB Health Sector Leadership Forum 6 September 17

HAWKE'S BAY District Health Board Whakawāteatia	**MRB Chair's Report**
	For the attention of: **Māori Relationship Board (MRB)**
Document Owner:	Heather Skipworth, Deputy Chair
Month:	November 2016
Consideration:	For Information

8

RECOMMENDATION

That MRB

Note the content of this report.

PURPOSE

The purpose of this report is to update the Māori Relationship Board (MRB) on relevant discussions at the Board meeting held in October 2016 pertaining to Māori health.

INTRODUCTION

For this month, I provide an overview of the Chief Executive Officers (CEO) report including the Havelock North Campylobacter Outbreak, RMO Strike Action and a Financial and Performance Report. This month's report also provides a brief outline of the Advisory Committee's Chair's Reports to the Board.

Chief Executive Officers (CEO) Report

Havelock North Campylobacter Outbreak

The National Inquiry into the outbreak commenced in Hastings on the 27 October 2016. Since the request for a full review was agreed at the September Board, a significant amount of work has been undertaken. Rose Laloli (Central Technical Advisory Services) has been gathering information and debriefing activities on behalf of the DHB. Rose has spent the last three weeks working and meeting with teams that were involved in the outbreak management and gaining an understanding of the legislative requirements around drinking water monitoring. Simultaneously, a piece of work has been undertaken to centralise all the documents, emails and texts that occurred during the period from 1 August – 26 August 2016. The report that will be discussed is still a draft working document and a final version will be presented in November for Board endorsement. In conjunction with this, the DHB recently met with the Government Independent Inquiry lead and are liaising with Buddle Findlay as to how we manage and support this inquiry effectively.

RMO Strike Action

The hospital coped extremely well considering. Unfortunately, some elective procedures and outpatient appointments were proactively postponed. Senior medical staff and indeed many RMOs all collaborated well to ensure a high level of services has been maintained.

Performance Report

Shorter Stays in ED showed a noticeable improvement in October with the target being delivered over a three week period due to the work to improve patient flow supported by the Francis Group getting underway and two of our three new ED SMOs starting.

Elective Treatment remains below plan but has shown some improvement. An impact as a result of the national strike action is expected.

Faster Cancer Treatment showed a deterioration for September. Little has changed when considering the 6-month rolling average.

Immunisation at 8-months remains above target.

There were no new figures for *Smoking, and Heart and Diabetes Checks*.

First quarter data on the new target for *Healthy Kids* should be available next month.

Financial Report

September showed an adverse variance of $85 thousand for the month, with to date adverse variance of $203 thousand for the first three months of the year. Not alarming at this stage but is being monitored.

HB Health Clinical Council

Clinical Council s**upported** holding a Palliative Care, Advanced Care for a Workshop with Consumer Council on 9 November. Wide consultation is factored in to the palliative care planning process and this workshop will give both Councils an early opportunity to discuss these issues. MRB will be considering the 'Palliative Care in Hawke's Bay' paper the same day.

The establishment of a New Quality Dashboard was **endorsed** by Clinical Council, however further work was required. A revised Quality Dashboard Concept Report will be provided to FRAC in December.

Clinical Council **supported** a review of the Clinical Council Annual Plan 2016/17, noting the plan needed to be reviewed in conjunction with the Clinical Governance Committee Structure, Quality Dashboard and Clinical Services Plan, when finalised.

At the Council's AGM in August there was some discussion around prioritising of the Council agenda, moving away from overview of many agenda items to a focus on those where Clinical Council input can make a difference, and having some proactive presentations around innovation.

HB Health Consumer Council

Consumer Council approved its Annual Plan for 2016/17. Key objectives for the next period are:

- Actively promote and participate in' co-design processes for:
  - Youth
  - Mental Health
  - Older Persons
- Participate in the development of Health and Social Care Networks
- Provide consumer perspective into Customer focussed Booking

To achieve these objectives and other parts of the plan members have agreed to be assigned into portfolios to enable them to focus their energies on the work ahead. Areas where there is alignment and collaboration with Clinical Council have been set out in the plan.

Palliative Care in Hawke's Bay 2016-2026

A session was held with Consumer Council, senior executives of Cranford and strategic services to discuss an early draft of the revised strategic plan for palliative care across the next 10 years. The Council had reviewed an earlier draft some 18-months ago. Apart from checking whether consumer feedback of the time had been incorporated in this revised draft the overall strategy was discussed along with some suggestions for the workstreams which will inevitably follow its adoption. Overall feedback was strongly positive for example:

- Well written, clear and you can hear the consumer voice throughout the document
- The original document was from a clinical perspective this one is from the patient / whanau perspective.

The role and challenges of enabling more Advanced Care Planning was also discussed. This strategic plan will go back for refining and evaluation prior to a further round of consultation.

Working for Tamariki in Hawke's Bay

Following on from a session with MRB, Dr Wills led a session with Consumer Council to seek their input into "what matters" and what their views were. A wide ranging conversation followed with detailed feedback for Dr Wills. Members of Consumer Council will have an opportunity for further input at a hui being organised with MRB and other community leaders on the 7 November 2016.

HAWKE'S BAY District Health Board Whakawāteatia	**General Manager Māori Health Report**
	For the attention of: **Māori Relationship Board (MRB)**
Document Owner:	Tracee Te Huia, General Manager (GM) Māori Health
Month:	November 2016
Consideration:	For Information

9

RECOMMENDATION

That MRB

Note the content of this report.

PURPOSE

The purpose of this report is to update the MRB on implementation progress of the Māori Annual Plan objectives for October 2016.

INTRODUCTION

This month's report provides a brief update on the following matters:

- Under 18 Primary Care Co-Payment Subsidy Project
- Annual Māori Health Plan Report Writers Workshop
- Tūruki Workforce Development Mid-Term Evaluation Report
- Tu Kaha Conference 2016
- Co-Designing Services - Relationship Centred Practice
- Māori Health Welcome Two New Staff
- Gastro Outbreak Review

UNDER 18 PRIMARY CARE CO-PAYMENT SUBSIDY PROJECT

Programme measures were developed for the Under 18 Primary Care Co-Payment Subsidy proposal including ASH rates, ED admissions, GP Practice Utilisation, and Other Youth Health specific indicators (mental health etc.). Individual tailored measures would be general practice specific and negotiated with each practice. The scope of the plans would be based on the level of funding they are likely to receive. However, there would be baseline expectations that include changes to model of care and zero fees.

These additions were presented to EMT on 4 October 2016. However, EMT asked that the proposal be simplified and included a two-page summary of how the proposal would be implemented. Therefore the following programme approach has been developed by Māori Health with support from the Acting CEO Health Hawke's Bay PHO and HBDHB Portfolio Manager of Primary Care.

Programme Approach

1. Removal of Cost

Directly fund general practices with co-payment subsidy based on a utilisation rate of 2.15 per annum costed at $25.00 per consult, inclusive of a 25% buffer for potential increases.[1]

After hours consultation subsidy is also included and will be slightly higher at $40.00 per visit (utilization rate of 0.26 visits per annum per person) as well as a pharmacy subsidy of $5.00 per item, per GP consultation (see attached paper for breakdown of funding formula calculations, options and analysis).

2. Target High Need – Māori and Pacific Population Groups

Practices with the above demographic have been consulted and their feedback on model of care sought. Currently it is anticipated that 14 practices will be included in the programme, which includes two practices aligned to The Doctors Hastings.

3. Changes to Model of Care

General practices that agree to enter the zero fees subsidy programme will be expected to adopt changes to their model of care. The overarching principles for the model are:

- Provide a range of 'youth friendly' clinical health services, staffed by health professionals who are well trained, skilled and knowledgeable in youth health.
- Provide comprehensive and 'joined up' youth friendly care.
- Work across sectors to encourage population, community, school and family level interventions that will improve the health of young people.

4. Implementation:

- There are currently fourteen practices[2] that have indicated an interest in being part of the program of work.
- To qualify for funding each practice will need to demonstrate a commitment to improving youth health outcomes through an agreed plan – developed with each of the practices.
- The funding received by the practices is a nominal figure of $25 per consultation calculated against their enrolled 13-17 year old population, and multiplied against a utilisation rate of 2.15 visits per annum.
- Within a number of practices the following services are current and will provide a further platform to develop the model of care
    - Sexual health contract provided free of charge to the person in Napier, Hastings and Central Hawke's Bay for youth up to and including 20 year olds, and in Wairoa for youth up to and including age 24 years.
    - Whānau wellness programme provided free of charge to the person and their whānau which includes pharmacy scripts.
    - PC/ED cooperative which includes an intensive case management approach

[1] Table 1.0 provides 'indicative' funding to practices identified that fit the criteria. However it is not certain that all practices identified will participate as it is a voluntary scheme. This could reduce the overall expenditure and/or provide for a redistribution of allocated funds. Furthermore, there is a funding differentiation between VLCA practices and non VLCA practices, and reducing the co-payment subsidy to $15 per consultation for VLCA practices would reduce the overall funding request to within budget.

[2] Table 1.0 – lists practices identified that meet the criteria of the programme. Shaded practices are VLCA practices (Very Low Cost Access). Many of which offer low or no fees for the 0-18/20 age group

- A number of practices have also been supported to employ social work services and kaiawhina

Where these services are in place the implementation process will ensure alignment to the best use funding or augments what's in place as appropriate. The sum per practice ranges from $11,933 to $83,958 per annum. (Refer to Table 1.0 below)

Napier	Existing Fees	Total	% MPI	General consult funding	Urgent care consult	Pharmacy funding (based on $5.00 per consult)	Full Utilisation costs
The Doctors - Napier	$27.00	1400	42%	$75,250	$14,560	$16,870	$106,680
Tamatea Medical	$28.00	453	32%	$24,349	$4,711	$5,459	$34,519
Maraenui Medical (VLCA)	$11.50	417	74%	$22,414	$4,337	$5,025	$31,775
						$0	
Wairoa	**Fees**	**Total**				$0	
Wairoa Medical (VLCA)	$12.00	106	66%	$5,698	$1,102	$1,277	$8,077
Queen St Medical (VLCA)	$11.50	222	84%	$11,933	$2,309	$2,675	$16,916
Health Care Centre Ltd (VLCA)	$11.50	245	79%	$13,169	$2,548	$2,952	$18,669
						$0	
Central Hawkes Bay	**Fees**	**Total**				$0	
The Doctors – Waipawa*	$24.00					$0	
Tuki Tuki Medical	$24.00	503	29%	$27,036	$5,231	$6,061	$38,329
						$0	
Hastings	**Fees**	**Total**				$0	
Totara Health (VLCA)	$0.00	1214	65%	$65,253	$12,626	$14,629	$92,507
Medical & Injury (VLCA)	$0.00	278	65%	$14,943	$2,891	$3,350	$21,184
Hauora Heretaunga (VLCA)	$0.00	590	93%	$31,713	$6,136	$7,110	$44,958
The Doctors - Hastings	$16.00	664	36%	$35,690	$6,906	$8,001	$50,597
The Doctors - Gascoigne St* (VLCA)	$11.00					$0	
Hastings Health Centre	$18.00	1562	25%	$83,958	$16,245	$18,822	$119,024
	Total Program funding p.a.			**$411,403**	**$79,602**	**$92,231**	**$583,235**
						Total funding available	**$520,000**
Urgent Care - based on $40.00 per consult at 0.26 consults p.a.						**Variance**	**$63,235**
Pharmacy - based on $5.00 per consult @2.41 consults (0.26 + 2.15 (UC+Genral conslut rate)) p.a.							

5. Programme Outcome Measures:[3]

Reduction in acute Emergency Department presentations and admissions for -

- Self -referred but not admitted Emergency Department attendance rate (in and out of hours)
- Serious Skin Infections
- Asthma
- Mental Health (presentations & admissions)

Individual Practice Plans - Each practice plan will:

- Be co designed with the practice staff and PHO practice development team and youth
- Include baseline expectations that involve changes to model of care and zero fees.[4]
- Include tailored measures that will contribute to the achievement of the program outcomes.

[3] The higher level programme outcome measures provide a challenge to ensure performance indicators included in the provider contract have a clear line of sight to what's intended. This will require utlising a broad base line with practices who are not recipients of the funding and would be part of the establishmnent stage.

[4] It is important to note that a number of the practices already provide zero fees.

Tailored practice measures - would be specific to individual general practices and negotiated with each practice. Options would include but are not limited to;

- Increased utilisation of primary care (> 25%) over current utilisation rates
- Youth Friendly General Practices
- Engagement in youth specific training
- Alignment of practice to recognised Youth Health Standards[5]
- Inclusion of findings from practice specific Youth Health Satisfaction Surveys in model of care design

Funding - would dictate the scope of each practice plan, however all practices will be guided to address all items listed above (The funding formula is provided in section: 'Removal of Cost' above. Table 1.0 below illustrates funding allocations per practice based on the formula).

Resources - used to guide Best Practice for the model would include the RNZGP Measures against the Youth Friendly General Practice Audit, and the Youth Health Standards developed in Counties Manukau DHB.

Alignment to the HBDHB Youth Health Strategy – This proposal, through its network of providers, development of practice plans and alignment to program outcomes, supports the HBDHB Youth Health Strategy implementation. The four key outcomes identified internationally and within the youth strategy aligned to creating positive youth development are:

1. Healthy and Safe thriving youth engaged in healthy active lives
2. Engaged and inspired youth engaged in positive relationships with peers and seniors
3. Productive learning and working environments where youth can achieve as participants and leaders
4. Communities that encourage inclusiveness supported through adequate resources in strength based environments.

ANNUAL MĀORI HEALTH PLAN REPORT WRITERS WORKSHOP

A joint workshop between Māori Health and the Planning, Informatics and Finance teams for the Annual Māori Health Plan (AMHP) Action Leads and Report Writers was successfully carried out on 20 October 2016. The purpose of the workshop is to bring together Action Leads and Report Writers from HBDHB and Health Hawke's Bay PHO involved in the planning and implementing of the AMHP to:

1. Establish a common understanding of Ministry of Health and HBDHB Executive Management Team and Governance planning, monitoring and reporting requirements for the AMHP and Te Ara Whakawaiora.
2. Share the simplified, standardized reporting template and timeframes and establish consistency for AMHP quarterly and Te Ara Whawaiora reports.
3. Introduce the new and simplified "exceptions" report and the required contributions of the Action Leads and Report Writers.
4. Introduce the requirements for the new quarterly updates of Te Ara Whawaiora reports and their recommendations.
5. Introduce Māori Health Service's Annual Report Monitoring Framework for ensuring 'quality of the AMHP implementation and reporting.

[5] 2006 (Draft) Youth Health Standards Commissioned by Counties Manukau

A review of the 2015-2016 AMHP Quarterly reports was successfully carried out using the AMHP Quarterly Performance Monitoring Tool. Highlights of the findings were presented at the AMHP Action Leads and Report Writers Workshop.

TŪRUKI WORKFORCE DEVELOPMENT MID-TERM EVALUATION REPORT

Dr George Gray, Public Health Physician has completed a value for money analysis report for the Tūruki Programme. Key draft findings include:

1. The development of programme logic,
2. Forecasting's and planning for workforce demand,
3. Ensuring the supply of scholarships meet the projected workforce demands
4. Further development of a monitoring system of past and current scholarship recipients.
5. Re-establishment of a governance group with a refined scope of monitoring,

Dr Gray will provide a presentation and discussion of findings to the Māori Health Leadership team to interrogate further requirements of the recommendations. Key personnel have agreed to form the governance group including Programme Manager; Māori Health, General Manager Māori Health; Chief Operating Officer; Chief Nursing Office and Chief Allied Health Professions Officer.

TU KAHA CONFERENCE 2016

The following papers were presented at 2016 Tū Kaha Conference in Wellington from 21-23 September 2016:

- "The *Policy and Health Systems Implications of the HBDHB DNA Project"* jointly prepared with Māori Health Service DNA team and Customer Focused Booking Team at HBDHB.
- *"Looking beyond the numbers": The Te Kupenga Hauora Cervical and Breast Screening Services"* jointly prepared with Māori Health Service, Population Health Service and Te Kupenga Hauora.

The Māori Health Service had a strong presence and have met to develop an action plan based on the key learnings from the conference that can be put into practical applications. Justin Nguma, Health and Social Policy Advisor continues to represent the HBDHB in the monthly planning meetings for the Conference Organising Committee.

CO-DESIGNING SERVICES - RELATIONSHIP CENTRED PRACTICE

Māori Health Services' has been involved in the co-designing of 'relationship centred practice' with Dr Andy Phillips Chief Allied Health Professions Officer, Anne McLeod Lead Clinician and Laurie Te Nahu Programme Administration Officer. Working as part of the Relationship Centre Practice steering group, Laurie is responsible for articulating the 'Meihana' (Hui) Model into the Relationship Centred Practice design and pathway. Currently a 'Relationship Centred Practice' Toolkit is being produced to support staff and teams, and, an online learning resource package is being developed in order to support the Māori content and resource materials.

MĀORI HEALTH WELCOME TWO NEW STAFF

Two new staff members were appointed in September. Te Whetu Henare has been employed to fill the Kaitakawaenga position with the Children, Adolescent and Family Service (CAFS). Te Whetu replaces Laurie Te Nahu who has taken up the new Programme Administration Officer role. Charrissa Keenan was also appointed into the new Health Gains role. Both Te Whetu and Charrissa started on the 17 October 2016.

GASTRO OUTBREAK REVIEW

As you will be aware the DHB is undertaking an internal review of how we as an organisation and the wider sector responded to the Gastro Outbreak. The purpose of the review is to understand

what we did well, what we didn't do so well and what are the areas for improvement. It is very much focussed on continuous learning. As part of this process a number of debriefs have been undertaken, with further ones still to occur and there is an opportunity for MRB to provide their perspective and feedback about how the DHB responded to the outbreak to be included into this report before the report is finalised. To that end if you have any feedback on what you believe went well, and what from your perspective we could do better in the future, then please feel free to email Kate Coley, Director of Quality Improvement & Patient Safety, who is leading this internal review by 16 November 2016 on kate.coley@hbdhb.govt.nz.

GENERAL MANAGER MĀORI HEALTH
Tracee Te Huia

HAWKE'S BAY
District Health Board
Whakawāteatia

MĀORI RELATIONSHIP BOARD

FLUORIDATION – THE KEY FACTS

Presentation by

Dr Robin Whyman, Clinical Director Oral Health

Co-presenters

Dr Bethany Jones, Neurologist
Dr Kate Robertshaw, Neurodevelopmental Paediatrician

HAWKE'S BAY District Health Board Whakawāteatia	**Transform & Sustain Programme Refresh**
	For the attention of: **Māori Relationship Board, HB Clinical and HB Health Consumer Council**
Document Owner:	Tracee Te Huia, GM Māori Health
Document Author(s):	Tracee Te Huia & Kate Rawstron, Project Management Office Manager
Reviewed by:	Transform & Sustain Steering Group, Executive Management Team
Month:	November, 2016
Consideration:	For Discussion

11

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Council:

1. **Note** the contents of this report.
2. **Endorse** the proposed new projects.

OVERVIEW

The Transform & Sustain Programme was initiated back in 2013 and is now more than half-way through its five year horizon. Whilst the overarching Transform & Sustain Strategy will not require refreshing until the second of 2017, a mid-point refresh of the programme of projects (that underpin of the strategy) is critical to ensure that we remain on track to delivery against all of our key intentions as planned.

The paper includes:

- The refreshed Transform & Sustain programme workplan
- High-level outline for each of the new proposed projects
- Programme success criteria
- Key next steps

BACKGROUND

The refresh of the Transform and Sustain programme workplan was kicked off with an evaluation of the outcomes achieved at the 'half-way point'. This review highlighted five priority areas where outcomes had not yet been achieved as intended.
These priority areas, plus a sixth that was added subsequently, were identified, validated and endorsed by a wide range of stakeholders as summarised below:

- Project Management Office identified 24 outcome statements from Transform & Sustain document
- EMT members scored each statement as doing well/ making some progress/ not yet making change - scores are aggregated

- Health Services Leadership Team identifies the 8 outcomes with 'least progress' - these are mapped against the EMT scores
- There is a strong degree of consensus and 'five areas' emerge to which EMT add 'organisation development' as a sixth area
- These six priority areas are validated with front line project leaders and change managers
- 'World Café' exercise held at Waipatu Marae with wider health sector leadership forum to confirm priority areas and to gather input to inform future project plans
- List of 21 proposed new projects, across the six priority areas, is generated
- EMT members assigned to a priority area to work with the Project Management Office to establish full programme of work

(Refer Transform & Sustain Refresh 2016 – July 2016).

DEVELOPMENT OF THE REFRESHED PROGRAMME WORKPLAN

Taking the information gathered during the 'World Café' exercise and the list of proposed projects, a benefits mapping exercise was undertaken for each priority area. The purpose of this exercise was to ensure a clear relationship exists between the identified problem statements, business outcomes and objectives, and to ensure the proposed projects aligned to this and would deliver the desired set of business outcomes and benefits. Each session included three nominated EMT members and was facilitated, and outputs documented, by the PMO Manager.

Overall these sessions were very productive, generating a lot of good robust challenge and discussion, and for the majority of priority areas this resulted in a number of refinements to the list of proposed projects.

In addition to the project changes, this exercise also highlighted the high degree of working dependencies between projects within a single priority area but also across priority areas. In recognition of this, and programme lessons learned thus far, it was agreed that a single EMT member should be assigned as SRO to all projects under one priority area, and that a priority area would be managed as a workstream under the programme.

It is important to note that further lessons, learned during the first half of Transform & Sustain, have also been applied at a project level and will continue to be applied as new projects are initiated and stood-up as part of the refresh activity.

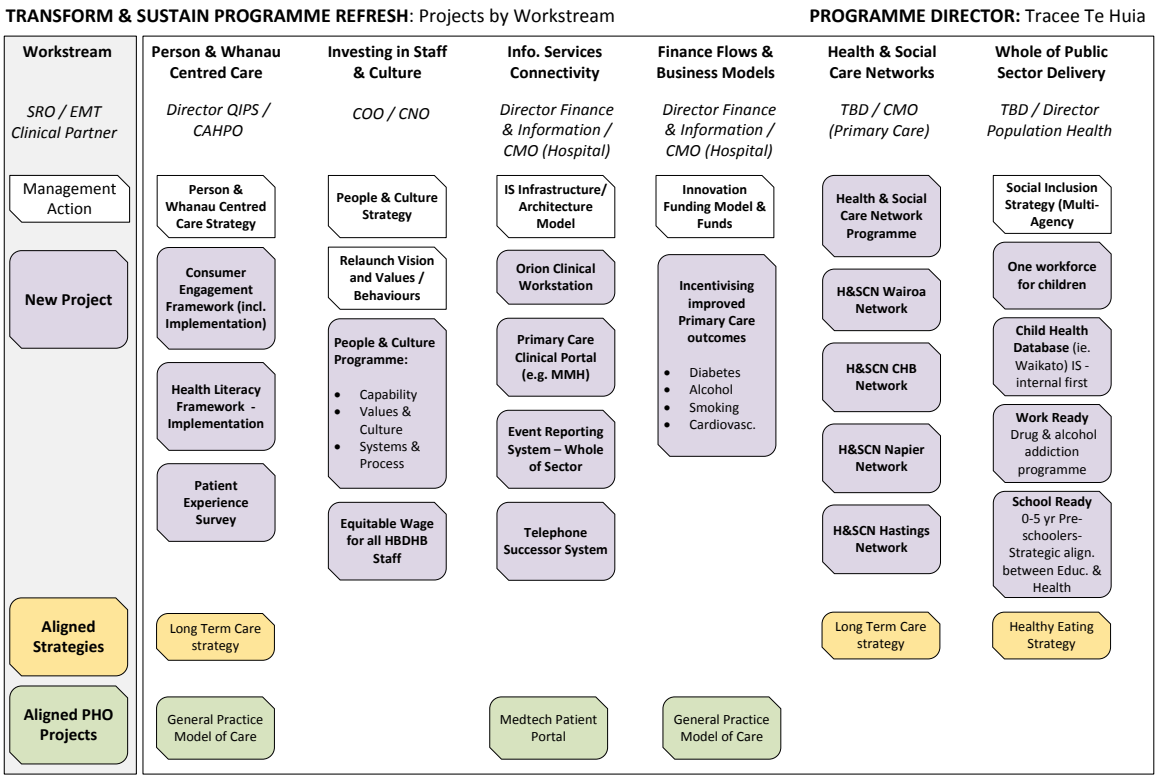
Following the documentation of outputs from the benefit's mapping sessions, one further review, by workstream, of the proposed projects was undertaken with the nominated workstream SRO before final review by the Transform & Sustain Programme Director and Transform & Sustain Steering Group.

CLINICAL LEADERSHIP

By moving to a workstream management structure (with a single SRO per workstream) this enables increased management and alignment to operational functions however, it does not enable the desired level of clinical partnering. As such a 'EMT Clinical Parter' role will be established at the workstream level to partner with the workstream SRO. Clearly defined roles and responsibilities for this role, and that of the workstream SRO, are currently being developed.

In addition to this new role, the programme will also ensure clinical leadership is maximised at a project level (e.g. within project roles such as Project Sponsor, Steering Group membership etc.), ensure clinical leadership is distributed across the team and development opportunities for future leaders identitied.

The final list of 19 proposed projects, by workstream, is shown on the next page.



***QIPS** = Quality Improvement & Patient Safety / **CAHPO** = Chief Allied Health Professions Officer / **COO** = Chief Operating Officer / **CNO** = Chief Nursing Officer / **CMO** = Chief Medical Officer*

Further detail on each of the projects can be found in the following tables.

It is important to note, however, that this information should be viewed as indicative only at this time. Once the programme workplan has been approved each project will undergo full scoping, as per the prescribed HBDHB project methodology, with any significant new investment approved via the normal prioritisation and funding processes.

WORKSTREAM: Person & Whānau Centred Care – Director QIPS / CAHPO

Key Intention	**Project**	Short Description	Dashboard KPI
2	**Patient Experience Survey**	To develop and implement a local patient experience survey, and set of processes to utilise results alongside the National Patient survey, to support continuous improvement.	Patient Experience
2	**Consumer Engagement Framework (CEF)**	Design and implementation of a CEF to ensure the voice of the consumer is utilised in the right way on a consistent basis across the health sector, through the application of a co-design model.	Patient Experience
3	**Health Literacy Framework (HLF) - Implementation**	Implementation of the HLF (Action Plan & detailed Implementation Plan), this project includes: - Stanford Programme; empowering self-management - Relationship centred practice; clinical engagement tool - Health Passport - Review of all info provided to consumers/patients	Patient Experience

WORKSTREAM: Investing in Staff and Changing Culture – GM HR / CNO & COO

Key Intention	**Project**	Short Description	Dashboard KPI
Enabler	**People & Culture Programme**	A 2-5 year programme of work to change the culture of health sector focusing initially on the 'hospital'; the programme will be planned and implemented on a rolling 12-mth basis and is made up of the 3 strands: **Capability** - Workforce development (CI) - leadership (including Māori leadership development) - Talent Mapping and succession planning - Training Hub **Values & Culture** - Behaviours - creation of a Healthy at Work Programme (incl. nurse-led assessment clinics) - Resilience / kindfulness / mindfulness - Employee Brand - Staff Engagement Survey **Systems & Process** - BAU - Better, Smarter, Faster - Staff discounts / confidential budgeting services	KPI - Better staff engagement KPI - Culturally competent workforce KPI - Better staff retention KPI- Improved hospital workforce productivity
Enabler	**Equitable Wage for All HBDHB Staff**	To establish a training route for DHB staff, paid below the living wage, to attain the living wage, this project will include: - framework and processes i.e. appraisals - training programme tailoring for each staff group	KPI - Improved hospital workforce productivity KPI - Better staff engagement KPI - Better staff retention KPI - Reduced infant mortality KPI - Fewer premature deaths KPI - Fewer women smoking in pregnancy KPI - Reducing Rheumatic fever

WORKSTREAM: Financial Flows and Business Models – Director Finance & Information / CMO (Hospital)

Key Intention	**Project**	Short Description	Dashboard KPI
11	**Incentivising improved Primary Care outcomes**	Establishment of new funding flows to target evidence based interventions within Primary Care, initial focus will be on reducing ASH rates in particular those issues relating to: - Diabetes - Alcohol - Smoking - Cardiovascular	KPI - Care close to home KPI - More treatments out of hospital

WORKSTREAM: Information Services Connectivity – Director Finance & Information / CMO (Hospital)

Key Intention	**Project**	Short Description	Dashboard KPI
Enabler	**Orion Clinical Portal**	Implement an enhanced version of the regional standard clinical workstation, standardise and document associated business processes.	KPI - A safer hospital KPI - Improved hospital workforce productivity
Enabler	**Primary Care Clinical Portal**	Implementation of a system which allows clinical access to a single Primary Care Record, is centred on the patient and facilitates multi-disciplinary recording & patient management.	KPI - Care close to home KPI - Fewer premature deaths
Enabler	**Event Reporting System**	Upgrade of the current system (RL6 solution) and subsequent roll out to the community.	KPI - Patient Safety
Enabler	**Telephone Successor System**	Design and implementation of a replacement system for the current switchboard and Wi-Fi telephone system that enables both current and enhanced functionality e.g. mobile devices.	KPI – More efficient building

WORKSTREAM: Health & Social Care Networks – SRO TBD / CMO (Primary Care)

Key Intention	**Project**	Short Description	Dashboard KPI
8	**Health Social Care Network - Overarching Programme**	Establish a framework that supports community-led redesign of health and wellness services, based on the needs and aspirations of the local population. There is a focus on collaborative working practice across health and social service providers.	KPI - Reduced Readmissions KPI - Emergency Department Waits KPI - Fewer premature deaths KPI - Care closer to home KPI - More treatments out of hospital KPI - Better staff engagement
7	**HSCN - Wairoa**	Design and implement a network with locality based planning and delivery of services - includes: - Health Needs Assessment - Asset Mapping - MSD profiling	
7	**HSCN - CHB**		
8	**HSCN - Napier**		
8	**HSCN - Hastings**		

WORKSTREAM: Whole of Public Sector Delivery – SRO TBD / Director Population Health

Key Intention	Project	Short Description	Dashboard KPI
4	One Workforce for Children	Identify and address the gaps in knowledge and skills of the vulnerable children's workforce in Hawke's Bay in order to work effectively with families and improve outcomes (particularly for tamariki and rangatahi Māori and their Whānau) including: - benchmark skills against the Children's Action Plan Core Competency Framework and relevant registration bodies - aggregate the results up to each service, each sector and as a region - design, deliver and evaluate a training programme to address the skills gaps identified, and assess the impact on outcomes for children and families	Living healthier and longer lives KPI - Reduced infant mortality KPI - Healthier weight KPI - Reduced rheumatic fever KPI - Reduced readmissions
4	School Ready	Through the strategic alignment between Education and Health sectors, developing an integrated view of services provided/ aimed at Pre-schoolers (0-5yrs) to ready children for the best possible start to schooling.	Living healthier and longer lives KPI - Reduced infant mortality KPI - Healthier weight KPI - Reduced rheumatic fever KPI - Reduced readmissions
4	Work Ready	A drug & alcohol addiction programme providing a health service response to current addiction issues within our population who would otherwise be available to work.	Living healthier and longer lives
4	Child Health Database	To evaluate, recommend and implement the preferred solution to combine the various child health databases into a single repository (i.e. Waikato model)	Living healthier and longer lives KPI - Reduced infant mortality KPI - Healthier weight KPI - Reduced rheumatic fever KPI - Reduced readmissions

Currently there are 23 projects in-flight; of which 14 are planned to be in closure or closed by the end of the year. A further 4 projects ('next phase' or from the capital master plan) are either in the process of starting up or are planned to start in early 2017. Combined with the 19 new proposed projects this brings the total number of projects to 32:

23	-	14	+	4	+	19	=	**32**
In- flight Projects		Closing		Other Projects		Refresh Projects		**Total Projects**

A draft Transform & Sustain Programme workplan, based on the planned and estimated projects timeframes, can be found in **Appendix 1**.

KEY ASSUMPTIONS / KEY RISKS

- Resource availability e.g. Project Manager resource, IS support, funding
- Necessary Clinical engagement and availability of subject matter experts
- Feasibility of the planned programme of change and ability for the health system to absorb this schedule of change
- The number of new projects to be scoped and stood-up in the next 3-6 months
- Alignment with PHO and Primary Care programme of change

TRANSFORM & SUSTAIN PROGRAMME SUCCESS CRITERIA

As we move into the second half of the Transform & Sustain Programme it is critical that we continue to remain focused on delivering transformational change that meets the original objectives as outlined in the 11 key intentions and delivers sustainably business outcomes and benefits.

Whilst it is important that appropriate structures and discipline are applied at an individual project level, it is the collective change to the way we 'do business' across the sector that will ultimately determine the success (or otherwise) of the programme.

This means that by December 2018:

- Our staff are happier; they feel valued and supported, and are more resilient
- Consumers have a voice; they are engaged consistently across the health sector, co-design is just how we do things and consumers own their own health plans
- Our primary and secondary clinicians, and patients, have access to the same patient information, interventions are faster, and paper has been removed from our processes
- Patients are happier, safer and receiving more treatment in the community
- Communities have increased ownership of the services delivered in their locality
- The HBDHB is leading the way on building intersectoral relationships with a multi-agency programme of work in-place and visible

KEY NEXT STEPS

09/11/16 Workplan reviewed and endorsed by:

- Clinical Council
- Consumer Council
- MRB

16/11/16 Refresh update at Bi-partite meeting

30/11/16 Review and endorsement of workplan by FRAC

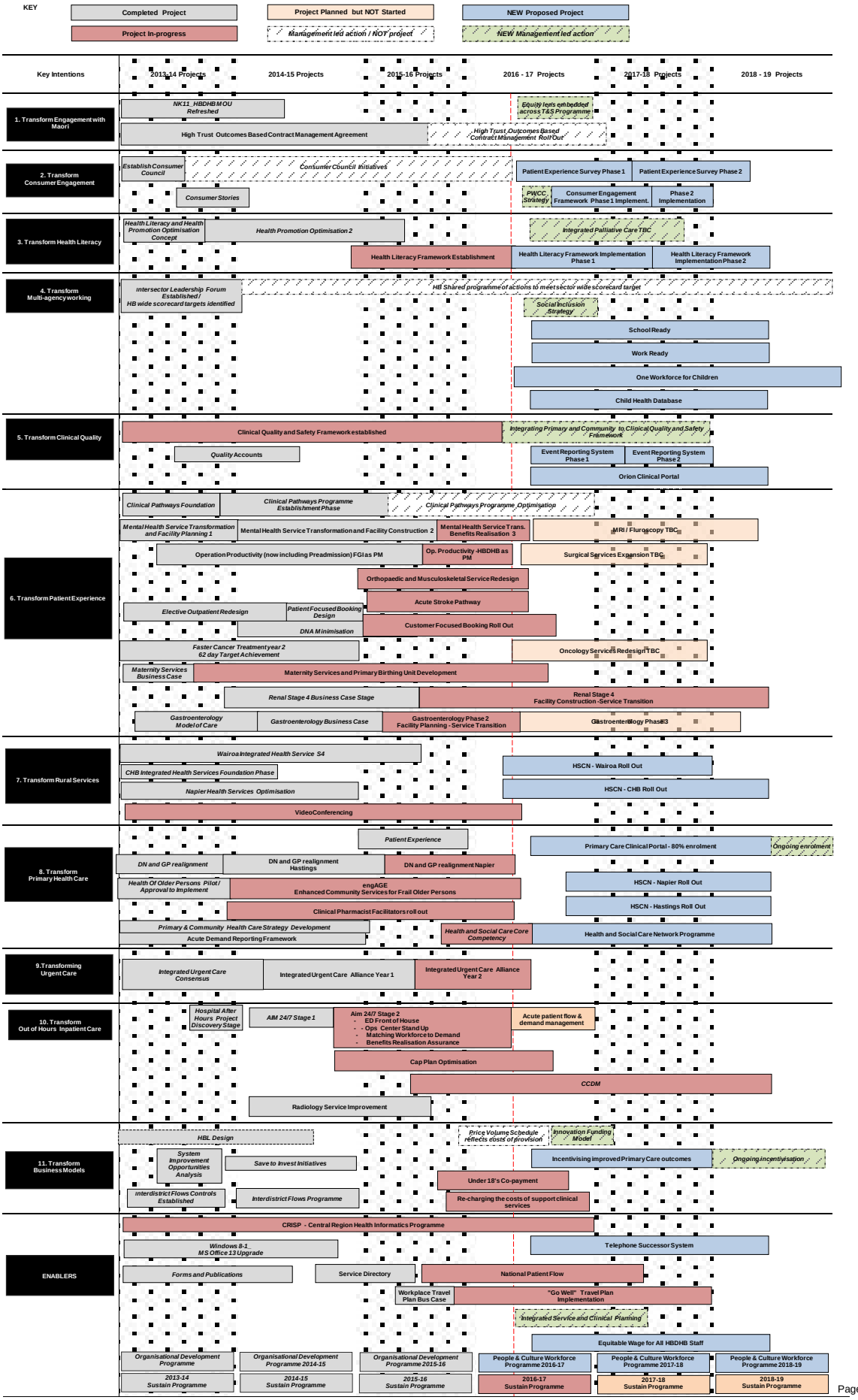
30/11/16 BOARD approval of workplan – *alternative date December Board meeting*

Post approval:

Dec 2016 Syndication with PHO/ HSLT / Service Directorate / Unions

Feb 2017 T&S Refresh launched – *exact date TBC*

APPENDIX 1: TRANSFORM & SUSTAIN PROGRAMME WORKPLAN DRAFT



Page 8 of 10

APPENDIX 2: Strategic Dashboard Q4 2014/2015

Transform and Sustain Strategic Dashboard – Q4

HEALTHY HAWKE'S BAY

Excellent health services working in partnership to improve the health and well-being of our people and reduce health inequities within our community

OURHEALTH HAWKE'S BAY Whakawateetia

NZ TRIPLE AIM

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

TRANSFORM & SUSTAIN

Delivering consistent high-quality health care	Being more efficient at what we do	Responding to our population

VITAL SIGNS

		Baseline	Previous	Current	Target
Patient experience	Patient Experience Survey Score	8.5	8.7	8.7	≥ 8.5
				*Communication	

SUPPORTING DIMENSIONS

		Baseline	Previous	Current	Target
Better access to specialist outpatients	Did not attend (DNA) rate across first specialist assessments	6.10%	7.80%	7.40%	≤ 7.50%
A safer hospital	Standardised Hospital Mortality Rate	101	108	103	≤ 100
More Very High Quality General Practices	General Practices with Cornerstone Accreditation	50.0%	86.0%	86.0%	≥ 80.0%
All General Practices are Demonstrably Good	General Practices that meet Foundation Standards	0.0%	64.0%	71.0%	≥ 100.0%
Reduced readmissions	Hospital Standardised Readmission Rate	7.5%	7.7%	7.7%	≤ 7.4%
A culturally responsive workforce	Percentage of DHB Staff Ethnicity who are Māori	11.6%	12.4%	12.5%	≥ 13.9%
Emergency Department Waits	Patients waiting less than 6 hours in ED	91.5%	93.9%	92.5%	≥ 95.0%

		Baseline	Previous	Current	Target
Resource sustainability	Financial Surplus DHB $'000		(-188)	$376	≥ $0
	Breakeven PHO			On track	
Older people living independently	Over 85s Living Independently	78.4%	78.1%	78.4%	≥ 80.0%
Improved hospital workforce productivity	Case Weight per Health Service FTE	3.04	3.158	3.12	≥ 3.08
Better staff engagement	Staff Engagement Survey Satisfaction Rate	76.0%	76.0%	-	≥ 76.0%
More Efficient Buildings	Buildings Infrastructure Efficiency	2.59%	2.59%	2.7%	≤ 2.41%
Better staff retention	Staff Turn-over	8.10%	9.11%	9.3%	Between 9.5% and 10.5%
Care close to home	Strategic Spending Shift	-0.3%	0.1%	0.4%	≥ 0.2%
More Treatments Out of Hospital	Ambulatory-sensitive Hospital Admissions	76.0%	73.0%	70.0%	≤ TBC

		Baseline	Previous	Current	Target
Live healthier and longer lives	Difference in Maori Death rates (Below 50 years of age)	17%	17%	9%	≤ 14%
Reduced infant mortality	Infant Mortality Rate	4.41	4.41	2.79	≤ 5
Fewer premature deaths	Maori All Cause Mortality Rate (less than 75 years and per 100,000 population)	469	469	-	≤ 310
Healthier weight	Maori Children Obesity Rate	7.9%	9.3%	10.5%	≤ 8%
More heart and diabetes Checks	Diabetes and Cardiovascular Services Checks	88%	90%	89%	≥ 90%
Faster cancer treatment	Faster Cancer Treatment (FRAC: July 16)	62%	63%	63%	≥ 85%
Fewer women smoking in pregnancy	Maori Women Smoking During Pregnancy	44%	44%	44%	≤ 22%
Reducing Rheumatic Fever	Rheumatic Fever Hospitalisation Rates	0.6	0.6	1.88	≤ 2

Page 9 of 10

APPENDIX 3: Benefit Mapping Session Attendees

PRIORITY AREA	ATTENDEES			
Investing in Staff and Changing Culture	Tracee Te Huia	Kate Coley	Chris McKenna	
Person & Whānau Centred Care	Tracee Te Huia	Kate Coley	Andy Phillips	
IS Connectivity	Tim Evans	John Gommans	Chris McKenna (apologies)	
Financial Flows & Business Models	Tim Evans	Tracee Te Huia	Ken Foote	Allison Stevenson
Health & Social Care Networks	Tracee Te Huia	Liz Stockley	Mark Petersen (apologies)	Belinda Sleight
Whole of Public Sector Delivery	Kevin Snee	Tracee Te Huia	Caroline McElnay	

APPENDIX 4: Transform & Sustain Key Intentions

1. Transform Engagement with Māori
2. Transform Consumer Engagement
3. Transform Health Literacy
4. Transform Multi-agency working
5. Transform Clinical Quality
6. Transform Patient Experience
7. Transform Rural Services
8. Transform Primary Health Care
9. Transforming Urgent Care
10. Transform Out of Hours Inpatient Care
11. Transform Business Models

HAWKE'S BAY District Health Board Whakawāteatia	**13-17 Year Old Primary Care Zero Fees Subsidy Project**
	For the attention of: **Māori Relationship Board, HB Clinical Council & HB Health Consumer Council and**
Document Owner: Document Author):	Tim Evans, GM Performance, Informatics & Finance Patrick LeGeyt, Programme Manager Māori Health
Reviewed by:	Executive Management Team
Month:	November, 2016
Consideration:	For Approval by HB Clinical Council; and For Information of MRB and HB Health Consumer Council For Endorsement by the HBDHB Board (in November)

12

RECOMMENDATION

That HB Clinical Council:

1. Approve funding Eligible General Practices within the geographical area of Wairoa, Napier, Hastings and CHB to provide zero fees to their 13-17yr old population.
   - Eligible practices include those with high enrolled Māori (84.5%) and Pacific (89.6%) 13-17 year olds; and
   - cover 67.7% of all enrolled 13-17 year olds
   - costs $583,235 ($63,235 over budget)
3. Approve the requirement of general practices within programme to make 'youth friendly' changes to the model of primary care;
4. Approve the Programme Level Measures;
5. Endorse the content of this report and acknowledge that further work is required to develop an implementation plan, outcomes and evaluation framework to reach a go live date of 1 January 2017.

BACKGROUND

In May 2015 a budget investment paper, containing three investment options, was submitted to HBDHB Clinical Council for consideration. The following options were supported:

- Extend Free Primary Care for all 13-17 years olds in Hawke's Bay
  a. Ring Fence the funding for targeted access to Decile 4 & 5 to Primary Care.
  b. Reduce the amount to $500,000 per annum; proposition to come back to Clinical Council.
- Extend Free Primary Care for all 13-17 year olds in Wairoa
  a. An estimated $20,000 per annum was approved

Consultation: Following consultation with ten general practices as well as Directions Youth Health service, HHB Priority Population Committee and HHB Clinical Advisory Group; as well as targeted groups of youth from Hastings, (Camberley, Flaxmere) and Wairoa, it was agreed that a programme be introduced that addressed zero fees and changes to the model of care with associated programme performance measures.
Barriers to access: Cost is recognised as the most significant barrier to access but other areas were also identified by youth as needing to be included in the model of care.

"What Youth have told us they want"

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

PROGRAMME APPROACH

1. Removal of Cost

Directly fund general practices with co-payment subsidy based on a utilisation rate of 2.15 per annum costed at $25.00 per consult, inclusive of a 25% buffer for potential increases.[1]

After hours consultation subsidy is also included and will be slightly higher at $40.00 per visit (utilization rate of 0.26 visits per annum per person) as well as a pharmacy subsidy of $5.00 per item, per GP consultation (see attached paper for breakdown of funding formula calculations, options and analysis).

2. Target high need – Māori and Pacific Population Groups

Practices with the above demographic have been consulted and their feedback on model of care sought. Currently it is anticipated that 14 practices will be included in the programme, which includes two practices aligned to The Doctors Hastings.

[1] Table 1.0 provides 'indicative' funding to practices identified that fit the criteria. However it is not certain that all practices identified will participate as it is a voluntary scheme. This could reduce the overall expenditure and/or provide for a redistribution of allocated funds. Furthermore, there is a funding differentiation between VLCA practices and non VLCA practices, and reducing the co-payment subsidy to $15 per consultation for VLCA practices would reduce the overall funding request to within budget.

3. Changes to Model of Care

General practices that agree to enter the zero fees subsidy programme will be expected to adopt changes to their model of care.

The overarching principles for the model are:

- Provide a range of 'youth friendly' clinical health services, staffed by health professionals who are well trained, skilled and knowledgeable in youth health.
- Provide comprehensive and 'joined up' youth friendly care.
- Work across sectors to encourage population, community, school and family level interventions that will improve the health of young people.

4. Implementation:

- There are currently fourteen practices[2] that have indicated an interest in being part of the program of work.
- To qualify for funding each practice will need to demonstrate a commitment to improving youth health outcomes through an agreed plan – developed with each of the practices.
- The funding received by the practices is a nominal figure of $25 per consultation calculated against their enrolled 13-17 year old population, and multiplied against a utilisation rate of 2.15 visits per annum.
- Within a number of practices the following services are current and will provide a further platform to develop the model of care
    - Sexual health contract provided free of charge to the person in Napier , Hastings and Central Hawke's Bay for youth up to and including 20 year olds, and in Wairoa for youth up to and including age 24 years.
    - Whanau wellness programme provided free of charge to the person and their whanau which includes pharmacy scripts.
    - PC/ED copperative which includes an intensive case management approach
    - A number of practices have also been supported to employ social work services and kaiawhina

Where these services are in place the implementation process will ensure alignment to the best use of funding or augments what's in place as appropriate.

The sum per practice ranges from $11,933 to $83,958 per annum. (Refer Table 1.0 below)

5. Programme Outcome Measures:[3]

Reduction in acute Emergency Department presentations and admissions for -

- Self -referred but not admitted Emergency Department attendance rate (in and out of hours)
- Serious Skin Infections
- Asthma
- Mental Health (presentations & admissions)

[2] Table 1.0 – lists practices identified that meet the criteria of the programme. Shaded practices are VLCA practices (Very Low Cost Access). Many of which offer low or no fees for the 0-18/20 age group

[3] The higher level programme outcome measures provide a challenge to ensure performance indicators included in the provider contract have a clear line of sight to what's intended. This will require utlising a broad base line with practices who are not recipients of the funding and would be part of the establishmnent stage.

Individual Practice Plans - Each practice plan will:

- be co designed with the practice staff and PHO practice development team and youth
- include baseline expectations that involve changes to model of care and zero fees.[4]
- include tailored measures that will contribute to the achievement of the program outcomes.

Tailored practice measures - would be specific to individual general practices and negotiated with each practice. Options would include but are not limited to;

- Increased utilisation of primary care (> 25%) over current utilisation rates
- Youth Friendly General Practices
- Engagement in youth specific training
- Alignment of practice to recognised Youth Health Standards[5]
- Inclusion of findings from practice specific Youth Health Satisfaction Surveys in model of care design

Funding - would dictate the scope of each practice plan, however all practices will be guided to address all items listed above. (The funding formula is provided in section: 'Removal of Cost' above. Table 1.0 below illustrates funding allocations per practice based on the formula).

Resources - used to guide Best Practice for the model would include the RNZGP Measures against the Youth Friendly General Practice Audit, and the Youth Health Standards developed in Counties Manukau DHB.

6. Alignment to the HBDHB Youth Health Strategy

This proposal, through its network of providers, development of practice plans and alignment to program outcomes, supports the HBDHB Youth Health Strategy implementation The four key outcomes identified internationally and within the youth strategy aligned to creating positive youth development are:

- Healthy and Safe thriving youth engaged in healthy active lives
- Engaged and inspired youth engaged in positive relationships with peers and seniors
- Productive learning and working environments where youth can achieve as participants and leaders
- Communities that encourage inclusiveness supported through adequate resources in strength based environments.

FINANCIAL IMPACT

Although the theoretical costing of this recommended option is $63,235 over this years budget, this potential overspend is not specifically addressed in this paper because:

- Costing is based on 100% uptake by all qualifying practices – which may not be the case.
- Implementation from 1 January 2017 will have only a 50% cost impact on this financial year.
- Data gathered over the first 3-4 months of implementation will assist with the practical calculation of the budget required for 2017-18.
- Any potential 'shortfall' in 2017-18 budget can be addressed through various optons at that time.

[4] It is important to note that a number of the practices already provide zero fees.
[5] 2006 (Draft) Youth Health Standards Commissioned by Counties Manukau

Table 1.0 – Funding Allocation

Napier	Existing Fees	Total	% MPI	General consult funding	Urgent care consult	Pharmacy funding (based on $5.00 per consult)	Full Utilisation costs
The Doctors - Napier	$27.00	1400	42%	$75,250	$14,560	$16,870	$106,680
Tamatea Medical	$28.00	453	32%	$24,349	$4,711	$5,459	$34,519
Maraenui Medical (VLCA)	$11.50	417	74%	$22,414	$4,337	$5,025	$31,775
						$0	
Wairoa	**Fees**	**Total**				$0	
Wairoa Medical (VLCA)	$12.00	106	66%	$5,698	$1,102	$1,277	$8,077
Queen St Medical (VLCA)	$11.50	222	84%	$11,933	$2,309	$2,675	$16,916
Health Care Centre Ltd (VLCA)	$11.50	245	79%	$13,169	$2,548	$2,952	$18,669
						$0	
Central Hawkes Bay	**Fees**	**Total**				$0	
The Doctors – Waipawa*	$24.00					$0	
Tuki Tuki Medical	$24.00	503	29%	$27,036	$5,231	$6,061	$38,329
						$0	
Hastings	**Fees**	**Total**				$0	
Totara Health (VLCA)	$0.00	1214	65%	$65,253	$12,626	$14,629	$92,507
Medical & Injury (VLCA)	$0.00	278	65%	$14,943	$2,891	$3,350	$21,184
Hauora Heretaunga (VLCA)	$0.00	590	93%	$31,713	$6,136	$7,110	$44,958
The Doctors - Hastings	$16.00	664	36%	$35,690	$6,906	$8,001	$50,597
The Doctors - Gascoigne St* (VLCA)	$11.00					$0	
Hastings Health Centre	$18.00	1562	25%	$83,958	$16,245	$18,822	$119,024
	Total Program funding p.a.			**$411,403**	**$79,602**	**$92,231**	**$583,235**
						Total funding available	**$520,000**
Urgent Care - based on $40.00 per consult at 0.26 consults p.a.						**Variance**	**$63,235**
Pharmacy - based on $5.00 per consult @2.41 consults (0.26 + 2.15 (UC+Genral conslut rate)) p.a.							

12

Appendix One

(Contains all background and appendices for the initial and subsequent papers)

1. Cost as a Barrier to Access to Primary Health Care

In New Zealand primary health care is heavily subsidised and the out of pocket expense of primary health care for consumers is relatively low. NZ is in the top quartile for government funded health care in the OECD countries with just over 80% of health costs funded by general government revenues.[6] Whilst the level of out-of-pocket contributions for health care in New Zealand is bottom quartile and, despite increased funding of primary health care, cost remains the most significant barrier of access for some population groups to primary health care in NZ.

The NZ Health Survey 2013-2014 found that cost is the most significant barrier to accessing primary care service in New Zealand. Those in the more highly deprived areas, on low-medium incomes, young people aged under 25 years of age, Māori and Pacific peoples, those who use more services, and those in poorer health, are more also likely than other New Zealanders to forego visits as a result of the cost of primary health care[7]. In Hawkes Bay, the survey found that youth (15-24 years) have higher rates of unmet need for primary care than NZ national average (34% compared to 23%).

NZ research has consistently shown significant inequities in access to, and use of, services. A number of studies have particularly focused on differences between Māori and non-Māori utilisation of health services.[8] Overall, the results suggest that in many cases Māori have less access to primary health care, relative to the whole population, particularly when proxies for need (e.g., mortality, hospital discharges) are taken into account. Poor access to primary health care for Māori is considered a key factor in higher rates of illness and hospitalisations, in generating poorer health outcomes and inequalities in health. Similarly, research available on Pacific peoples' experiences of health services shows that Pacific peoples living in New Zealand generally have poorer health status than other New Zealanders; are more exposed to risk factors for poor health, and experience barriers in accessing health services.[9]

Cost also contributes to some groups seeking out free health care from HBDHB Emergency Department (ED). This can be evidenced by a significant increase in ED presentations of 17.6% over the last 5 years. ED presentations grew by 5.6% in 2015 alone. Attendances by children (5-14 years) and youth (15-24 years), increased by 10.5% and 9.7% respectfully.[10] The high utilisation rates and low conversion rate to inpatient admissions suggest ED is being used as a first level primary care health service, especially for those in close proximity to the hospital and also impoverished populations.

In October 2013, HBDHB and HHBPHO performed a survey of consumers and/or their whānau/support people, who presented at the Emergency Department, HB Hospital, between 9am

[6] Treasury Report: Improving the targeting of co-payments in primary care. June 2012
[7] Ministry of Health. NZ Health Survey 2013-2014.
[8] Evaluation of the Primary Health Care Strategy: Practice Data Analysis 2001-2005. Gribben & Cumming. 2007
[9] Ibid.
[10] HBDHB Information Services. Hawke's Bay Regional Emergency Department Trends 2011-2015

to 7pm over the period 09 September 2013 to 13 September 2013[11]. The purpose of the survey was to find out from consumers who access ED:

1. What they knew of available health services in the community
2. their experience of primary care services
3. their preference for options in accessing primary care services in the future

A total of 67 surveys were initiated with 63 being fully completed. Forty-two or 67% of respondents that answered the demographic questions identified Māori as an ethnicity. Eleven or 18% of respondents identified as Pacific and of these, six were Cook Island, four Samoan and one Tongan. Fourteen identified as New Zealander or European only. When asked what barriers prevented the respondents from accessing primary care services the majority indicated cost as a barrier, followed by transport, outstanding debts with their GP and availability of appointments.

Ambulatory sensitive hospitalisations (ASH) can be considered an indicator of reduced access to primary care. ASH related hospitalisations are potentially avoidable through preventive interventions or treatments deliverable in a primary care setting and account for around 1/5 of acute and arranged medical and surgical discharges. ASH rates amongst 0-4 years show disparities with Māori rates 1.6 times those of non-Māori rates. However this disparity has decreased as ASH rates have declined faster for Māori which coincides with the implementation of free primary care for children aged under 6. Theoretically the ASH rates for other groups of children and young people would be impacted in a similar way if access to primary care was improved.

Improved access to primary health helps prevent the early onset of long term conditions. There is growing evidence that prevention and intervention strategies applied early in life are more effective in altering outcomes, and reap more economic returns over the life course, than do strategies applied later in life. [12] Health research also confirms that risk factors for long term health conditions often present during childhood and adolescence and that targeted investment in earlier intervention at the primary care level is cost effective and has the potential to reduce some of this burden.

Improved resourcing of primary care improves population health outcomes and lowers the overall long term cost on the health system. International research also supports the focus on providing additional resources to encourage greater use of primary health care services. International research finds that primary health care in countries with stronger primary health care systems with lower costs have better health outcomes (most notably in infancy and childhood) [13].

This paper proposes a primary care zero fees approach for 13-17 year olds in Hawkes Bay that builds upon the national rollout of zero fees for under 13 year olds but is targeted towards those populations where cost is known to be a barrier to access.

2. Targeted Primary Care Funding

Over the last 15 years, primary health care funding has undergone a transformation. The Primary Health Care Strategy 2001 signalled a move away from the targeted funding approach to a universal approach, where all New Zealanders are eligible for government funding for primary health care. The PHCS emphasised capitation based funding payments based on community health and health prevention. The result has been health expenditure increase for higher income deciles more quickly than spending on lower income deciles.[14]

[11] HBDHB, Māori Health Services: Internal Report. Māori and Pacific Access to Health Services Survey. 3 October 2013.
[12] Improving the Transition Reducing Social and Psychological Morbidity During Adolescence: A report from the Prime Minister's Chief Science Advisor, May 2011
[13] Treasury Report: Improving the targeting of co-payments in primary care. June 2012
[14] Treasury Report: Improving the targeting of co-payments in primary care. June 2012

Primary health funding capitation formula and associated allocation methodologies has also been heavily criticised. It's argued that the co-payments a consumer pays to see a GP are unrelated to that consumer's ability or inability to pay, but rather to the make-up of that practice's population as a whole and to the pricing policy of the individual medical centre.

In 2015, the Primary Care Working Group (PCWG) on General Practice Sustainability provided a report to the Minister of Health detailing recommendations to improve the equitable access to affordable primary health care, workforce sustainability and shifting services closer to the community. The PCWG reviewed current targeted funding mechanisms including Community Services Cards (CSC), Working for Families Tax Credits (WFTC), deprivation and ethnicity. It found that CSC as a sole targeting mechanism had a low income threshold below the minimum wage, had a low uptake by consumers and were administratively burdensome for providers to manage. Similarly, WFTC required active application by individuals and did not cover low income individuals without children. However, PCWG found that deprivation had a strong correlation to Māori and Pacific ethnicity and therefore served as a proxy for targeting for Māori and Pacific ethnicity. The group recommended primary health funding be targeted towards a combination of CSC, deprivation and ethnicity. However, most of the components related to the recommendations, such as CSC income thresholds and primary care funding formulas, required central government policy level changes and the funding formula remains unchanged.

Given the findings of the PCWG Report require major policy changes at central government level, this paper proposes using a targeting approach focused on general practices with high Māori, Pacific and Quintile 4 & 5 enrolled populations.

3. Hawkes Bay 13-17 Year Old Population Information

HB Population 13-17 Year Olds

Hawke's Bay has proportionally more people in the more deprived sections of the population than the national average (40%) with 47% of the population living in Quintile 4 and 5 areas.[15] Of 13-17 year olds living in the HBDHB region, 5,755 (52.7%) live in Quintile 4 and 5 areas.[16]

There are approximately 11,096 children aged 13-17 years enrolled with Health Hawke's Bay PHO general practices.

- Hastings has the highest number of 13-17 year olds enrolled in general practice (5,428 or 49%).
- Māori (35.8%) and Pacific (4.9%) make up a combined 41% of 13-17 year olds within the enrolled population of Health Hawke's Bay PHO general practices.
- VLCA[17] practices make up 30% (3,248) of 13-17 year olds within the enrolled population of Health Hawke's Bay PHO general practices.

Māori and Pacific enrolled populations are concentrated in under half of the general practices in HB.

- Just twelve general practices in HB have 85% of the total enrolled Māori and Pacific 13-17 year olds.
- High needs areas, such as Wairoa, Māori make up 77.3% of the enrolled population of general practices.

[15] Ministry of Health website: Population of Hawkes Bay DHB 2015/16

[16] Ministry of Health website: PHO Enrolment Demographics 2016

[17] Very Low Cost Access (VLCA) practices receive higher capitation rates in return for lower zero fees capped levels for standard consultations (zero fees for children 0–5 years, $11.50 maximum for children 6–17 years, $17.50 maximum for adults 18 years and over). A general practice must have at least 50% "High Needs" people (Māori, Pacific, or Quintile 5) enrolled to qualify for VLCA funding.

- In Hastings, Māori and Pacific 13-17 year olds make up 42% of the total enrolled population with 76% enrolled in just three general practices (Totara Health, Hastings Health Centre and Hauora Heretaunga[18]).
- Napier only has 13% of the HB Māori and Pacific 13-17 year olds. However, 73% of Napier Māori and Pacific population are enrolled in only three general practices (The Doctors Napier, Maraenui Medical Centre and Tamatea Medical Centre).
- General Practices with the largest 13 to 17 year old Māori and Pacific populations include Totara Health, The Doctors Napier, Hauora Heretaunga, Hastings Health Centre, The Doctors Hastings (includes Gascoigne St, Waipawa), Wairoa Health Centre, Queen Street Medical and Medical and Injury.

53% of Hawkes Bay 13-17 year olds live in Quintile 4 & 5 areas

85% of the total Māori and Pacific 13-17 year olds are enrolled in only 12 GP practices

76% of Māori and Pacific 13-17 year olds living in Hastings are enrolled in only three general practices

73% of Māori and Pacific 13-17 year olds living in Napier are enrolled in only three general practices

12

(See Appendix for greater breakdown of HB Population 13-17 Year Olds)

4. Primary Care Utilisation Rates

In 2015, the average GP consultations for 13-17 year olds was 1.72 consults per annum. There is very little difference between VLCA and Non-VLCA average GP consultation rates at 1.70 and 1.73 per annum respectfully. Combined GP and Nurse Consultations for 13-17 year olds is 2.15 consults per annum.

In 2015, Māori and Pacific received less average GP consultations than Asian and Other NZers. Māori and Pacific received 1.56 and 1.28 average GP consultations per annum in comparison with Asian and Other NZers which had 1.75 and 1.86 per annum. However, Māori received higher Nurse Consultations than any other ethnic group with 0.58 per annum. This increased the combined GP and Nurse average consultations for Māori to 2.13 per annum in comparison to Non-Māori 2.21, Asian 1.75 and Pacific 1.62 per annum.

The average GP consultations for 13-17 year olds was only 1.72 consults per annum

(See Appendix for further information on GP and Nurse Consultation Rates)

Utilisation Ratio Equation
When the zero fees for Under-6s and Under-13s scheme were introduced throughout New Zealand, practices experienced an initial increase of 10% in utilisation rates, which then levelled off. Experience in HBDHB which introduced consultation fees for Under-13s indicates that visits to general practice have reportedly increased on average 23 percent in the 6-12 age group in the first six months of the scheme.

The average GP consultation utilisation for 13-17 year olds is 1.72 consults per annum. This will need to have a 25% buffer included for any potential increases in utilisation. Therefore the HBDHB consultation fees subsidy for 13-17 year olds will be based on a rate of 2.15 visits per annum. The funding formula mechanism will need to be monitored to ensure utilisation do not exceed an average of 2.15 visits per year. Agreements will need to allow a review of utilisation rates annually.

[18] Hastings Health Centre, Totara Health, Hauora Heretaunga make 62% of the total 13-17 year old enrolled population of Hastings general practices

HBDHB zero fees subsidy for 13-17 year olds will be based on a rate of 2.15 visits per annum (inclusive of 25% buffer)

5. Primary Care Consultation Fees

In Hawkes Bay, consultation fees for 13 to 17 year olds range from $0 to $39. Where After Hours services are in place, the charges are usually approximately $5 more expensive per visit. Pharmacies charge a flat fee of $5 per item dispensed and may charge $1-2 extra per item after hours.

There is a geographical distinction in consultation fees costs in HB. Although the average consultation fee per person is only $17.69, there is a clear distinction between Napier and CHB with Hastings and Wairoa. In Hastings and Wairoa there are eight no cost and very low cost consultation fees practices charging between $0 – $18 per consultation. Whereas Napier has only two low cost consultation fees practice charging between $11.50 - $18 and fourteen practices charging between $20 - $39 consultation fees. In CHB the consultation fees are $24.

(See Appendix for HHBPHO GP Practice Consultation Fees)

Consultation Fees Subsidy Rate[19]

The average consultation fees for the General Practice above is only $14.70. This is impacted by VLCA practice capped consultation fees of $12.00 with three practice charging consultation fees. However in order to capture a significant section of the Māori and Pacific community, as well as Napier and CHB, General Practices, such as The Doctors Napier, Hastings Health Centre and Tuki Tuki Medical need to be included. Therefore the consultation fees subsidy must be attractive enough to include them. Therefore a consultation fees of $25.00 (GST Excl) per visit is recommended.

There is variability in the afterhours charges to people aged 13 to 17. At a price offer of $40.00 per visit and a current utilization rate of 0.26 visits per annum per person.

It is assumed all pharmacies would accept an offer of $5.00 per item, per GP consultation (2.41 per person).

HBDHB zero fees subsidy will be $25.00 per visit

After hours fees subsidy will be $40.00 per visit

Pharmacy subsidy will be $5.00 per item

6. Option Analysis

The HBDHB Clinical Council approved funding investment for:

- All of Wairoa enrolled 13-17 year olds (estimated $20,000 per annum)
- 60% of the rest of HB enrolled 13-17 year olds (estimated $500,000)
    - Focus should be on Decile 4 & 5 populations

To achieve the Clinical Council's targeted funding allocation, three options have been developed.

Option One – Targeted Approach

[19] There is a funding differentiation between VLCA practices and non VLCA practices, and reducing the co-payment subsidy to $15 per consultation for VLCA practices would reduce the overall funding request to within budget.

- Option One provides a targeted approach towards general practices with the largest Māori and Pacific population groups (13-17 year olds).

Māori (35.8%) and Pacific (4.9%) make up a combined 41% of 13-17 year olds within the enrolled population of Health Hawke's Bay PHO general practices. VLCA practices make up 30% of 13-17 year olds within the enrolled population of Health Hawke's Bay PHO general practices. In Wairoa, Māori make up 77.3% of the enrolled population of General Practices. Other General Practices with significant Māori and Pacific populations include The Doctors Napier, The Doctors Hastings, Hastings Health Centre, Tamatea Medical Centre and Tuki Tuki Medical Centre with an additional 34.9% of the Māori and 26.0% of the Pacific enrolled population.

Therefore a selection criteria of General Practices with at least 30% enrolled 13-17 year old Māori patients and with over 100 enrolled 13-17 year old Māori patients has been applied. This will provide for a wider geographical coverage and ensure a capture of both high needs communities and the majority priority populations. (See Appendix for list of GP Practices)

12

Population Coverage
Option One provides for 84.5% of the total enrolled Māori population, 89.6% of Pacific and 67.7% of the total enrolled Health Hawke's Bay PHO population.

Option One zero fees subsidy will cover the following population and geographical areas:
- **67.7% of HBDHB for 13-17 year olds;**
- **Wairoa, Napier, Hastings and CHB,**
- **High needs communities of Wairoa, Maraenui and Flaxmere; and**
- **84.5% of Māori and 89.6% of Pacific populations**

Cost Analysis
Option One would be over the budget by $63,235 per annum and would cost an estimated $583,235 per annum.

Using local information on utilization rates in this age group, consultation fees at the different practices and the numbers of young people enrolled at each practice it is estimated that around 68% of people aged 13 to 17 years would be able to access free primary care visits during daytime hours at a price offer of $25 per visit. At the current utilization rate of 2.15 visits per person per annum the cost to the DHB to achieve 68% coverage is estimated at $411,408 per annum.

Afterhours costs based on a price offer of $40.00 per visit and a current utilization rate of 0.26 visits per annum per person is estimated to cost the DHB of $79,602 per annum.

Pharmacy costs based on $5.00 per item, per GP consultation (2.41 per person), is estimated to cost the DHB approximately $92,231 per annum.

The total cost of implementing zero fees and prescriptions for 68% coverage of HB population between aged 13 to 17 years is estimated at $583,235 (GST Excl).

- **Daytime GP consultations: $411,408**
- **After Hours GP consultations: $79,602**
- **Prescription Charges: $92,231**
- **TOTAL COST: $583,235**

These costings include the estimated cost for standard general practice consultations for enrolled patients, visits to general practice by casual (non-enrolled) patients, after hours visits primary care visits, pharmacy dispensing fees but exclude ACC consultation fees and any after hour's premium levied by pharmacies.

Option Two – Generic Approach

Option Two provides a different approach where HBDHB simply set the consultation fees at $25 per consult and generically offer it to all General Practices in HBDHB region. This approach is consistent with the MOH zero fees 6-13 year old subsidy.

The rationale for Option Two is to make the zero fees subsidy for 13-17 year olds a fair offer to all General Practices and let market forces determine the uptake of the offer. The offer still needs to be attractive enough to ensure those uptake of those General Practices serving population groups where cost is a barrier to accessing primary care and who experience unequal health outcomes. If the consultation fees subsidy is $25.00 per consultation the following General Practices may accept the HBDHB offer consultation fees subsidy for 13-17 year olds.

Population Coverage
Option Two this would cover 100% of the total enrolled 13-17 year olds HB population.

Option Two zero fees subsidy will cover the total population and HBDHB geographical areas:

- **100% of HBDHB for 13-17 year olds;**
- **Wairoa, Napier, Hastings and CHB,**
- **High needs communities of Wairoa, Maraenui and Flaxmere**

Cost Analysis
Option Two would not be within budget and would cost an estimated $845,514 per annum.

Option Two provides for 100% of people aged 13 to 17 years to access free primary care visits during daytime hours. At a price offer of $25.00 per visit, with a utilization rate of 2.15 visits per person per annum, the cost to the DHB to achieve 100% coverage for daytime GP consultations is estimated at $596,410 per annum.

Afterhours costs based on a price offer of $40.00 per visit and a current utilization rate of 0.26 visits per annum per person is estimated to cost the DHB of $115,398 per annum.

Pharmacy costs based on $5.00 per item, per GP consultation (2.41 per person), is estimated to cost the DHB approximately $133,706 per annum.

The total cost of implementing zero fees and prescriptions for 82% coverage of HB population between aged 13 to 17 years is estimated at $845,514

- **Daytime GP consultations: $596,410**
- **After Hours GP consultations: $115,398**
- **Prescription Charges: $133,706**
- **TOTAL COST: $845,514**

Option Two is not within budget and therefore a lower consultation fee subsidy rate should be considered.

Option Three – Generic Approach of Lower Subsidy

Option Three provides for a set zero fees subsidy offer of $20.00 per GP consultation to all General Practices in HBDHB region. A lower subsidy offer could reduce the uptake of GP practices that may accept the offer:

Population Coverage
Based on GP practices that currently charge equal or around $20 per consultation, approximately only 56.8% of the total enrolled 13-17 year olds would be covered, including 66.7% of the total

enrolled Māori population, 81.2% of Pacific and 48.2% of Other of the total enrolled Health Hawke's Bay PHO population. (See Appendix for List of GP Practices likely to accept offer).

Option Three zero fees subsidy will cover the following population and geographical areas:

- **56.8% of HBDHB for 13-17 year olds;**
- **Wairoa, Napier, and Hastings (not CHB),**
- **High needs communities of Wairoa, Maraenui and Flaxmere; and**
- **66.7% of Māori and 81.2% of Pacific populations**

Cost Analysis

Option Three would be within budget and would cost an estimated $412,662 per annum.

Option Three provides for 56.8% of people aged 13 to 17 years to access free primary care visits during daytime hours. At a price offer of $20.00 per visit, with a utilization rate of 2.15 visits per person per annum, the cost to the DHB to achieve 56.8% coverage for daytime GP consultations is estimated at $271,115.00 per annum.

Afterhours costs based on a price offer of $40.00 per visit and a current utilization rate of 0.26 visits per annum per person is estimated to cost the DHB of $65,572.00 per annum.

Pharmacy costs based on $5.00 per item, per GP consultation (2.41 per person), is estimated to cost the DHB approximately $75,975 per annum.

The total cost of implementing free primary care visits and prescriptions for 56.8% coverage of HB population between aged 13 to 17 years is estimated at $412,662

- **Daytime GP consultations: $271,115.00**
- **After Hours GP consultations: $65,572.00**
- **Prescription Charges: $75,975**
- **TOTAL COST: $412,662**

Comparative Analysis

Options	Population Coverage (Percentage)					Cost	+/- Budget $520,000
	Māori	Pacific	Other	Asian	Total		
One	84.5	89.6	57.4	26.4	67.7	$583,235	+$ 63,235
Two	100	100	100	100	100	$845,514	+$325,514
Three	66.7	81.2	48.2	67.8	56.8	$412,662	- $107,338

Option One

Option One provides for:

- targeted approach towards General Practices with high enrolled Māori and Pacific 13-17 year olds
- $25.00 consultation fees subsidy
- covers 67.7% of all enrolled 13-17 year olds
- contains a high percentage of Māori (84.5%) and Pacific (89.6%) enrolled population
- wide geographical coverage Wairoa, Napier, Hastings and CHB
- Includes all VLCA practices

Option One does not provide for:

- 'fairness' with an open offer to all General Practices
- A cost structure close to budget
    - is $63,235 over budget

Option Two

Option Two provides for:

- an ‘opt in’ fair market approach to all General Practices
    - is consistent with consultation fees 6-13 year old approach
- $25 consultation fees subsidy
- covers 100% of all enrolled 13-17 year olds
- contains the highest percentage of Māori and Pacific enrolled population
- wide geographical coverage Wairoa, Napier, Hastings and CHB
- includes all VLCA practices

Option Two does not provide:

- a cost structure within budget
    - is $325,514 over budget

Option Two should not be considered due to the total cost being considerably outside the funding parameters.

Option Three

Option Three provides for:

- an ‘opt in’ fair market approach to all General Practices
    - is consistent with consultation fees 6-13 year old approach
- affordable costs structure
    - $115,534.25 under budget
- $20 consultation fees subsidy
- covers 56.8% of all enrolled 13-17 year olds
- includes all VLCA practices
- includes Clive and Havelock North

Option Three does not provide for:

- less geographical coverage
    - limited in Napier and does not include CHB
- less Māori population coverage (66.7%)
- sole focus on decile 4 & 5
    - potential inclusion of Havelock North

7. Feedback

Primary Care

Ten general practices as well as Directions Youth Health service, HHB Priority Population Committee and HHB Clinical Advisory Group were consulted over the zero fees proposition. The overwhelming majority favoured reducing costs for general practices services and a targeted approach of Māori, Pacific and Quintile 4 & 5.

Common themes from general practice included:

- Cost was a barrier to accessing primary care
- A targeted approach to Māori, Pacific and Quintile 4 & 5 was favoured
- Attitudes and behaviours of staff was a barrier for youth access
- Multidisciplinary approaches and partnerships with youth social services and youth specialist services would best suit youth health issues
- Youth health networks in each district that were accessible to all youth would improve access to youth health services

Local Consumer Feedback

HBDHB consulted with two groups of 13-17 year olds in Hastings (Camberley, Flaxmere) and Wairoa (Wairoa College) regarding the zero fees proposition. The groups were asked a range of questions related to primary care access and appropriateness.

Both groups stated that cost was the major issue and agreed that zero fees subsidy for 13-17 year olds was a good proposition. However, both groups also suggested that non-financial barriers also impacted on accessing general practice. The groups stated that the attitudes and behaviours of primary care staff were one of the most significant barriers faced in accessing services. They stated the barriers were that significant that they do not use general practice until they are extremely unwell. Furthermore they stated that school health services were difficult to access due to their limited availability and lack of privacy.

The groups of youth had many innovative suggestions for primary care to improve youth friendly services. They suggested that primary care needs:

- integrated with youth social services and offer ‘practical’ support and not just ‘quick advice’
- Telehealth and preappointment options needs to offered more fully
- Walk in clinic options
- Self-selection menu of services (electronic or tick box) should be offered at reception
- Consultation times need to be more generous
- Clinic locations closer to where they live
- Staff that specialise in youth health, are younger and from a variety of cultural backgrounds
- Staff need training to be more friendly, responsive and accommodating for youth

Youth Experience of General Practice

Most young people in New Zealand see the GP or family doctor as the main place they get health care. However, many young people report barriers or problems (such as cost, embarrassment, not wanting to be bothered or concerns regarding confidentially) to seeking health care. Often barriers are found to be particularly high for Māori, Pacific and sometimes Asian or other migrant groups; young people in higher deprivation communities and same sex attracted young people. Additionally

when young people do see GP's this is often for short term illnesses or difficulties (especially respiratory or skin care issues) not for issues that represent the main burden of disease in this age group (such as mental health and behavioural issues).

There is little research regarding the impact of General Practice care for young people. However, available evidence[20] suggests:

- Most New Zealand high school students have seen a General Practitioner (GP) within the last year.
- The majority of New Zealand high school students say GPs or family doctors are the main place that they seek health care.
- Where young people do see GPs this is often for short term illnesses and not for issues such as mental health or health risk behaviours. This is the case even when young people do have mental health difficulties and even when they would like help for them.
- GP's often report difficulties in providing youth friendly care (such as lack of training or time).
- Where young people are more familiar with their GP they report fewer barriers to accessing health care.
- GP's who have received high quality training in adolescent health have been shown to be more likely to offer high quality adolescent health care.
- There are a range of actions (such as increased utilization of trained practice nurses, routine psychosocial screening and continuity of care approaches) that may be taken to enhance General Practice care for young people; however few of these approaches have been evaluated.

8. Key Considerations for A 'Youth Friendly' Primary Model Of Care

Research, literature reviews and consultation feedback all pointed towards the need to change the model of primary care for youth to address non-financial barriers to access.[21] A systematic review[22] of factors that young people perceived to make health care youth-friendly found that:

- accessibility,
- staff attitude (respectful and supportive, honest, trustworthy and friendly),
- communication (clarity of information and listening skills of the clinician),
- medical competency, guideline driven care (confidentiality, autonomy, and well-managed transition to adult health care),
- age appropriate environments,
- youth involvement
- appropriate health outcomes were central to young people's positive experience of care.

The literature reviewed in this document suggests that to improve young people's health the health sector should:

- Provide a range of 'youth friendly' clinical health services, staffed by health professionals who are well trained, skilled and knowledgeable in youth health.

[20] Assessment of youth-friendly health care: a systematic review of indicators drawn from young people's perspectives. 2013. Ambresin AE, Bennett K, Patton GC, Sanci LA & Sawyer SM. *J Adolesc Health* 52(6) 670-81.

[21] Fleming & Elvidge. Youth Health Services Literature Review. 2010.
Craig E, Jackson C, Han DY, NZCYES Steering Committee. *Monitoring the Health of New Zealand Children and Young People: Indicator Handbook*. 2007. Auckland: Paediatric Society of New Zealand, New Zealand Child and Youth Epidemiology Service.
The Health Status of Children and Young People in the Hawke's Bay 2015. Dunedin: New Zealand Child and Youth Epidemiology Service, University of Otago; 2016.

[22] Assessment of youth-friendly health care: a systematic review of indicators drawn from young people's perspectives. 2013. Ambresin AE, Bennett K, Patton GC, Sanci LA & Sawyer SM. *J Adolesc Health* 52(6) 670-81.

- These should provide comprehensive and 'joined up' youth friendly care.
- Work across sectors to encourage population, community, school and family level interventions that will improve the health of young people.

9. Best Practice Models and Standards

Provider Training

A transformation towards a youth friendly model of care will require specific training package for general practice. A comprehensive adolescent health training package for GP's was tested in a robust trial in Melbourne, Australia[23]. The educational programme (2.5 hours per week for 6 weeks) in the principles of adolescent health care, followed 6 weeks later by a 2-hour session of case discussion and debriefing was developed and evaluated. General Practice care for young people knowledge, attitudes and self-reported behaviours were improved following the training and were maintained at a five year follow up. A training package should be developed by Health Hawkes Bay PHO, in collaboration with general practice and youth health and social service providers, for participating general practices in the zero fees proposition.

Standards for Youth Health Care

Accreditation to standards or frameworks for youth health care can also support the hardwiring of a youth primary care model. Standards have been developed for Primary Care and other providers in numerous settings. In New Zealand the College of General Practitioners published a guide for GP's in working with young people (RACGP, 2006). This has been developed and reviewed by New Zealand practitioners and provides practical guidance for communication, screening, managing key adolescent health issues. Additionally there are local draft standards for youth health services (Kidz First Centre for Youth Health and the Youth Health Expert Working Group 2006). Other frameworks include the WHO Principles for Adolescent Friendly Care and the New South Wales Centre for the Advancement of Adolescent Health Youth Health Better Practice Framework (2005).[24] Either established standards and frameworks or the development of localised standards, in partnership with Directions Youth Health Centre, should be adopted as a baseline expectation for participating general practices in the zero fees proposition.

Viewing youth as new users of health services

The UK Royal College for Paediatrics and Child Health paper on Health Care for Adolescents (Royal College for Paediatrics and Child Health 2003) suggests that young people should be regarded as new users of health services and offered a specific appointment to meet their GP and discuss and negotiate their general practice service. This could include a discussion regarding confidentiality; the range of issues addressed by the GP and other professionals in the practice and having an opportunity to decide whether to continue with their parents GP or chose their own. If this is offered as a routine process to young people as they grow up and is explained to parents and young people in advance, such an introduction appointment could potentially address many of the identified barriers to high quality GP care for young people.

Integrated health and social services with General Practice

Research identified that school based health services, youth health centres and youth social service providers often provided more satisfactory care and support to young people than general practices do. The former services are typically provided by youth health trained nurses or social workers, youth workers or peer supporters in the first instance. It is widely acknowledged that general practice alone cannot solely address youth health related issues. Ideally, youth friendly general practice would

[23] Fleming & Elvidge. Youth Health Services Literature Review. 2010.
[24] Fleming & Elvidge. Youth Health Services Literature Review. 2010.

collaborate with other youth specific providers and offer a multidisciplinary, holistic approach, including primary care, reproductive and sexual health care, substance abuse treatment, mental health care, and education and counselling. Establishing and hardwiring collaborative relationships with local school health, youth health and youth social services should be a baseline expectation for participating general practices in the zero fees proposition.

Youth Friendly Environments

Studies demonstrate that youth want health service environments to be more youth appropriate. Youth prefer livelier décor, youth orientated reading material, and music. Youth also reported that clinic-sponsored incentives (e.g., gift certificates) would increase the likelihood that they would attend appointments. It will be recommended that participating general practices consider youth friendly environments as part of their youth friendly model of care.

Free appointments

All appointments being free or a schedule of free appointments (e.g. for an annual visit) might increase young people's use of health care. This approach has been effective for a HB sexual health clinics initiative. It is critical that people know that the appointments are free. Free appointments is a key baseline component for participating general practices in the zero fees proposition.

Flexible Appointments

Youth friendly models of care should also involve flexibility around consultations. General practices should consider walk-in clinics and telehealth appointments. Furthermore, general practice should use text reminders so young people are prompted about their appointment. It will be recommended that participating general practices consider flexible appointments as part of their youth friendly model of care.

Extended appointment times

Extended appointment times are suggested as part of providing youth friendly health services by the World Health Organisation (2002) and others. Extended appointments can allow time for explaining confidentiality, relationship building, screening and following up sensitive heath issues. This might be done by funded appointments and or by utilising non-medical health staff. Extended appointments maybe considered appropriate by participating general practices in the zero fees proposition.

Health Screening

There is considerable advocacy for routine screening for sensitive health issues among young people. This is on the basis that young people do not typically proactively disclose sensitive behaviours to health providers and yet they are often willing to, or indeed want to discuss them. Further many of these behaviours can have significant health consequence or interact with other health problems, for which the young person may be being treated. In New Zealand the year 9 assessments and opportunistic youth health screens when young people return to school clinics have been reported as a key part of the success of the HEADS Assessments. Research estimates that for every dollar spent on screening in adolescence long term health costs are reduced by a greater amount.[25] It will be recommended that participating general practices consider a health screening and assessment approach as part of their youth friendly model of care.

A baseline requirement of general practices within the Zero Fees 13-17 Year Old programme will be to make 'youth friendly' changes to their model of primary care

[25] Fleming & Elvidge. Youth Health Services Literature Review. 2010.

10. Measuring Benefits

Successful implementation of the project will show significant improvements within the NZ Triple Aim as follows:

Triple Aim Outcome Profile

Dimension	Measure
1. Improved Quality/Safety / experience of Patient Care	• Improved access to primary care including better information to Manage my own health (Health Literacy) • Early detection of health risks and access to treatment
2. Improved Health & equity for all populations	• Decreased burden of disease across the population • Increased equity of health status including Māori, Pacific, Low deprivation populations
3. Best Value for Public Health system resources	• Decreased cost of disease management associated with Long term conditions across the system

Population Health Measures

The Zero Fees Proposition for 13-17 Year Olds will implement a set of Programme Measures as well as Individual Tailored Measures for participating general practices.

The New Zealand Child and Youth Epidemiology Service provide a set of "Top 20" Indicators of Child and Youth Health indicators (see Appendix Four). [26] Most relevant to the zero fees proposition are:

- Most Frequent Causes of Hospital Admission and Mortality
- Primary Health Care Provision and Utilisation
- Exposure to Cigarette Smoke in the Home

Furthermore, the Otago University and New Zealand Child and Youth Epidemiology Service Health Status of Children and Young People in the Hawke's Bay 2015 Report provides Ambulatory Sensitive Hospitalisation (ASH) rate indicators and relevant, in terms of significant incidences, attributable to access to primary health care for 13-17 year olds.

Programme Measures

Therefore the health indicators within the Programme Measures for the Zero Fees 13-17 Year Old proposition include a reduction in acute Emergency Department presentations and admissions[27] for:

- Self -referred but not admitted Emergency Department attendance rate (in hours and out of hours)
- Serious Skin Infections
- Asthma
- Mental Health (presentations & admissions)

Non-clinical indicators for the Programme Measures for the Zero Fees 13-17 Year Old proposition include:

[26] Craig E, Jackson C, Han DY, NZCYES Steering Committee. *Monitoring the Health of New Zealand Children and Young People: Indicator Handbook*. 2007. Auckland: Paediatric Society of New Zealand, New Zealand Child and Youth Epidemiology Service

[27] ASH Rates and ED Presentation baseline data yet to be determined by HBDHB

- Increased utilisation of primary care (≥ 25%) over current utilisation rates
- Youth Friendly General Practices
    - Free consultations, Youth specific training, Accredited to Youth Health Standards, Flexible consultations, Youth Health Satisfaction Surveys

Individual Tailored Measures
Individual tailored indicators would be general practice specific related to the clinical and non-clinical programme indicators. These would require breakdown of HBDHB and PHO data to determine specific health indicators directly attributable to access to primary care. The tailored measures would be negotiated with each practice and the scope of the plans would be based on the level of funding they are likely to receive. However there would be baseline expectations that include changes to model of care and zero fees.

Health Hawkes Bay and HBDHB will develop 0-18 year old population profiles for each general practice that opts in for the 13-17 year old primary care zero fees subsidy. Each general practice will be asked to provide a plan on how they will improve their responsiveness to their youth population. Depending on the general practice population profile they could be asked for a population health plan on how they will respond to health issues.

11. Risks

Unintended Consequences

The following potential unintended consequences have been identified:

1. Patient Flight – Some patients and their whanau could leave their General Practice to enrol in a practice with consultation fees.
2. Lack of Capacity - General Practices providing consultation fees could be inundated with enrolment requests impacting on their capacity to deliver quality health care.
3. Funding Sustainability - funding could be compromised if General Practices that have opted into the consultation fees subsidy grow their enrolled population beyond the ability of the funding parameters.

Risk Analysis

Risk	Likelihood Hi/Med/Lo	Impact Hi/Med/Lo	Planned Response
Activity increase leads to reluctance of General Practices to participate	Med	Hi	Identify optimal practices and also Work with consider existing VLCA (very low cost access practices)
Ability of selected practices to provide an optimal 13- 17 year old service as per requirements identified.	Med	Hi	Work with selected practices to find optimal ways to meet the requirements

12. Implementation

Project Approach
The 13-17 year old primary care zero fees subsidy is being implemented under the formal HBDHB project management methodology. The project has a terms of reference with a project manager, governance committee and project team.

Implementation by Health Hawkes Bay
The implementation of the13-17 year old primary care zero fees subsidy project will be a partnership between HBDHB Strategic Services and Health Hawkes Bay. HBDHB and Health Hawkes Bay will visit each eligible general practice and discuss the programme detailing the 13-17 year old primary care zero fees subsidy and model of care expectations. HBDHB will contract Health Hawkes Bay to contract with general practice. It will build upon current transformation work with general practice being carried out by Health Hawkes Bay.

Procurement
HBDHB Contracts will manage the procurement process. A letter of offer will be sent to the targeted general practices detailing the zero fees subsidy including criteria and expectations.

HBDHB and Health Hawkes Bay will provide a population profile for each general practice including significant health issues for 13-17 year olds. Each general practice will be asked to submit a proposal on what new services or service model they intend to implement to improve access to primary care services for 13-17 year olds. The service plan should cover objectives, targets and measures for areas such as addressing significant health needs, reducing ASH rates and ED admissions as well as detailing the provision of any additional 'youth friendly' services.

HBDHB Māori Health, Strategic Services and Health Hawkes Bay must approve and sign off the service plan before funding is released.

Timeline:

High Level Milestone	**Date of Completion**
EMT paper - Preapproval SG - EMT / Clinical Council	October 2016
Implementation	
Preparation for Go Live _ systems/ processes as per plan completed – Contracts developed and agreed	October – December 2016
Go Live	1 January 2017

Appendix Two

Implementation of 'Zero Fees' For Children Under 13 Years

In July 2015 the Government invested $90 million nationally over three years to make doctors' visits and prescriptions free for children aged under 13 years at any time of the day or night. The intent is to remove cost as a barrier to access to primary care services by replacing the zero fees made by patients to general practices, Accident and Medical centres and pharmacies with government funding.

The zero-fee visits for children under 13 policy was an 'opt in' approach where general practices could choose whether or not to provide 'zero fees' to under-13s. Those that opt in receive an additional subsidy of around $45 per annum from the Government. (The General Medical Subsidy (GMS) rate for casual visits for 6–12 year olds remains unchanged, helping to incentivize enrolment with a regular practice and continuity of care). Nationally, 96% of general practices with enrolled children aged 6 - 12 have opted in to the zero-fees for under-13s scheme, and 98% of practices with enrolled under-sixes offer zero-fee visits.

Utilization rates for zero fees for under-13s have been modelled on existing average utilization rates of an average of 2.2 visits per year. The Government subsidises an additional $44 - $45 for 'Zero Fees Under 13 year olds' over and above the $94.28 - $99.48 (non-Access Practices) and $117.31 - $125.33 (Access Practices) first contact non-high user card subsidy.

In Hawke's Bay practices, Health Hawkes Bay report an increase of 23% in utilization rates for the 6-12 year old group.

Appendix Three:

HEALTH HAWKES BAY ENROLLED POPULATION 13-17 YEARS

There are approximately 11,096 children aged thirteen to seventeen enrolled with Health Hawke's Bay PHO general practices. Māori and Pacific make up 35.2% and 4.8% of 13-17 year olds within the enrolled population of Health Hawke's Bay PHO general practices.

Health Hawkes Bay - 2015 Calendar Year 13-17 Enrolled Population by Ethnicity

Ethnicity	HEALTH HAWKES BAY Patients
Asian	292
Māori	3,905
Other	6,362
Pacific	538
Total	**11,096**

Around 3,215 of those are registered with one of the eight Very Low Cost Access practices (VLCA)[28] with Health Hawke's Bay PHO general practices.

Health Hawkes Bay - 2015 Calendar Year 13-17 Enrolled Population by Age and VLCA/Non-VLCA

Age	HEALTH HAWKES BAY Patients	VLCA Practices	Non-VLCA Practices
13	2,205	685	1,521
14	2,221	674	1,547
15	2,272	659	1,613
16	2,168	604	1,564
17	2,230	594	1,637
Total	**11,096**	**3,215**	**7,881**

Primary Care Utilisation Rates

In 2015, the average GP consultations for 13-17 year olds was 1.72 consults per annum. There is very little difference between VLCA and Non-VLCA average GP consultation rates at 1.70 and 1.73 per annum respectfully. Combined GP and Nurse Consultations for 13-17 year olds is 2.15 consults per annum.

Health Hawkes Bay - 2015 Calendar Year 13-17 Year Old Enrolled Population & Total Consultations

Age	HEALTH HAWKES BAY Patients	Average GP & Nurse Consults	Average GP Consults	Average Nurse Consults
13	2,205	1.68	1.40	0.28
14	2,221	1.89	1.50	0.39
15	2,272	2.05	1.66	0.39
16	2,168	2.42	1.92	0.50
17	2,230	2.70	2.13	0.57
Total	**11,096**	**2.15**	**1.72**	**0.43**

[28] *Very Low Cost Access (VLCA) practices receive higher capitation rates in return for lower zero fees capped levels for standard consultations (zero fees for children 0–5 years, $11.50 maximum for children 6–17 years, $17.50 maximum for adults 18 years and over). A general practice must have at least 50% "High Needs" people (Māori, Pacific, or Quintile 5) enrolled to qualify for VLCA funding.*

Health Hawkes Bay - 2015 Calendar Year 13-17 Year Old Enrolled Population & Total Consultations Non-VLCA Practices

Age	Average Patients	Average GP & Nurse Consults	Average GP Consults	Average Nurse Consults
13	1,521	1.57	1.38	0.19
14	1,547	1.77	1.49	0.28
15	1,613	1.97	1.68	0.29
16	1,564	2.22	1.88	0.35
17	1,637	2.61	2.17	0.44
Total	**7,881**	**2.04**	**1.73**	**0.31**

For VLCA the average combined GP and Nurse Consultations were slightly higher at 2.42 per annum than Non-VLCA practices 2.04 per annum. This is primarily due to VLCA practices having a higher nurse consultation average rate of 0.71 in comparison to Non-VLCA average rate of 0.31.

Health Hawkes Bay - 2015 Calendar Year 13-17 Year Old Enrolled Population & Total Consultations VLCA Practices

Age	Average Patients	Average GP & Nurse Consults	Average GP Consults	Average Nurse Consults
13	685	1.93	1.43	0.50
14	674	2.16	1.51	0.65
15	659	2.24	1.61	0.64
16	604	2.93	2.03	0.91
17	594	2.94	2.01	0.93
Total	**3,215**	**2.42**	**1.70**	**0.71**

In 2015, Māori and Pacific received less average GP consultations than Asian and Other NZers. Māori and Pacific received 1.56 and 1.28 average GP consultations per annum in comparison with Asian and Other NZers which had 1.75 and 1.86 per annum. However, Māori received higher Nurse Consultations than any other ethnic group with 0.58 per annum. This increased the combined GP and Nurse average consultations for Māori to 2.13 per annum in comparison to Non-Māori 2.21, Asian 1.75 and Pacific 1.62 per annum.

Health Hawkes Bay - 2015 Calendar Year 13-17 Year Old Average Consultations of Enrolled Population by Ethnicity

Ethnicity	Average Patients	Average GP & Nurse Consults	Average GP Consults	Average Nurse Consults
Asian	292	2.01	1.75	0.26
Māori	3,905	2.13	1.56	0.58
Other	6,362	2.21	1.86	0.35
Pacific	538	1.62	1.28	0.34

Appendix Four

Primary Care Subsidy and Zero Fees Structures

Primary Care Subsidies

The Government currently subsidises first contact primary care for 13 - 17 year olds between:

- Access Practices
  - $63.65 - $117.31 for Males
  - $115.65 - $125.33 for Females
- Non-Access Practices
  - $63.65 - $94.28 for Males
  - $99.48 - $115.65 for Females

Primary Care Subsidy Rates by Age – High User Card, Access Practices, VLCA, Under 14 Yrs & Under 6 Yrs

Age Group	Gender	First Contact				Vlca	Free Under Sixes	Free Under 13s
		Access Practices		Non Access Practices				
		Huhc	Non Huhc	Huhc	Non Huhc			
5 - 14	Female	$379.5048	$125.3340	$379.5048	$99.4860	$52.2740	$2.4168	$45.0256
	Male	$379.5048	$117.3144	$379.5048	$94.2880	$51.6556	$2.2616	$44.8704
15 - 24	Female	$365.5776	$115.6512	$365.5776	$115.6512	$29.6752	N/A	N/A
	Male	$365.5776	$63.6512	$365.5776	$63.6512	$16.3328	N/A	N/A

Primary Care Consultation Fees

In Hawkes Bay, consultation fees for 13 to 17 year olds range from $0 to $42 (GST Incl). Where After Hours services are in place, the charges are usually approximately $5 more expensive per visit. Pharmacies charge a flat fee of $5 per item dispensed and may charge $1-2 extra per item after hours.

There is a geographical distinction in consultation fees costs between Napier and CHB with Hastings and Wairoa. In Hastings and Wairoa there are eight no cost and very low cost consultation fees practices charging between $0 – $18 per consultation. Whereas Napier has only two low cost consultation fees practice charging between $11.50 - $18 and fourteen practices charging between $20 - $39 consultation fees. In CHB the consultation fees are $24.

General Practices with the largest 13 to 17 year old Māori and Pacific populations include Totara Health, The Doctors Napier, Hauora Heretaunga, Hastings Health Centre, The Doctors Hastings (includes Gascoigne St, Waipawa), Wairoa Health Centre, Queen Street Medical and Medical and Injury.

Health Hawkes Bay Practices - Enrolled Population Consultation Fees for 13-17 Year Olds

Napier	Fees	Māori	Pacific	Other	Asian	Total
The Doctors - Napier	$27.00	546	40	773	41	1400
Carlyle Medical	$27.00	76	8	355	6	445
Central Medical	$28.00	50	1	151	2	204
Shakespeare Road Medical	$20.00	29	2	31	3	65
Greendale Medical	$30.00	43	1	241	8	293
HB Wellness Centre	$27.00	14	2	35	6	57
Tamatea Medical	$28.00	133	10	307	3	453
Taradale Medical Centre	$39.00	93	8	640	28	769
Dr Luft	$30.00	24	0	26	1	51
Dr Craig	$25.00	16	1	59	0	76
Dr Hendy	$25.00	6	1	26	3	36
Dr Harris	$18.00	15	1	3	0	19
Maraenui Medical	$11.50	249	60	107	1	417

Wairoa	Fees	Māori	Pacific	Other	Asian	Total
Wairoa Medical	$12.00	70	0	36	0	106
Queen St Medical	$11.50	184	3	31	4	222
Health Care Centre Ltd	$11.50	189	4	49	3	245

Central Hawkes Bay	Fees	Māori	Pacific	Other	Asian	Total
The Doctors – Waipawa*	$24.00					
Tuki Tuki Medical	$24.00	141	3	354	5	503

Hastings	Fees	Māori	Pacific	Other	Asian	Total
Totara Health	$0.00	616	175	399	24	1214
Medical & Injury	$0.00	147	33	66	32	278
Hauora Heretaunga	$0.00	485	64	33	8	590
The Doctors - Hastings	$16.00	206	31	394	33	664
The Doctors - Gascoigne St*	$11.00					
Hastings Health Centre	$18.00	336	59	1102	65	1562
Te Mata Medical	$15.00	51	5	718	20	794
Mahora Medical	$27.00	8	3	67	2	80
Dr Jolly	$24.00	16	0	50	1	67
Dr Wakefield	$24.00	8	1	41	0	50
Clive Medical Centre Ltd	$21.00	27	0	97	5	129

VLCA Practices

***** Enrolled population included in The Doctors Hastings total population

Appendix Five

Recommended "Top 20" Indicators of Child and Youth Health[29]

Individual and Whanau Health and Wellbeing	Socioeconomic and Cultural Determinants	Risk and Protective Factors
Most Frequent Causes of Hospital Admission and Mortality	Children in Families with Restricted Socioeconomic Resources	Breastfeeding
Low Birth Weight: Small for Gestational Age, Preterm Birth	Household Crowding	Overweight and Obesity
Infant Mortality	Educational Attainment at School Leaving	Exposure to Cigarette Smoke in the Home
Oral Health	Primary Health Care Provision and Utilisation	Immunisation
Injuries Arising from Assault in Children		
Total and Unintentional Injuries		
Serious Bacterial Infections		
Lower Respiratory Morbidity and Mortality In Children		
Selected Chronic Conditions: Diabetes and Epilepsy		
Disability Prevalence		
Self-Harm and Suicide		
Teenage Pregnancy		

12

Appendix Six

[29] Craig E, Jackson C, Han DY, NZCYES Steering Committee. *Monitoring the Health of New Zealand Children and Young People: Indicator Handbook*. 2007. Auckland: Paediatric Society of New Zealand, New Zealand Child and Youth Epidemiology Service

Consumer and Primary Care Consultation

Consumer Consultation – Youth Questions

Youth Questions

1. If you had to look after the health of young people, what would a good health service look like?
    a. What are the key features?
    b. Where, when, who and how?
2. What is working well at the moment? Why?
    a. What isn't working well?
    b. What would you change?
    c. What would you keep?
    d. What would you stop?

Primary Care Consultation - Questions

- Proposition of zero fees for 13-17 Year Olds (Decile 4-5)

Questions:

1. What do you think would improve access to primary care for young people Dep 8-10
2. What else other than financial barriers would enhance young people engaging proactively with general practice?
3. Do you think general practice is the best place for young people to access health services?
4. If you had to look after the health of young people, what would a good health service look like?
    a. What are the key features?
    b. Where, when, who and how?

HAWKE'S BAY District Health Board Whakawāteatia	**Alcohol Harm Reduction Position Statement**
	For the attention of: **Māori Relationship Board, HB Clinical and HB Health Consumer Council**
Document Owner: **Document Author(s):**	Dr Caroline McElnay, Director Population Health Dr Rachel Eyre, Medical Officer of Health
Reviewed by:	Executive Management Team
Month:	November 2016
Consideration:	For Endorsement

13

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Council:

1. Note the contents of this Position Statement.
2. Seek endorsement to go to Board for adoption.

D R A F T

POSITION STATEMENT ON REDUCING ALCOHOL-RELATED HARM

Hawke's Bay District Health Board Position

Although alcohol is a legal drug consumed and enjoyed by many people, the Hawke's Bay District Health Board recognises that alcohol–related harm is a significant health issue for our community that must be addressed.

Harmful alcohol consumption is a major risk factor which contributes to the physical, mental and social ill-health in our community and to Māori: non-Māori health inequities in Hawke's Bay. This health and social burden is borne not just by drinkers but often by others.

The Hawke's Bay District Health Board recognises that the widespread promotion of and accessibility to alcohol has a significant role to play in people's drinking behaviour. Similarly, the DHB understands that the strongest measures to reduce alcohol-related harm operate at a policy level and include increasing price, reducing availability and reducing advertising.

Hawke's Bay District Health Board commits to taking a leadership role in reducing alcohol-related harm in our community. The first steps involve the DHB developing a high-level Strategy and a more detailed Implementation (and Communication) Plan to take action in collaboration with our stakeholders and community.

OUR VISION

"Healthy communities, family and whānau living free from alcohol-related harm and inequity"

The Core DHB Values that underpin the *process* for developing the DHB's Strategy and plans to address alcohol-related harm are:

Rāranga te tira -Working in partnership across the community

The improvement of Māori outcomes will require Iwi defined and led strategies

Community engagement & ownership will be critical to change attitudes to alcohol – related harm

Tauwhiro - High quality care

Effective strategies need to be evidence informed

Population-based prevention strategies are the most effective and efficient, where possible to deliver at the local level

Improving early intervention support & treatment has an important role

He kauanuanu - Showing respect to staff, patients and community

A harm minimisation approach is realistic for many people, accepting that target groups need tailored advice and strategies

Systems thinking is critical to develop strategies which work synergistically

Akina - Continuous improvement

DHB leadership entails being a role model, e.g. holding alcohol-free events within our health system and thus leading the way towards moderation in the community

Relies on strengthened intelligence through improving health system data collection

DRAFT

The Hawke's Bay District Health Board is committed to supporting our government's National Drug Policy 2015-2020[1] to:

- reduce excessive drinking by adults and young people
- protect the most vulnerable members of our community when it comes to alcohol-related harm e.g. children and young people, pregnant women and babies (Foetal Alcohol Spectrum Disorder)
- reduce the harm caused by alcohol use including crime, disorder, public nuisance and negative public health outcomes
- support the safe and responsible sale, supply and consumption of alcohol
- improve community input into local alcohol licensing decisions
- improve the operation of the alcohol licensing system.

Further to the above, the Hawke's Bay District Health Board is committed to:

- reduce and eliminate alcohol and other drug-related harm inequities – particularly for Māori, young people, pregnant women and others who experience disproportionate alcohol-related harm in our community.

NEXT STEPS

The Hawke's Bay District Health Board will undertake the following next steps as a priority.

1. Identify the appropriate capacity and resource to lead the development of an Alcohol Harm Reduction Strategy and Implementation.

2. Identify a governance and management structure to guide and provide an accountability mechanism for the 'Coordinator', and Strategy/Plan delivery.

3. Support high-level Champions within our health system and in the community to act as spokespersons and be credible role models to help shift staff, community, whanau, family and individual attitudes to reduce harmful alcohol consumption.

4. Identify the best way to input into the review and delivery of the Napier City and Hastings District Councils' Joint Alcohol Strategy to limit availability and promote safe, responsible drinking.

5. Establish the best method to engage the relevant departments across our DHB and PHO, and to engage with Iwi, Pasifika, young people and community (building on existing groups -Safer Communities, Māori NGOs etc), to develop appropriate strategies and to provide support.

6. Consider the development of a local Alcohol Coalition of NGOs and other agencies, akin to the Hawke's Bay Smokefree Coalition to build support at a community level.

7. Identify service gaps and priority objectives for local DHB action to include:
   - improved systems for health data collection/screening and brief intervention (e.g. in the Emergency Department, Maternity and Primary Care)
   - appropriate clinical referral pathways and treatment services
   - support for strong, consistent health messaging (such as no drinking in pregnancy).

[1] http://www.health.govt.nz/system/files/documents/publications/national-drug-policy-2015-2020-aug15.pdf

D R A F T

KEY OUTCOMES

Consistent with the National Drug Policy the key outcomes our District Health Board is striving for, include:

- Reduced hazardous drinking of alcohol
- Delayed uptake of alcohol by young people
- Reduced illness and injury from alcohol
- Changed attitudes towards alcohol and reduced tolerance for alcohol-related harms

August 2016
Position Statement Review date: October 2017 and on a 3 year cycle thereafter.

LINKAGES

National Drug Policy Framework (2015-2020) (Inter-Agency Committee on Drugs, 2015)

Rising to the Challenge - The Mental Health and Addiction Service Development Plan (2012-2017)

Hawke's Bay District Health Board: Health Equity in Hawke's Bay (McElnay C 2014), *Health Equity in Hawke's Bay Update* (McElnay C 2016) *Youth Health Strategy* (2016-2019), *FASD Discussion Document* (December 2015), *Intimate Partner Violence Intervention* (Reviewed September 2016) *Mai, Māori Health Strategy* (2014-2019), *Māori Health Annual Plan* (2016 – 2017).

HAWKE'S BAY District Health Board Whakawāteatia	**Palliative Care in Hawke's Bay**
	For the attention of: **Māori Relationship Board, HB Clinical and HB Health Consumer Council**
Document Owner: Document Author(s):	Chris McKenna Director of Nursing Mary Wills Head of Strategic Services
Month:	November 2016
Consideration:	For feedback

14

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Council:

1. Provide feedback on the draft plan
2. Note that further consultation with the community will follow.

OVERVIEW

The attached draft plan has been developed with a combined clinical steering group involving primary and specialist palliative care. The initial draft plan has been shared with Consumer Council to check the content is on the right track before broader engagement and feedback.

The MRB meeting and Council Workshop on 9 November will discuss the paper and the broader issues of end of life and advance care planning.

Following this, consultation workshops will be planned with key stakeholders and the community. This will shape the resulting work programme and where these will be led from.

All people who are dying and their family/whānau who could benefit from palliative care have timely access to quality palliative care services that are culturally appropriate and are provided in a coordinated way

(NZ Palliative Care Strategy 2001)

Palliative Care in Hawke's Bay

Our vision and priorities for the future 2016 – 2026

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Executive Summary

"You matter because you are you, and you matter to the last moment of your life.
We will do all we can, not only to help you die peacefully, but also to live until you die"
Dame Cicely Saunders

Dying is a normal part of the human experience and affects people regardless of age. Whenever a person dies in Hawke's Bay, there are impacts for their family/whānau, friends, work colleagues and the community in which they live. Many people would prefer to die in their own home, cared for and surrounded by their loved ones. [24] Others will die in hospice, hospital or aged residential care, by choice or by necessity.

The experience of dying, and of caring for loved ones at the end of life, can have a deep and lasting impact on those involved. Poorly supported dying, with inadequate symptom control and failure to meet the needs of those who are dying as well as those who care for them, may lead to a complicated bereavement process for those left behind. In contrast, high quality and well-co-ordinated care at the end of life provides a setting for a healthy experience of death for both family/whānau and surrounding community.

The quality of care provided in the Hawke's Bay region to those at the end of life is everyone's responsibility. Death is not a subject that should be avoided or concealed. It is one of the great certainties of life, and involvement in caring for those people who are dying can, not only strengthen family relationships, encourage compassion and resilience, and promote positive connections in the community, enhance respect for health and life, and reduce community fears about death and dying.

We will extend the ways we receive patient feedback and hear what is important to patients and family/whānau. As the numbers of people needing palliative care grows rapidly over the next 10 years, we will need to be culturally responsive in our practice. This will be supported by shared leadership, working as one team and with agreed priorities for the next 10 years.

We will recruit and train staff in palliative care. This includes sustainable medical staff and replacement of our retiring nursing workforce. Allied health and family support team members will work with primary care to provide a multidisciplinary response for patients with dementia and who are frail. Our focus on education and training will develop the next generation of palliative care practitioners in primary and specialist palliative care.

We will agree how services provide access 24 hours a day 7 days a week. As the national strategies for Health of Older people and Palliative Care are implemented in Hawke's Bay, we will invest in sustainable specialist palliative care services and education and training. This will be supported by technology, shared information across services and using information to inform service improvement.

Our six priorities for the future will improve care for people and their family/whānau. To achieve this requires us to work together as one team to strengthen the foundations on which our vision is built.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Our six priorities:

1. **Each person and their family/whānau will have their individual needs as the centre of care**
2. **Each person gets fair access to high quality individualised care**
3. **Comfort and wellbeing maximised**
4. **Care is seamless**
5. **The community is involved**
6. **People are prepared to care**

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Introduction

In today's society, people are increasingly expressing the importance of choice and independence as major components of dignity in advancing illness and old age. Most of us expect to make decisions, not only on how we live our last years, months, weeks and days of life but also on how and where we die. With advances in chronic disease management, single disease approaches for planning end of life will make less sense as functional decline towards end of life could be very hard to predict. This will have wide reaching implications for the co-ordination of care, health and social needs, predictions of future outcomes, referrals and patient, family/whānau experience and choice.

Increasing numbers of people with neurodegenerative conditions like dementia suggests an increasing need for early participation in planning for, and conversation about dying if we are going to be able to provide quality care to those at end of life.

Palliative care is recognised as a speciality that focuses on patient centred care, but as future demands for services increase, more than ever we will need to ensure we continue to place the patient and their family/whānau needs and goals at the centre. Our response to needs will have to be tailored so that we are providing just the right amount of support to empower and enable individuals to achieve their goals and to live their lives until they die. Services will need to ensure that they are providing a culture of enablement alongside our care. This will enable people greater choice, independence and dignity in advancing illness and/or old age.

For Hawke's Bay the level of need for palliative care is hard to predict. There is literature stating that for most people their palliative care needs can be met through good primary palliative care provided by general practitioners, hospitals, aged residential care, district nurses and Māori health providers without the need for direct care provision of specialist palliative care. [18;20.] Providing palliative care needs to be a core part of everyone's practice.

What is palliative care?

Palliative care is the care of people who are dying from active, progressive diseases or other conditions that are not responsive to curative treatment. Palliative care embraces the physical, social, emotional and spiritual elements of wellbeing–tinana, whānau, hinengaro and wairua – and enhances a person's quality of life while they are dying. Palliative care also supports the bereaved family/whānau. 13.

The principles of palliative care are that it:

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten or postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patient's illness and in their own bereavement
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- will enhance quality of life, and may also positively influence the course of illness
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Palliative care is provided according to an individual's need, and may be suitable whether death is days, weeks, months or occasionally even years away. It may also be suitable sometimes when treatments are being given aimed at extending quality of life.

It should be available wherever the person may be located. It should be provided by all health care professionals, supported where necessary, by specialist palliative care services.

Palliative care should be provided in such a way as to meet the unique needs of people from particular communities or groups. This includes but is not limited to: Māori, children and young people, immigrants, those with intellectual disability, refugees, prisoners, the homeless, those in isolated communities and lesbian, gay, transgender and intersex people. 16.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Palliative care will be delivered by both primary palliative care and specialist palliative care providers working together as one team.

Primary palliative care (PPC) refers to care provided by general practices, Māori health providers, allied health teams, district nurses, aged residential care staff, general hospital ward staff as well as disease specific teams e.g. oncology, respiratory, renal and cardiac teams. The care provided is an integral part of usual clinical practice. Primary palliative care providers assess and refer people to specialist palliative care services when the needs of the person exceed the capability of the primary palliative care provider. [7.]

Specialist palliative care (SPC) is palliative care provided by those who have undergone specific training or accreditation in palliative care/medicine, working in the context of a multidisciplinary team of palliative care health professionals.

Specialist palliative care may be provided by hospice or hospital based palliative care services where people have access to at least medical and nursing palliative care specialists.

Specialist palliative care is delivered in two key ways:

- Directly – direct management and support of the person and family/ whānau where more complex palliative care needs exceed the physical, spiritual or social resources of the primary provider. SPC involvement with any person and the family/ whānau can be continuous or episodic depending on the changing need.
- Indirectly – to provide advice, support, education and training for other health professionals and volunteers to support the primary provision of palliative care.

Future need

Like all of New Zealand, and the World, the increasing numbers of people dying and the changing patterns of illness means the number of people who could benefit from a palliative approach to care is increasing. We will need to manage resources and ensure that we have the right people equipped to care and support the needs of those with a life limiting condition.

Evidence is showing us that in the next 20 years we will have more people dying. They will be living with and dying from not only malignant conditions such as cancer, but chronic conditions and multiple comorbidities, including dementia. Their longevity will be frequently compromised by fragility and disability.[10.]

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

For New Zealand the estimates are:

- Projected deaths will increase by almost 50 percent (from 30,000 to 45,000 per annum in 2038).
- Deaths will reach 55,500 per annum by 2068. This is the result of people living longer than before, coupled with an absolute increase in numbers due to the "baby boom" generation (born between 1946 – 1965) entering their older years.
- There will be rapid ageing of those deaths. In 20 years over half of the deaths will be in the age group 85 years and older. Deaths at the oldest ages will be predominantly women.
- Over the last decade deaths from circulatory system conditions have been declining and deaths from other conditions, including respiratory conditions, dementia and frailty, have been proportionally increasing.

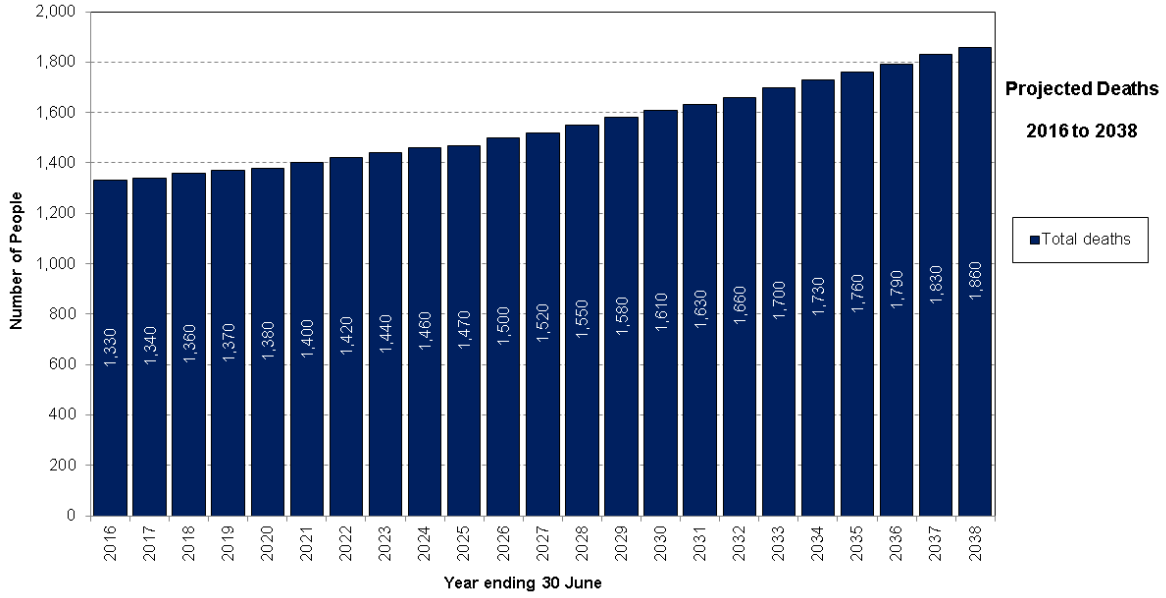
For Hawke's Bay our data is showing us:

- The number of deaths per year will increase by over 500 people. From 1,330 predicted for 2016 to 1,860 by 2038. See graph 1.
- People in the 84-94 age group will more than double from 420 in 2016 to 870 by 2038. See graph 2.
- We will also see an increase in the 95 years and over age group with increases from 100 in 2016 to 200 by 2038.
- The number of Māori and Pasifika people dying will increase and whilst the numbers are relatively small per annum, the increased incidence of poverty plus barriers to access caused by cultural differences and lack of resources means that they are likely to require more support to achieve equitable outcomes.
- The estimated number of people dying who are likely to benefit from palliative care services is 822 in 2015 rising to 927 in 2025.
- The Hospice NZ Palliative Care Demand Model suggests that Cranford Hospice could possibly have been involved with 822 deaths in 2015 based on population data. They were actually involved in 663 deaths. There may be an unmet need of approximately 160 patients currently per annum.

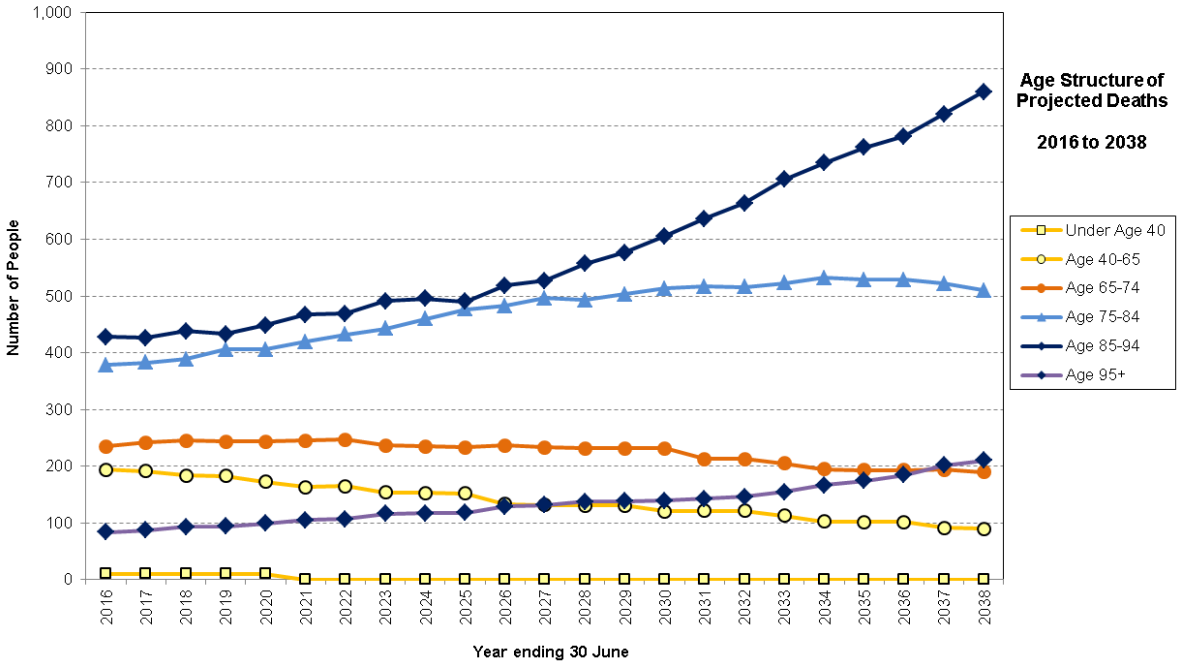
Uptake of specialist and primary palliative care services by Māori (15.8%) and Pasifika (1.1%) was in line with their younger population profiles in 2014. However, it is not known whether the experiences of those groups is equitable, or whether they receive similar number of contacts per person as other non-Maori, non-Pasifika people.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Graph 1 : Number of projected deaths in Hawke's Bay 2016 to 2038



Graph 2 : Estimated change in age of death in Hawke's Bay from 2016 to 2038

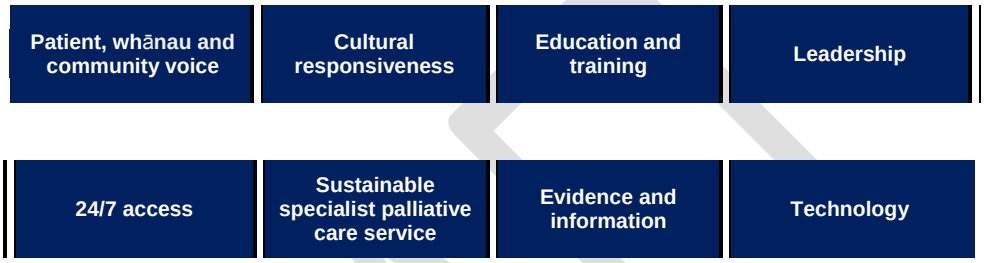


Acknowledgement: This document was developed using the National Palliative and End of Life Care Partnership. Ambitions for Palliative and End of Life Care; A national framework for local action 2015-2020. www.endoflifeambitions.org.uk.

Foundations on which our vision is built

"All people who are dying and their family/whanau who could benefit from palliative care have timely access to quality palliative care services that are culturally appropriate and are provided in a coordinated way" [13].

To realise our vision we have identified eight foundations that need to be in place to meet our commitments to palliative care in Hawke's Bay. They are necessary for each and underpin the whole. These foundations are prerequisites for success in providing quality palliative care to our community now and into the future.



1. Patient, Whānau and Community Voice

Systems for palliative care are best designed in collaboration with people who have had personal experience of death, dying and bereavement. We need to ensure that we are listening to the voices of patients, family/whānau, carers and communities in all that we do.[3]. We need to engage communities in their own care design and how health services are delivered. Patients and whānau have told us they need better information so they are aware of support and can access it when they need it.[21].

2. Cultural responsiveness

We will provide culturally responsive care that is mindful of the beliefs and values of patients, family/whanau. This will include considering how to provide palliative care for the growing numbers of Māori and Pasifika who will need these services. Whānaungatanga, kanohi ki te kanohi, wairuatanga, and the availability of Māori kaitakawaenga are all important for effective communication with Māori patients and their family/whānau. [11].

3. Education and Training

To have palliative care as everybody's business there is a large education programme that needs to be implemented. We will need to educate patients, family/whānau, carers and primary palliative care providers in palliative care. With increasing demands on time we will need to look at a range of methods to teach appropriate knowledge and skills in end of life care. They include face-to-face, e-learning, simulation, reflective learning, health promotion, telemedicine, case studies, death reviews, mentoring and supervised clinical practice. We also need to look at ways to educate and train our informal workforce, unpaid volunteers and carers so they too are well equipped to provide hands on care and support. We will need to understand death and dying and advance care planning.

For PPC providers core elements will include:

- Identifying patients who need palliative care
- Breaking bad news
- Conversations with patients and their family/ whānau around advance care planning
- Providing care according to patient and family/whanau needs
- Basic symptom management
- Psychosocial support
- Knowledge of when to refer to specialist palliative care

These should be routine aspects of care delivered by any PPC health practitioner.

With a greater focus on primary palliative care, we will need a sustainable and sufficient specialist workforce to provide advice, support and education to PPC providers. They will also be educated, trained and equipped to manage and care for those who will need complex palliative care management including those with dementia and frailty.

There needs to be a focus on increasing opportunities for introducing and training students in all disciplines in palliative care.

4. Leadership

Shared leadership with clear responsibilities will deliver our vision and priorities. A business case will describe the priorities for investment so that services are planned to meet Hawke's Bay population needs.

Clinical leadership must be at the heart of this strategic vision to ensure that each person and their family/whānau receives the care they need, at the right time, by the right people. They must be committed to the priorities and are key in ensuring outcomes are met. As the Ministry of Health finalises the Palliative Care Strategy and Health of Older People Strategy, we will link new national priorities to our agreed local priorities.

5. Access 24 hours, 7 days a week

Every person at the end of life should have access to services 24 hours, 7 days per week (24/7). In times of distress, uncontrolled pain and other symptoms cannot wait for office hours. People need to know who to contact, no matter what the time. PPC providers, especially GPs, are providing the majority of care. They need to be resourced to meet the demands, with access to 24/7 advice and support from SPC. For those who experience complex symptoms, the SPC nursing and medical team needs to be able to provide advice, care and support to those in need.

In Hawke's Bay we have a PPC programme that is intended to support patients who have a life limiting condition. The funding allocated to this programme is focussed on providing patients with dedicated care led by their primary health care team that works to moderate symptoms, pain, physical stress and the mental stressors associated with serious illness. The goal of this programme is to support planned care to improve the quality of life for both patients and their families.

A patient is offered access to this programme when they meet criteria and when there is a sense of need to provide palliative care therapies when no cure can be expected and when there is an expected length of life of six months or less. We will plan for sustainable funding past 30 June 2017.

6. Sustainable Specialist Palliative Care Service

Specialist palliative care is a vital foundation if we are to realise our vision and our priorities. Our specialist service needs to be equipped and resourced to meet the needs of complex patients, family/whānau, increased education needs, support of primary palliative care providers, advice and support 24/7.

There is a national shortage of palliative medicine specialists, an ageing nursing workforce and the low use of allied health teams.[24] Allied health professionals are commonly part of the palliative care multidisciplinary team in other countries (e.g. United Kingdom) but are not always in New Zealand.

SPC has been working hard since 2011 to build its workforce for the future needs with the introduction of advanced trainee positions, the introduction and expansion of clinical nurse specialists in hospice and hospital and the development of a nurse practitioner role. There is still work to do to ensure that we have a sustainable workforce that is well educated and equipped to meet needs.

In 2016 Cranford Hospice was successful in its submission for Ministry of Health innovation funding. The following roles have been established, based on feedback from General Practice and Aged Residential Care.

The existing Aged Residential Care Palliative Care Resource Nurse position increased from 0.6 to 1.2 full time equivalent. The Aged Residential Care liaison nurse will support and teach skills in palliative care.

A new 0.9FTE Palliative Care Nurse Practitioner supports primary care and rural services. This role works within General Practice with an emphasis in the first instance on rural populations in Central Hawke's Bay and Wairoa. The focus of this role will be to develop the skills, capacity and systems/processes required in primary care to deliver high quality primary palliative care. The Nurse Practitioner will support a primary care training programme and establish a process for regular case review with practices.

A new Caregiver Support Coordinator provides support to family/whanau caring for palliative patients by mobilising existing support services and volunteer networks.

Alongside new innovation and new roles the core clinical team positions need development to meet current and future demands.

Our specialist medical workforce is an urgent priority. We do not have a sustainable medical workforce to meet required needs. With increasing complexity of patient and family/whānau needs and population growth we need to plan to increase resources.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

This is not unique to Hawke's Bay. In 2014 the national Palliative Medicine and Training Coordination Committee surveyed District Health Boards and reviewed work force projections for Senior Medical Officer positions. They found 12 Senior Medical Officer positions were vacant and over the next five years to 2019, vacancies due to retirement would increase this to 30.[10.]

The current medical, nursing, allied health, family support workforce is summarised in Appendix 1. Proposed roles and FTEs are described for 2026, to be able to cope with an increased demand for clinical care provision, advice, mentorship, supervision, rural support and education.

Over 50% of our SPC nursing workforce are eligible for retirement in the next 2 to 5 years. In the last few years we have been successful in recruiting for positions, as more nurses are considering palliative care as a speciality. These nurses will need time (2 to 3 years) to specialise and train. As half of our experienced workforce retires in the next 5 years providing support, mentorship and training will be challenging.

We have proposed increases in the nursing workforce to meet the increased need for complex care provision, an increase in inpatient beds at Hospice from 8 to10, increased education and mentorship of primary care providers and training new specialist nursing staff. Staff, services and facilities will respond to the growing numbers of people with dementia and frailty.

To provide a holistic approach to care, SPC has also been growing its family support team and allied health team. This team will almost double to be able to meet demands in the community, especially with increased frailty, the need for a rehabilitative approach and patients living for longer with multiple comorbidities. As interdisciplinary teams develop further with primary care we will improve our communication and systems so we coordinate with new services such as engAGE services for frail older people.

To respond to the needs of the Hawke's Bay population, we will integrate Cranford Hospice and the Hospital Specialist Palliative Care team (HPCT) to form one specialist palliative care service for Hawke's Bay. This integrated service will provide quality clinical care at Cranford Hospice, within the community, and an in-reach consultation liaison service to the Hawke's Bay Fallen Soldiers Memorial Hospital. The service will use the same management support, human resources and clinical guidelines across all care settings. There will be one single point of entry to SPC, and care will be more seamless no matter what bed you are in or which setting that bed is placed in. SPC will be delivered equitably, with greater care coordination and with opportunities for workforce development. There will be rotation of staff across hospice, community and hospital areas.

7. Technology

Care planning conversations need to be effectively recorded and appropriately shared through electronic systems. Electronic systems will need to support wider access to information, extended information context and new functions, such as write access by multiple sources. Access to Advanced Care Plans, pre-emptive charting and crisis plans must be maximised. [19].

8. Evidence and Information

We need to ensure that data and evidence, including people's accounts of their experience of care are used effectively to inform learning, improvement. We will improve the collection, analysis, interpretation and dissemination of data related to palliative and end of life care. This will include evidence relating to needs, provision, activity, indicators and outcomes.[19].

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

1 Each person and their family/whanau will have their individual needs as the centre of care

"On one occasion the hospice nurse arrived after he was discharged from hospital and worked through the discharge summary to make sure we understood the plan"
Wife of patient

What we already know

- People are unique, they want to be listened to, respected and involved in their care.
- People and their family/whānau require care. The needs of all individual members need to be identified and addressed.
- Leaders and care professionals need to be innovative in how they ask, record and work to support choices, particularly with limited resources.
- People, family/ whānau want to be involved in their care. They should be given all the information, advice and support they need to make decisions about it.
- Advance care planning gives everyone a chance to say what is important to them, ahead of time. It helps people understand what the future might hold and to say what treatment they would and would not want. It helps people, their families and healthcare teams plan for the future and end of life care .14.
- Having conversations about death, dying and end of life requires compassion, knowledge, experience, sensitivity and skill on the part of the health professional involved. A series of conversations may be needed to determine the goals, values and wishes of the person and their family/ whānau in order to reach decisions about the appropriate plan of care.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

The building blocks we need in place

Enablers for person centred care

Care must be delivered by systems that are carefully and consciously designed to ensure people retain control and are active participants in their care. Whenever possible care must be respectful of the person's values and preferences **16**.

Access to social support

There is a mix of health, personal and social need at the end of life and afterwards which requires skilled assessment and available resources, delivered in an appropriate environment.

Meaningful conversations

People should have the opportunity to say what's important to them and be well informed about dying, death and bereavement by the right people in the right way at the right time **.14.**

Clear expectations

People and their family/whānau should know what they are entitled to expect as they reach the end of their lives.**15.**

Integrating the philosophy

The philosophy of person centred care is promoted and integrated into models of care across the health and social sectors.

Good end of life care includes bereavement

Caring for the individual includes understanding the need to support the unique set of relationships between family, friends, carers, other loved ones and their community, and includes preparations for loss, grief and bereavement.

2 Each person gets fair access to high quality care

"The hospital palliative care team explained what 'hospice' meant, communication was great. Once this had been explained they were happy to accept a referral"
Consumer feedback

What we already know

- The number of Māori and Pasifika people dying will increase and whilst the numbers are relatively small per annum, the increased incidence of poverty in this population and the barriers to access caused by cultural difference and lack of resources means that they are likely to require more support to achieve equitable outcomes .11.
- We cannot identify and predict when every person will die. The population is ageing and chronic conditions and co-morbidities will increase, making this even more difficult.
- Adults living in Wairoa and Central Hawke's Bay had fewer face to face contacts with SPC than in urban areas. They did not receive a corresponding increase in GP contacts, suggesting an inequity between urban and rural service delivery. 22.
- There is substantial data available regarding the palliative population. This needs to be standardised and used appropriately to identify the needs of the Hawke's Bay population and inform decision making. 23.
- Access to good and early palliative care can improve outcomes, not only with regards to quality of life, but also life expectancy 15; 18
- The way messages relating to the likely outcomes of medical conditions are communicated to people, affect their transition from curative to palliative care and willingness to accept referral to specialist palliative care.
- A public health approach recognises and plans to accommodate those disadvantaged by the economy, including rural and remote populations, tangata whenua, the homeless, lesbian, gay, bisexual, transgender and intersex communities.
- "Until recently, almost all assessments of the quality of palliative care focused on care structures and processes rather than on outcomes. Outcome measures are widely used in palliative care research to describe patient populations or to assess the effectiveness of interventions, but they are not, as yet, always incorporated into routine clinical practice". 2.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

The building blocks we need in place

Person centred outcome measurement

With a consistent data set, improvement can be tracked and action taken to ensure all providers are accountable for enabling fair access to quality care.

Using data

"Well-organised data collection can help us to target different population groups and track their progress towards better outcomes, access and wider goals shared with other agencies. Information we collect can improve our understanding of the cause and effect relationships between health and other social services, the effectiveness of different ways of working, and the value for money offered by different interventions" 13

Unwavering commitment

To achieve equity and access, provision and responsiveness requires unwavering commitment to local contracts and sustainable funding.

Referral criteria

A clear referral process is designed to ensure limited resources are appropriately allocated to serve those most in need. Other barriers to access are proactively evaluated and reduced to ensure an equitable service.

Community partnerships

Local plans should include partnerships between different faith groups and cultural communities, as well as the diverse organisations that support children and young adults, people living with different life shortening illness, and those managing the difficulties of older age.

Population based needs

Palliative care needs for the Hawke's Bay population should inform service design and resource allocation.

3 Comfort and wellbeing maximised

"The hospice doctor was the first to look at my whole picture, she asked "what sort of person are you? Do you want to know anything? She was the first to work with my interest in other therapies"
Patient feedback

What we already know

- What matters most to people at the end of life is good control of pain and other symptoms and being accompanied by but not a burden to their family/whānau. [10].
- People want to be considered as a whole. We need to care for physical, spiritual, family and mental health needs.
- Many people approaching death are fearful of being in pain or distress. Dying and death can be a powerful source of emotional turmoil, social isolation and spiritual or existential distress. [15]
- The experience of dying, and of caring for loved ones at the end of life, can have a deep and lasting impact on those involved. Poor support and inadequate symptom control may mean we fail to meet the needs of those who are dying, as well as those who care for them. This may lead to a complicated bereavement process for those left behind.
- A rehabilitation approach to palliative care is central to the person-centred ethos of hospice care, and promotes a culture that helps patients to thrive, not just survive, when faced with uncertainty and serious illness. [8.]
- "The benefits of this rehabilitative approach are huge, not only for patients and their families but for hospices too, as they seek to respond to the challenges of supporting more people living longer with chronic conditions". [8.]
- Members of the interdisciplinary team offer a diverse range of skills in the provision of emotional, social, psychosocial, cultural, religious and spiritual support, and it is recognised that all team members play a vital role.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

The building blocks we need in place

Recognising distress whatever the cause

"Promptly recognising, acknowledging and working with the person to assess the extent and cause of the distress, and considering together what might be done to address this is important. This must be available in every setting." **15**

Skilled assessment and symptom management

Attending to physical comfort and pain and symptom management is the primary obligation of health professionals at this time of a person's life. Their skills to do so must be assured and kept up to date. **15**

Addressing all forms of distress

The experience of suffering associated with physical symptoms may be caused or made worse by emotional or psychological anguish or social or spiritual distress. Addressing this requires professionals to recognise, understand and work to alleviate the causes.

Priorities for care of the dying person

The delivery of care is respectful, individualised and tailored to the person who is in their last days of life. This includes acknowledgement of physical, spiritual, social, mental and cultural factors important to each individual and their family/whanau. Mechanisms to incorporate these factors into the delivery of care are prioritised as decided by the person, wherever they may be dying.

Specialist palliative care

Specialist palliative care is available to those people whose assessed needs exceed the capability of the primary palliative care provider. Specialist palliative care is responsible for supporting primary palliative care to achieve improved outcomes for patients and their family/whānau.

Rehabilitative palliative care

Rehabilitation aims to improve quality of life by enabling people to be as active and productive as possible, with minimum dependence on others, regardless of life expectancy **8.**

Fit for purpose facility

A suitable, well located facility will ensure that everyone has access to expertise and care. It also provides a hub for community engagement.

4 Care is seamless

"It feels like the nurses are all up with the play, we don't have to repeat the story each time, it quickly felt like they really know us"

Patient feedback

What we already know

- People report not having a clear understanding of the role of the multiple health services involved in their care.
- Feedback indicates that lack of coordinated care and services increases the stress experienced by the patient, their carer/s, family and whānau. The alleviation of this would add significantly to their quality of life.
- People feel supported and safe with 24 hour advice available. The quality of the advice directly influences the level of trust people have with a service as a whole.
- Poor communication and failure to share information about the person who is dying is a recurrent theme when care is not good enough. **15**.
- Primary palliative care professionals, including aged residential care staff report the increased confidence and increased ability to provide quality of care when access to specialist advice is available.
- High quality and well-co-ordinated care at the end of life provides a setting for a healthy experience of death for both family/whānau and the surrounding community. **19.**
- People at the end of life with high levels of health, support and palliative needs require flexible packages of quality home nursing and support services to enable them to die at home, and to support their family and whanau at this time.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

The building blocks we need in place

Systems for shared records

Health records for all people living with a life-limiting condition must include documentation of their assessed needs, as well as their preferences for end of life care. The person must have given their informed consent and the records should be shared electronically with all those involved in their care.

Clear roles and responsibilities

People living with life limiting conditions may have different services involved in their care. It is essential that people and their families know who and where to turn to for advice in times of change or crisis.

A system-wide response

Coordinated services need to be responsive to need in the community. These systems must include enabling dying people and their family/whānau access to 24/7 advice and support.

Continuity in partnership

Communication between service providers and consistent knowledge across settings, facilitates the smooth and timely delivery of quality care.

5 The community is involved

What we already know

- Talking about death, dying and bereavement is avoided in most community groups.
- Many members of the community do not understand what palliative care is.
- People who are dying and bereaved people often feel disconnected or isolated from their communities and networks of support. [15]
- Globally there is much known about helping to nourish compassionate and resilient communities, and how to build capacity to provide practical support. [15]
- Death, dying and loss affect everybody.
- The majority of people living and eventually dying from life-limiting conditions spend the greater part of their time at home being cared for and supported by family members, friends and neighbours.
- Many people feel unprepared when faced with the experiences of life-limiting conditions, death and bereavement and are uncertain about how to offer support and assistance.
- The experience of death, dying and bereavement can bring additional personal, health and social costs to those left behind. Much of this is preventable and/or relievable if the right supports are available in the right place at the right time. [9].
- The use of volunteers maximises community engagement and promotes partnerships between agencies and the community. Volunteers add value to the patient and family experience and complement the work of paid staff.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

The building blocks we need in place

Compassionate and resilient communities

In a compassionate community, people are motivated by compassion to take responsibility for and care for each other with collective benefit.
http://www.charterforcompassion.org/index.php/shareable-community-ideas/what-is-a-compassionate-community

Public awareness

A community will be in the best position to care when they are comfortable with death and dying, can understand the difficulties people face, and know what help is available.

Practical support

Practical support, information and training are needed to enable families, neighbours and community organisations to help.

Volunteers

To meet our commitment, more should be done locally to recruit, train, value and connect volunteers into a more integrated effort to help support people, their family/whanau and communities. **15.**

6 People prepared to care

"People didn't focus on physical symptoms – hospice staff were able to see the whole picture"

Consumer feedback

What we already know

- The recruitment and retention of palliative care medicine specialists in urban and provincial areas is a major issue. 12. This is also an issue for Hawke's Bay. 12.
- We have an ageing specialist palliative care nursing workforce.
- The demand for palliative care services, and thus workforce, will increase slowly over the next ten years but thereafter will increase more rapidly in line with the ageing population. 12.
- There is a growing need for a workforce that is culturally competent to accommodate diverse personal, cultural and spiritual customs and values. 10.
- Feedback suggests that the relationship people have with their GP and practice nurse is extremely important.
- The ageing population and emphasis on integrated care means that home and personal caregiver roles are becoming an increasingly critical part of the palliative care multidisciplinary team.
- Much of palliative care is provided by family members as informal carers. Reliance on informal carers and the volunteer workforce will only increase and we will need to support them to undertake potentially more complex roles. 10.
- A primary palliative care workforce works best when it is well-informed, educated and supported by specialist palliative care in caring for those with life-limiting conditions.
- Specialist palliative care services will need the capability and capacity to be able to provide care, support and educate others to meet projected demands and complexities of care.
- In order to meet identified needs of patients and their family/whanau we need a diverse range of skill and expertise within the interdisciplinary team.
- Staff can only compassionately care when they are cared for themselves. They must be supported to sustain their compassion so that they can remain resilient. This allows them to use their empathy and apply their professional values every time. 15.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

The building blocks we need in place

Knowledge base

Only well-trained competent and confident staff can bring professionalism, compassion and skill to the most difficult, and intensely delicate, physical and psychological caring. **15**

Support and resilience

Dealing with death and dying can be challenging. The potential impact of providing end of life care should not be minimised by clinicians, the team or the health service. **1.**

Sustainable workforce

A sufficient formal and informal workforce is needed to provide the necessary hands-on support, advice and education, now and into the future.

Using technology

Professionals have to adapt to new ways of learning and interacting with the people that they are supporting and they need help and guidance to do so. Technology can also play a significant role in enhancing professional's self-directed learning and development. **15**.

Clinical governance

Specialist and primary palliative care services will lead and co-ordinate a single system of care.

HOW WE PLAN TO STRENGTHEN OUR FOUNDATIONS AND MEET OUR PRIORITIES

OUR PRIORITIES

Each person and their family/whānau will have their individual needs as the centre of care

Enablers for person centred care	Access to social support	Meaningful conversations	Clear expectations	Integrating the philosophy	Bereavement Support

Each person gets fair access to high quality care

Using data	Unwavering commitment	Person centred outcome measurement	Population based needs	Referral criteria	Community partnerships

Comfort and wellbeing is maximised

Recognising distress	Skilled assessment & symptom management	Priorities for care of the dying person	Addressing all forms of distress	Specialist palliative care	Rehabilitative palliative care	Fit for Purpose Facility

Care is seamless

Systems for shared records	Clear roles and responsibilities	System-wide response	Continuity in partnership

The community is involved

Compassionate communities	Public awareness	Practical support	Volunteers

All staff are prepared to care

Knowledge base	Support and resilience	Using technology	Sustainable workforce	Clinical governance

ACTIONS REQUIRED

- Patients and family members know where to go for palliative care and are connected to services
- Information, education and visibility in the community on innovative ways to increase awareness and community culture around death and dying.
- Health and support workforce is skilled and informed to be able to support conversations around death and dying.
- Integration of Cranford Hospice and Hospital Palliative Care Team to form one specialist palliative care service.
- Specialist medical workforce developed to meet minimum recommended requirements.
- Training and supervision systems in place to support the development of SPC workforce.
- Confirm sustainable and responsive after hours primary palliative care arrangements
- Specialist palliative care provide education and support the efforts of primary palliative care providers in delivering patient care.
- Develop and expand nurse-led initiatives and expert roles such as the Nurse Practitioner.
- Last Days of Life (Te Ara Whakapiri) Pathway is developed and implemented across the region.
- Increase the role and size of the allied health and family support services.
- Research and evaluation outcomes are used to inform best practice.
- New purpose built facility for specialist palliative care. Increase from 8 to 10 inpatient beds as per recommendations (MOH 2013).
- Information technology systems accessible across primary and specialist settings. Palcare or other system.
- Look for opportunities to expand volunteer and informal support services in the community.
- Continued involvement in national data work – to develop measurable patient outcomes.
- Implementation of a rehabilitative approach to palliative care.

OUTCOME MEASUREMENTS

1. Increase in satisfaction with care by family members surveyed after death using a standard questionnaire relating to comfort and wellbeing. Measure baseline then increase by x to y by 2026.
2. National palliative care outcome measures are implemented and used for data collection and evaluation by 31 December 2017.
3. 95% of referrals to specialist palliative are accepted, reflecting appropriateness.
4. 70% of GP practice have access to the electronic patient management system Palcare by 1 July, 2018 and 70% of hospital by 1 July 2021.
5. Monitor access to SPC compared to our population profile & then adapt services to respond:
   - Death by ethnicity in HB.
   - Access by area reflects deaths in each area.
   - Access by condition reflects deaths by condition.
6. The proportion of people dying in their preferred setting will be 90% by 31 December, 2018.
   - The proportion of people dying in hospital will decrease by one third from 34% to 21% by 31 December 2018
7. 100% of aged residential care facilities and hospital wards have implemented the Last Days of Life Care (Te Ara Whakapiri) Plan supported by Specialist Palliative Care services.
8. People with palliative care needs living in aged residential care facilities have care plans reflecting individual needs and best practice via documentation peer review.
9. New SPC facility built by 31 December 2019.
10. One specialist palliative care team for Hawkes Bay providing hospice, community and hospital in-reach consultation-liaison services by 1 July 2018
11. 20% nursing staff under the age of 50 by 2021.
12. Increase the proportion of Maori nurses to reflect the population in Hawke's Bay from 8% to 24 by 2026.
13. SPC FTE medical staff increased from 3.2 to 6.4 by 31 December 2018

FOUNDATIONS

Patient, whānau and community voice	Cultural responsiveness	Education and training	Leadership	24/7 access	Sustainable specialist palliative care service	Evidence and information	Technology

14.1

Appendix 1

Table 1: Current & Proposed Medical Workforce

Role 2016	Full Time Equivalent (FTE)	Proposed Roles 2026	Full Time Equivalent (FTE)
Palliative medicine specialist (Hospital 0.5; Hospice 0.5)	1.0	Palliative medicine specialist	2.0
Medical officer special scale Advanced trainee (currently in Hospital)	1.8 0.4	Medical officer special scale or GP with special interest, or advanced trainee or registrar physician training. (Covering community, hospice inpatient unit and hospital services)	3.0
		House officer trainee Hospital & Hospice	1.0
Medical Director	0.4	Medical Director	0.4
TOTAL	**3.6**		**6.4**

This FTE does not include 30% non-clinical time as per contracts or leave requirements.

Table 2: Current & Proposed Nursing Workforce

Roles 2016	Full Time Equivalent (FTE)	Proposed Roles 2026	Full Time Equivalent (FTE)
Nurse Practitioner Candidate	0.9	Nurse Practitioner	0.9
Clinical Nurse Specialists Hospital 2.0; Hospice 2.8	4.8	Clinical Nurse Specialists Hospital 2.0; Hospice 3.0	5.0
Aged Care Liaison Nurses	1.2	Aged Care Clinical Nurse Specialist	2.0
Registered Nurses inpatient unit and community nurses	18.2	Registered Nurses inpatient unit and community nurses, new graduate position	21.8
Education	0.5	Education	2.0
	0.8	Enrolled Nurse	0.8
		Health care assistants	3.0
TOTAL	**26.4**		**35.5**

Table 3: Current & Proposed Allied Health & Family Support Workforce

Roles 2016	Full Time Equivalent (FTE)	Proposed Roles 2026	Full Time Equivalent (FTE)
Counsellor	1.0	Counsellor	2.0
Social Worker	1.0	Social Worker	2.0
Pastoral Care	0.8	Pastoral Care	1.0
Carer Support Coordinator	1.0	Carer Support Coordinator	1.6
Music Therapist	0.4	Music Therapist	0.6
Kaitakawaenga	0.8	Kaitakawaenga	1.0
Cultural Advisor	0.2	Cultural Advisor	0.2
Pharmacist	0.5	Pharmacist	0.8
Occupational Therapist	0.6	Occupational Therapist	1.0
		Physiotherapist	1.0
TOTAL	**6.3**		**11.2**

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Consumer feedback 2015 – 2016

This information is from written and verbal feedback. Quotes are adapted to maintain confidentiality

PRIMARY PALLIATIVE CARE

Almost all mentioned their GP – always expressed strongly, whether good or bad This is a very important relationship. Majority spoke positively about their GP, the sense of support, advocacy and availability. Practice nurses mentioned occasionally, positive addition to sense of support.
Criticisms related to communication:
- of prognosis and introduction of the idea of referral to Hospice
- availability, the need to be able to access as needed and not to have to see other GPs who don't know them
- concentration on physical / medical needs of the patient

SECONDARY PALLIATIVE CARE

Some people reported satisfaction with the service they were provided if/when admitted. Of those that met with the HPCT, all but one was positive and the communication provided relief and more confidence and understanding of hospice.
Several negative experiences expressed of communication from specialists / doctors regarding diagnosis and prognosis. These were all expressed with quite a bit of emotion. Mostly related to 'abruptness' or suddenness of the message. Some felt that this was even "rude" and left them with negative feelings including an inability to ask questions. Many left not knowing what 'palliative care' was and afraid to accept the referral.
Many felt the doctors at the hospital were only interested in one aspect of them and this was a barrier to quality care.

I can tell my GP anything, she is a great advocate

It is hard to get the same GP so we have to "start again" each time - this stopped us talking about Long Term Care like we wanted to. GP is there for/focuses on "medical matters"

My out-patient appointment made all the difference, they linked everything together

When we ask for a visit – the response is always "yip, no problem"

The Hospital Palliative Care Team explained what 'hospice' meant, communication was great. Once this had been explained they were happy to accept referral

When they decide they can't do anything medically for you, you are off on your own, they don't want to know you….

Cranford people are non-intrusive; responsive and great for advice

The doctor was the first to look at the "whole picture"

SPECIALIST PALLIATIVE CARE

The majority of those visited described having strong beliefs about Hospice as a 'place to die' and were unhappy about the referral, some saying that this meant they refused referral initially and later regretted this once they learned what it is really about.
All felt that Cranford Hospice staff were great and there were no complaints or criticism about this. Often people felt supported and safe with the 24 hour advice available.
People didn't focus on physical symptoms – most were more interested in talking about the general feeling of psychosocial support and several mentioned that the Hospice staff were able to see the 'whole picture'.
Actually coming into the Hospice building for an appointment was universally a positive experience and reduced fears / barriers to accepting admission if needed.
People talked about the need to keep 'living' and things like vague appointment times were interruptions to that.

HAWKE'S BAY District Health Board Whakawāteatia	**Travel Plan Update**
	For the attention of: **Māori Relationship Board, Clinical and Consumer Council**
Document Owner: Document Author(s):	Sharon Mason (Chief Operating Officer) Andrea Beattie (Property and Service Contracts Manager)
Reviewed by:	Executive Management Team
Month:	November, 2016
Consideration:	For Information

15

RECOMMENDATION

That MRB, Clinical and Consumer Council:

Note the contents of the report

OVERVIEW

The purpose of this report is to provide an update on progress since the previous update in August 2016.

UPDATE

In early September the first of the Go Well personnel started with HBDHB. This means there is now a dedicated and focussed resource to drive the implementation of the travel plan.

Engagement with the working groups and other staff stakeholders has continued with regular meetings taking place. A representative of Sport Hawke's Bay has now joined the working group.

A Go Well update was presented to staff including a few external stakeholders at the monthly Transform and Sustain seminar in October.

Bus Services

On 26 September, new and improved bus services commenced. Our partnership with Hawke's Bay Regional Council means our communications teams are working closely around developing messaging and promoting these services.

A proposal is currently in development around extending free bus transport for patients, and will be presented to the travel plan steering group in November.

Parking Management Controls

The request for proposals process to identify appropriate and suitable parking management control equipment closed in late September. After completing evaluations and vendor interviews a preferred vendor has been selected. The parking controls team has elected to implement the parking controls in a phased manner, commencing with pay and display equipment, with considering being given to adding barrier arms to some parking areas in future.

Parking Improvements

A new car park with approx. 40 parks in currently being constructed beside the Diabetes Service off McLeod Street.

The proposed car park remarking and signage updates are currently being finalised and we expect work to start on this shortly.

Cycling

A number of new cycle stands are now in place, and planning has commenced around the construction of a second secure bike store on the Hospital site.

Discussions are also underway with our landlord about providing a secure bike store for our corporate office staff.

HAWKE'S BAY District Health Board Whakawāteatia	**Orthopaedic Review – Closure of Phase 1**
	For the attention of: **Māori Relationship Board, HB Clinical Council and HB Health Consumer Council**
Document Owner: Document Author(s):	Andy Phillips and Sharon Mason Carina Burgess and Andy Phillips
Reviewed by:	Executive Management Team
Month:	November 2016
Consideration:	For Information

RECOMMENDATION

That Māori Relationship Board and Clinical and Consumer Councils:

- Note the progress to date in the Orthopaedic Review and the Closure of the First Phase.

16

PURPOSE

This paper gives a brief overview of the work that has been carried out to redesign Musculoskeletal and Orthopaedic Services and notes the closure of the first phase.

OVERVIEW

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

This paper describes the first phase of work to review and fundamentally redesign musculoskeletal and orthopaedic services to meet the needs of people in our community.

Initial work demonstrated the lack of threshold setting for surgical candidature and inconsistencies with prioritisation between surgeons, and delays experienced by patients along the pathway from referral to surgery. These concerns were focussed on hip and knee conditions joints but public feedback, staff concerns and workforce planning also highlighted the back, spine and acute orthopaedic pathways as other areas for review and redesign.

The redesign of Musculoskeletal and Orthopaedic services was set out in three phases. The first phase, now complete involved increasing surgical capacity and making conservative treatment options available. The second phase will involve the co-design of a long term plan to effectively manage demand and align capacity over two to five years. The third phase will address 'third horizon' issues over ten years that will require innovative approaches.

In 2015 a project was initiated to review Orthopaedic Services. The objective of the project was to reduce pain and disability to patients in our community from musculoskeletal conditions by reviewing and co-designing musculoskeletal services. A paper outlining the programme and actions for Phase One was presented to Clinical Council and the Board resulting in funding being approved for additional surgical capacity and a non-surgical intervention programme. The initiatives completed in the first phase included:

- Implementing non-surgical treatment options by increasing physiotherapy and other allied health resource.
- Implementing a new pathway for back pain patients offering an alternative non-surgical treatment option.
- Improved patient communication and collaborative services within the DHB.
- Reducing wait times throughout the pathway.
- Setting thresholds for surgery based on data for orthopaedic scoring and Oxford score.
- Increasing surgical capacity to deliver on the major joint replacement target.

Non-surgical Treatment Programme

Non-surgical assessment and treatment is now being provided by physiotherapists for those being referred to the orthopaedic department for hip, knee or back pain. Following assessment, patients who do not meet the threshold for surgery and/or those who are assessed as being likely to benefit from non-surgical interventions are offered physiotherapy or other allied health treatment and management.

1. Spine Clinic

The spine clinic delivered by Advanced Practitioner Physiotherapists was launched on 15th February 2016. Since then, there have been 333 referrals, 171 directly to the clinic and 162 were originally referred to Orthopaedic FSA by their GP and were redirected to the Physio Spine Clinic. All of these patients had complex worsening symptoms lasting between six months and forty years with average duration of eighteen months. Many had previous spinal surgery. A proportion of these are still undergoing treatment but discharge data has been collected for 50% of the referrals.

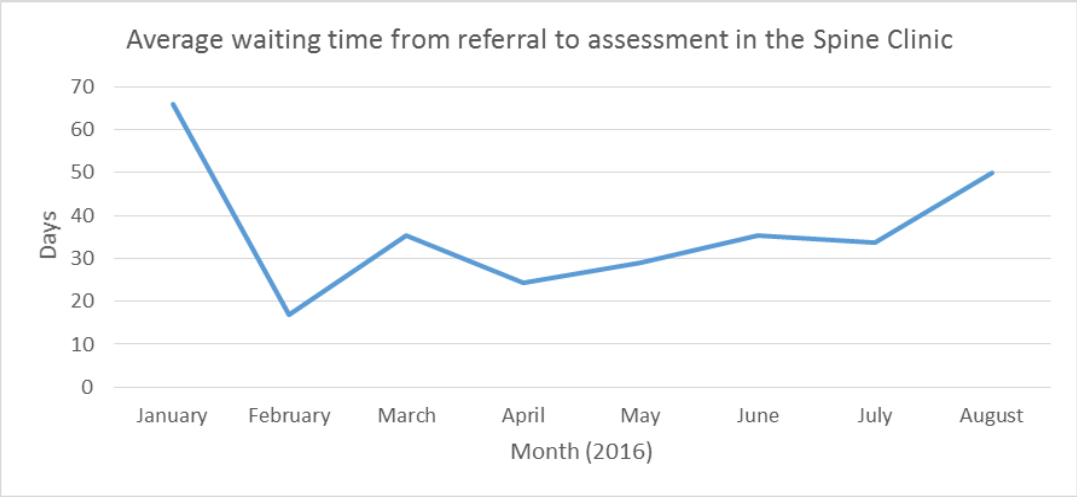
Total Referrals all sources	Discharge Data collected		Discharge Outcomes			
		Fully resolved or minimal signs and symptoms	Managing symptoms successfully	Did not access of did not complete	Inappropriate referral – discharge or referred on	Referred to FSA
333	165 (50%)	43%	18%	23%	3%	14%

Of the 162 patients originally referred to Orthopaedic FSA by their GP and redirected to the Physio Spine Clinic for assessment and treatment, only 14% were referred back to Orthopaedic clinics.

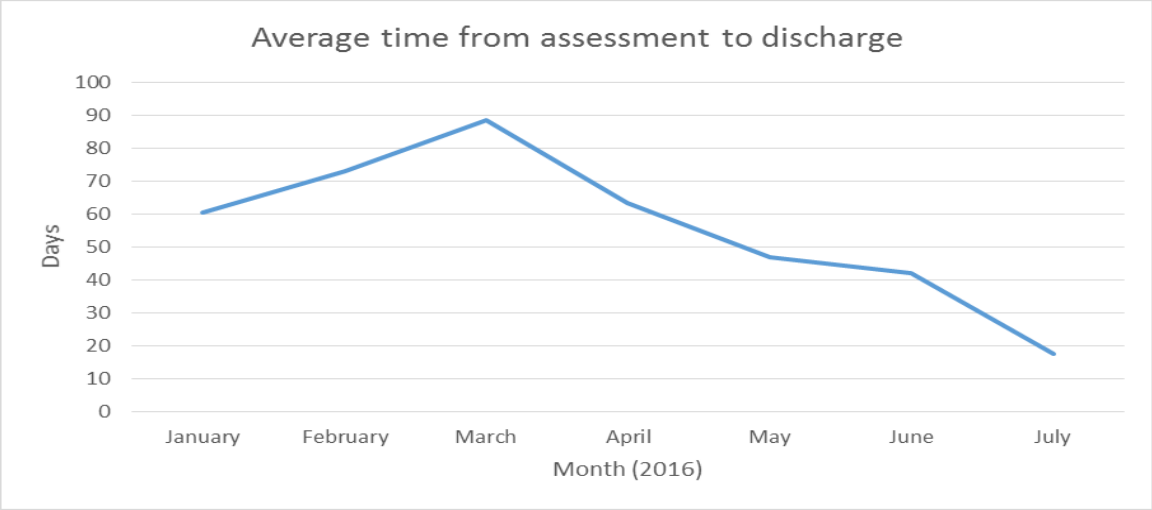
Intercepted FSA referrals	Discharge Data collected	Discharge Outcomes		% of patients 'Highly Satisfied' with the service
		Managed within the spine clinic	Referred back to FSA	
162	97	86%	14%	93%

Of the patients seen in Spine clinic, 76% had improvement in symptoms, 20% had no change whilst one patient had worsening of symptoms and was referred for Orthopaedic treatment.

Access and Timeliness:



The waiting time from referral to assessment had increased as the number of referrals to the clinic is increasing. GPs are now referring directly to the clinic.



With two advanced practice therapists now in post, patients are being followed up and discharged more promptly. One therapist is averaging three treatments per referral and the other four treatments per referral.

The clinic is primarily based in Hastings, and 94% of assessments have been carried out in Hastings, 4% in Napier and 1% in Waipukarau.

Patient Outcomes:

New outcome measuring tools were researched, trialled and developed over the six month period. New reports generated in August 2016 include percentage change data and client satisfaction recording. The data from these reports below show an improvement across all outcome areas – reduced pain, and increased function and self-management. The results also show a reduction in the STarT back score which is a measure of the risk factors for back pain disability. Of the 33 discharged patients using the new outcomes tool, 73% scored 10/10 on the patient satisfaction score.

Patient based average outcome scores (discharged patients)			
Average Reduction in Pain % change	**Average Improvement in Function % change**	**Average Improvement in self-management Ability % change**	**Average Improvement in STarT back score % change**
23.6%	12.5%	30.0%	14.8%

Patient Satisfaction score	**Frequency %**
1-5 Low	0
6	3
7	3
8	15
9	6
10 High	73

Communication and Education:

The spinal clinic has been promoted through letters to GPs and information pamphlets. GPs are now referring directly to the spine clinic rather than to FSA. Attendance is improving as patients are now better informed of the clinic and assessment process and are therefore willing to engage.

A number of resources have been made available such as back facts booklets, education packs for all referrers and an education tool which is widely available in GP practices and the community.

2. Hip and Knee Pathway

In March 2016 funding was made available to:

1. Expand the hip/knee scoring clinic to allow 6 and 12 month rescore by physiotherapist.
2. Establish multi-disciplinary education and exercise programme (MEEP) team to provide treatment to patients who had not met criteria for FSA and therefore had been declined hip/knee joint replacement surgery.

The aims were to provide treatment to:

- Improve patient satisfaction around arthritis surgical process.
- Increase self-management through greater patient knowledge of arthritis and utilisation of medications.
- Slow clinical decline of joints through better muscle strength/ posture.
- Support patients with activities of daily living through access to equipment.

FTE was provided primarily for physiotherapy to lead the programme of multi-disciplinary education and exercise [MEEP] and be the major speaker. Occupational Therapy, Social Work and Pharmacy disciplines each gained 0.3 FTE to provide educational segments of sessions.

Following early piloting of group programmes that was not successful, a change was made to individualised treatment and education provided by the physiotherapist alone, who had the ability to refer to other discipline as required.

The physiotherapist works with patients individually covering education topics of all the disciplines along with specific training in posture, gait, and muscle strengthening. Strengthening was provided as home programme along with access to supervised gym and/ or gym sessions.

Outcomes:

- Patients now have 6-12 month re-scoring to ensure they can access orthopaedic specialist appointment if required, rather than being referred back to Primary Care.
- The wait time for physiotherapy assessment has reduced to ten days from the previous 4-12 weeks.
- Patients report significant satisfaction in having access to gym and pool session in a safe environment which fits their level of activity, and where they gain individualised physiotherapist guidance.
- Arthritis New Zealand now use the pool after hours and this provides a community link to which patients can transition.

Individualised treatment and education format 17 June to 30 September 2016:

- 105 patients attended 188 individual sessions.

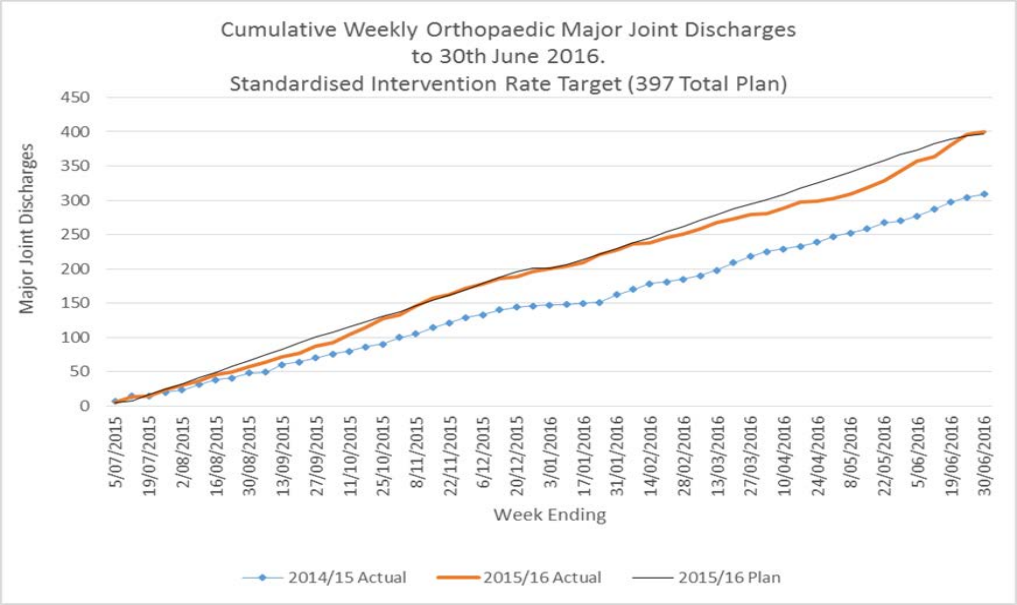
Areas for development:

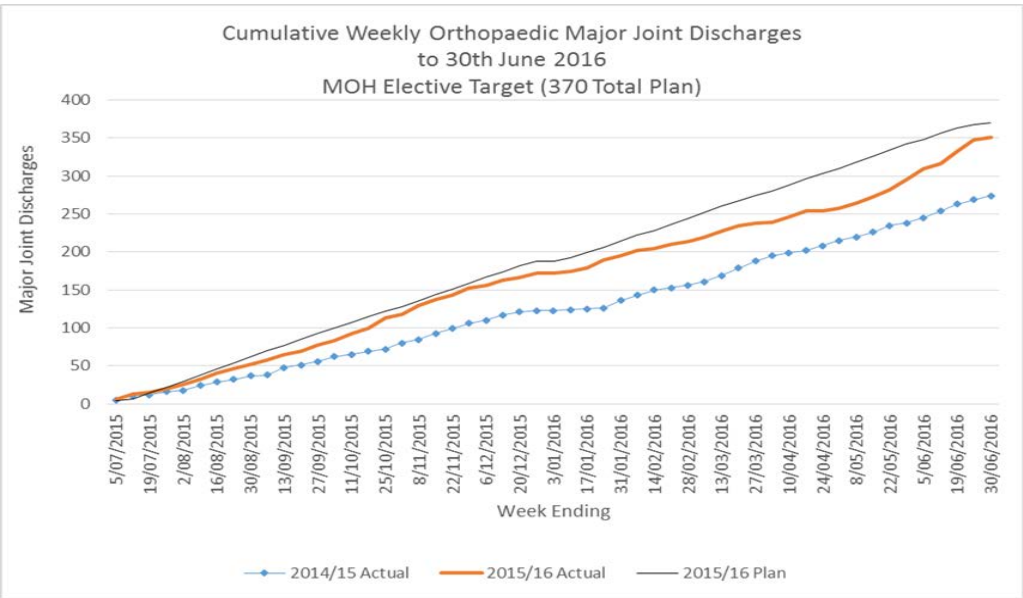
- There will be a focus on making clinics more accessible across Hawke's Bay, especially in Wairoa and Waipukarau.
- A triage tool and referral pathway has been developed using the StarT Back Tool, Keele University. This will be rolled out within the DHB and in the community to educate on when to refer to limit unnecessary referrals. Examples of when this will most useful are:
  - Use in ED to limit hospital admissions.
  - Use by HBDHB staff in ENGAGE, ORBIT, and prior to internal referrals.
  - Triage by general practitioners.
- Professional development of at least one new staff member to up skill over the next year to work within the clinic.
- Provide opportunities for current advanced practitioners to share data and success stories to support HBDHB initiatives nationally and internationally.

- Investigation of potential for physiotherapists to treat patients currently treated by radiologists with image guided injection of joints.
- Implementation of shoulder pathway.

Surgical Capacity

In 2015/16 there were 91 additional Orthopaedic Major Joint Replacement discharges than in 2014/15. The standardised intervention target of 397 was met as we delivered 400 discharges in the year. The elective target however was not met as only 351 of the 400 were elective surgeries (target 370) and the remaining were acute. We ended the year at 94.9%.





Outsourcing was required throughout the year. Fifty surgeries were outsourced to Royston and the majority of these occurred in the last three months. Going forward, outsourcing will be more planned.

Following an External Review of Orthopaedics the business case for an 8th orthopaedic surgeon has been approved and is being recruited to.

Additional orthopaedic surgical acute lists on a Sunday commenced on 23 October 2016 and have been evaluated as a success.

System Changes – Referral to Discharge

During the initial stages of the project it was determined that there were many delays in the process from referral to discharge. Many of these have been resolved and others are being addressed through the National Patient Flow (NPF) project which is targeted at orthopaedics and other surgical specialties. We have worked with the NPF project team to develop a referral pathway for effective data capture.

Patient Experience

Patient letters have been rewritten so that they are more informative and better explain the process. These have been developed in conjunction with the Consumer Engagement Manager. In the hip and knee pathway, following scoring, there is a set threshold for FSA. If the threshold is not met the decline is immediate rather than waiting three weeks which is what was happening previously.

Mobility Action Programme

The Ministry of Health is investing $6million over three years to improve diagnosis and treatment for people with musculoskeletal health conditions. The focus is on early intervention, community based, multidisciplinary community services.

HBDHB, with Health Hawke's Bay and Iron Māori, were successful in securing $380,000 of this funding to deliver the Mobility Action Programme. The proposal was based on a Whānau Ora, community model to improve access to services for people in high deprivation areas. The service offers walk in clinics located in targeted communities for early intervention to reduce pain and disability and support people to remain in work and live independently. Iron Māori will act as the hub of the Mobility Action Programme coordinating services from Community Physiotherapists, Mananui lifestyle collective and Long Term Conditions Programme (Stanford Model).

Co-designed Clinical Pathways

A Hip and Knee osteoarthritis clinical pathway was developed in early stages of the clinical pathways work. This pathway was published but not socialised. In the second phase of the programme a new pathway will be co-designed by consumer groups, NGOs and staff from November 2016.

Outstanding Issues for Resolution from the First Phase

Whereas additional funding of $60,000 was agreed for Coordinated Primary Options work, this has not eventuated. This funding was granted to support a GP with Special Interest in muscular skeletal treatment to provide additional management and treatment including joint injections for patients who had completed physiotherapy treatment and been referred for Orthopaedic FSA but declined for surgery due to not meeting the threshold. This service will be implemented once the GPSI is in post.

HAWKE'S BAY District Health Board Whakawāteatia	**Regional Tobacco Strategy for Hawke's Bay, 2015–2020 update**
	For the attention of: **Māori Relationship Board, HB Clinical and HB Health Consumer Council**
Document Owner: Document Author(s):	Caroline McElnay, Director Population Health Shari Tidswell, Team Leader/Population Health Advisor Johanna Wilson, Acting Smokefree Programme Manager
Reviewed by:	Exeuctive Management Team
Month:	November 2016
Consideration:	For information

17

RECOMMENDATION:

That the Māori Relationship Board, Clinical and Consumer Council:

Note the contents of this report.

OVERVIEW

In November 2015 the Regional Tobacco Strategy for Hawke's Bay, 2015–2020 was endorsed by the HBDHB Board with a yearly report to be provided to the Board and Committees. This is the first annual update of the Strategy with particular focus on progress towards the three objectives through monitoring of the six key indicators:

Indicator 1a: Smoking prevalence (particularly Māori)
Indicator 1b: Smoking prevalence in pregnant women (particularly Māori women)
Indicator 1c: Lung Cancer Incidence
Indicator 2a: Prevalence of Year 10 students who have never smoking (particularly Māori students)
Indicator 2b: Prevalence of Year 10 students living with one or more parent who smokes (particularly Māori students
Indicator 3a: Number of tobacco free retailers

BACKGROUND

The Health Equity Report 2014 identified tobacco use as the single biggest underlying cause of inequity of death rates and ill-health in Hawke's Bay[1]. Smoking is still more prevalent for Māori than any other ethnic group in New Zealand[2] and is more common in areas with a significant Māori population and in areas of deprivation. Pregnant women who are Māori or who live in a Quintile 5 area are five more times more likely to be smokers than non-Māori or women living in a Quintile 1 area[3].

[1] McElnay C 2014. Health inEquity in Hawke's Bay. Hawke's Bay District Health Board.
[2] Ministry of Health. 2011. Māori Smoking and Tobacco Use 2011. Wellington. Ministry of Health.
[3] McElnay C 2016. Health Equity in Hawke's Bay. Hawke's Bay District Health Board

While rates of tobacco use have declined over the years, the decrease for Māori in particular is not sufficient to reach equity nor to reach the national 2025 Smokefree target of smoking prevalence being less than 5%.

The Regional Tobacco Strategy for Hawke's Bay 2015-2020 goal is for communities in Hawke's Bay to be smokefree/auahi kore – with Hawke's Bay whānau enjoying a tobacco free life. The Strategy has a strong commitment to reducing the social and health inequities associated with tobacco use and has three objectives:

- Cessation – help people stop smoking
- Prevention – preventing smoking uptake by creating an environment where young people choose not to smoke
- Protection - creating smokefree environments

The main source of information on smoking rates comes from the NZ Census but this will not be updated until 2018. The Ministry of Health funded ASH (Action on Smoking and Health) year 10 tobacco use survey and we have preliminary results for 2015. This survey is an annual questionnaire of approximately 30,000 students from across New Zealand. It is conducted in schools throughout the country and is one of the biggest surveys of its kind. It provides valuable and robust insight into rates of youth smoking. HBDHB also collect smoking data on pregnant women engaging with our services, this included over 90% of women giving birth. We are able to report the data quarterly.

WHAT'S HAPPENED IN ONE YEAR?

OBJECTIVE 1: HELPING PEOPLE TO STOP SMOKING

Te Haa Matea (Stop Smoking Services, Hawke's Bay)

At the same time HBDHB adopted the Tobacco Strategy, the Ministry of Health announced the end of 32 Aukāti Kai Paipa services and six national smokefree advocacy groups at 30 June 2016. The formation of 16 regional Stop Smoking Services and one national smokefree advocacy group commenced on 1 July 2016. Hawke's Bay is fortunate to have one of the regional Stop Smoking Services. Te Haa Matea is a partnership between Te Taiwhenua o Heretaunga (Lead), Te Kupenga Hauora o Ahuriri, Choices Kahungunu Health Services and HBDHB. Te Haa Matea's mission is to help whānau stop smoking and 'breathe easy'. One of the goals of Te Haa Matea is to support and encourage 1,337 Hawke's Bay residents to stop smoking (and stay stopped) each year until 2025. Of these, 39% (516 per annum) will need to be Māori[4].

HBDHB are contributing specifically to Te Haa Matea outcomes by providing project management for the development of the new service, cessation services in Wairoa, providing cessation programmes for pregnant women and providing support for workplace cessation programmes. HBDHB also provides leadership for the Smokefree Coalition which coordinates and delivers health promotion activity.

Choices Kahungunu Health Services and HBDHB have been running a successful Increasing Smokefree Pregnancy Programme (ISSP) with Wāhine Hapū since 2014. ISSP is set to expand to all partners of Te Haa Matea, providing wider coverage with more resources and greater access for pregnant women. The resources include nappy incentives to Wāhine Hapu who can validate being smokefree at weeks 1, 4, 8 and 12. Whānau who live in the same household will receive food vouchers to the value of $30.00 if they can validate being smokefree at weeks 1, 4, 8, and 12. This is creating a smokefree environment for the new baby and whānau.

Te Haa Matea cessation support has expanded to include smokefree clinics in workplaces i.e. Trade and Commerce (Rangatahi and Young Adults), Silver Fern Farms in Central Hawke's Bay, Tumu Timbers in Hastings and Lighthouse / Wit in both Napier and Hastings.

[4] HBDHB. Tobacco Control Plan 2015 – 2018.

Rates of Smoking for Māori Women Remain High

Assisting women to stop smoking remains a priority. For Māori women giving birth this year, 37.6% were smokers (2016 data for women giving birth in HBDHB services). A review of the Smokefree Pregnancy Programme in 2015 recommended early engagement at confirmation of pregnancy is necessary to give brief advice and offer cessation support. Most Wāhine Hapū get confirmation of pregnancy from their general practitioner. A suite of Wāhine Hapū resources has been developed to remind GPs to conduct ABC with Wāhine Hapū and refer her onto ISPP as soon as possible. The distribution of Wāhine Hapū resources will occur at the same time as the Maternity "Early Engagement" project, whereby a collaboration approach between Maternity and the Smokefree Team will talk with all GPs in the Hawke's Bay region over the next six months.

HBDHB have funded Directions Youth Health Service to develop and deliver a programme to support young Māori wāhine to remain smokefree, working with year 8, 9 and 10 students to co-design the programme. In addition the Smokefree Team's Māori Support Worker is using a range of support tools including FaceBook to promote smokefree lifestyle before pregnancy. Having smokefree wāhine is critical in reducing smoking during pregnancy and reducing smoking rates.

Smokefree Education, Training, Cessation Support

The Smokefree Team continues to support primary and secondary care clinicians with: -

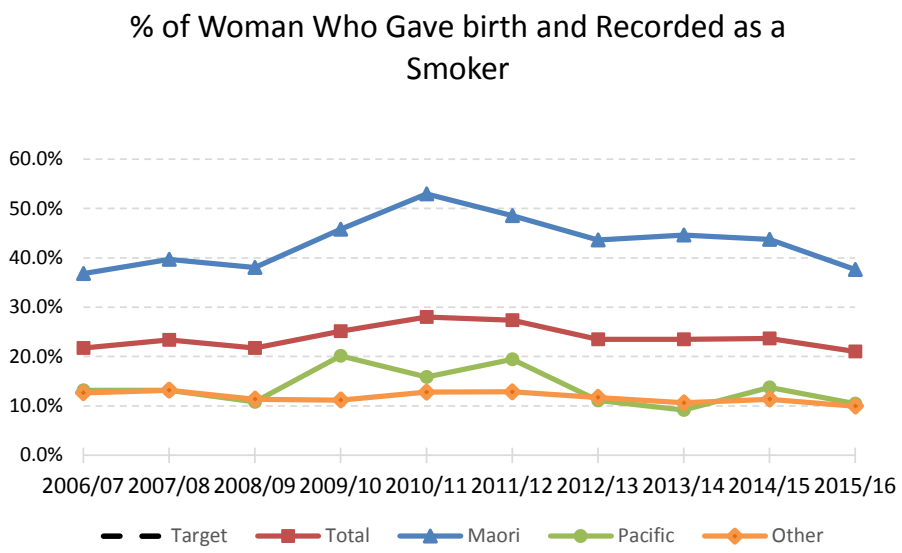
- Understanding Nicotine Replacement Therapy (NRT) medicines
- How to chart NRT for patients
- How to complete Quit Cards
- Confidence in NRT conversations and
- Completing the "Helping People Stop Smoking" Ministry of Health training.

17

This year, the above mentioned training was extended to clinical staff at Royston Hospital and Te Taiwhenua o Heretaunga. We will continue to provide smokefree education and training in clinical and community settings.

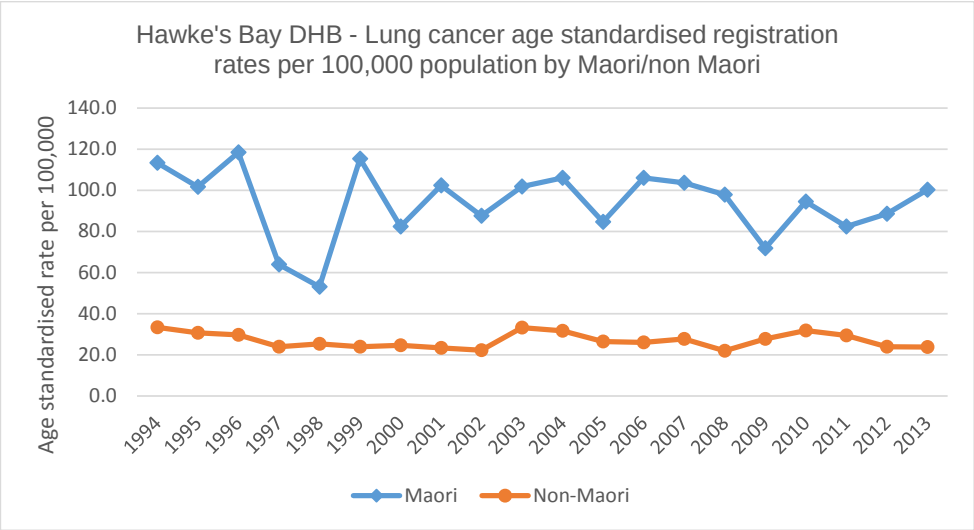
Indicator 1a: Smoking prevalence (particularly Maori)
No update on prevalence until 2018 census. Current data has smoking rates at 18% for non-Māori and 47.4% for Māori in Hawke's Bay. Please refer to the HB Tobacco Strategy for details.

Indicator 1b: Smoking prevalence in pregnant women (particularly Maori women)
The data below provides a time series from 2007 to June 2016 and illustrates a decrease in smoking rates for pregnant women from 2011. There is a significant reduction between 2015 to 2016 from 23.7% to 21% with the reduction of Māori women even greater from 43.7% to 37.6%. The delivery of the ISPP, greater engagement in healthy lifestyles programme (i.e. Maternal Nutrition), increases in the price of cigarettes and increased education/awareness have all contributed to this improvement.



Indicator 1c: Lung Cancer Incidence

Overall rates for lung cancer continues to decline slowly from 54 per 100,000 in 2004 to 31 in 2013, reflecting the reduction in the smoking population. However, the gap between Māori and non-Māori remains. This reflects the higher prevalence of smoking for Māori in Hawke's Bay.



OBJECTIVE 2: PREVENTING SMOKING UPTAKE

Young people who smoke may acquire the habit and become addicted before reaching adulthood, making them less able to quit smoking and more likely to have a tobacco-related health problem.

Te Haa Matea provide smokefree clinics and education in workplace settings, trade training establishments and teen parent units to target young people. These include Tumu Timbers, Silver Fern Farms (CHB), Wit/Lighthouse, EIT Hawke's Bay, Trade and Commerce and both Teen Parent Schools. The Smokefree Team's Māori Support Worker is working with rangitahi as outlined above.

Indicator 2a: Prevalence of Year 10 students who have never smoked (particularly Maori students)
The annual ASH survey shows that there has been a gradual increase in the number of Māori students who have never smoked. The percentage of all Māori year 10 students across New Zealand who never smoked was 16.2% in 2000 increasing to 59.2% in 2015. In 2015, Hawke's Bay noted 73% of year 10s, 54.33% of Māori year 10s and 50.95% of Māori wahine year 10s have never smoked.

This is a significant improvement. Anecdotally we are told that price increases were a major contributor with "family and friends not supplying young people due to the cost". This social supply remains the leading source of tobacco for this age group.

Indicator 2b: Prevalence of Year 10 students living with one or more parent who smokes
This information is sourced from the census so will not be available until 2018.

OBJECTIVE 3: CREATING SMOKEFREE ENVIRONMENTS

Hawke's Bay DHB continues to visit all retailers at least once a year to deliver reminders on the legislative requirements, encourage a smokefree policy and check compliance. A review of the Controlled Purchase Operations was completed this year and retailer education increased with the delivery of national resources.

A second visit by a Population Health Advisor or Smokefree Health Promoter is to encourage retailers to not sell tobacco. Three retailers located in Napier, Putorino and Wairoa become tobacco-free in the past year. Two articles were published in local newspapers that promoted retailers becoming tobacco free; "Hawke's Bay Retailers Care about Our Kids and Whānau".

An increase in burglaries at dairies and retail outlets has become a concern with cigarettes and cash targeted. Visits to all retailers located in Napier and Hastings during August and September 2016 confirmed this but did not provoke any retailer to not sell tobacco. Comments below are from three dairies who were burgled.

Support Legislation and Policy Change for Smokefree Environment

As a member of the HB Smokefree Coalition, HBDHB supported a coordinated submission to the joint Council Smokefree Policy (Napier and Hastings). Feedback from the joint committee reviewing submissions was that the information and constructive approach used in the submission was instrumental in achieving the changes to the policy. The new policy has extended smokefree environments to include bus stops, frontages of Council building, cafes and wider coverage in parks. HBDHB have supported awareness raising for these changes including signage and advertising.

Submissions on plain packaging and e-cigarettes aim to influence law change to further discourage smoking by reducing advertising and brand power, also providing other cessation support opportunities.

Indicator 3a: Number of Tobacco Free Retailers

In the past year, three retailers have stopped selling tobacco, which is a reduction. HBDHB has a process of visiting tobacco retailers to ensure compliance with the law and discuss becoming a tobacco free retailer. The decision to continue to sell is an economic one.

CONCLUSION

- It is exciting to have HBDHB involved in the development of Te Haa Matea in Hawke's Bay. All Smoking Cessation Services working collaboratively in all settings will help us achieve the Aotearoa Smokefree 2025 goal.

- Programmes led by and contributed to by HBDHB are seeing successes in supporting the reduction in smoking especially for Māori wāhine, as noted in the smoking data for pregnant women and improvement in never smoked for year 10 Māori wahine.

- The passing of legislation requiring tobacco products to have plain packaging this month is expected to further reduce smoking intiation. Tobacco products will no longer look attractive; as design and appearance has been a powerful marketing tool to initiate smoking for young people and encourage smokers to continue smoking.

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora – Smokefree**
	For the attention of: **Māori Relationship Board, HB Clinical and HB Health Consumer Council**
Document Owner: Document Author(s):	Caroline McElnay, Director Population Health Johanna Wilson, Acting Smokefree Programme Manager
Reviewed by:	Executive Management Team
Month:	November 2016
Consideration:	For information

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Council:

Note the contents of this report.

18

OVERVIEW

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

MĀORI HEALTH PLAN INDICATOR: Smokefree

- 95% of all patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking
- 90% of PHO enrolled patients who smoke have been offered help to quit by a health care practitioner in the last 15 months
- 90% of pregnant women who identify as smokers upon registration with a Lead Maternity Carer are offered brief advice and support to quit smoking
- 90% of young pregnant Māori women are referred to cessation support
- 95% of pregnant Māori women who are smokefree at 2 weeks post natal

WHY ARE THESE INDICATORS IMPORTANT?

Most smokers want to quit, and there are immediate and long-term health benefits for those who do. The risk of premature death from smoking decreases soon after someone quits smoking and continues to do so for at least 10 to 15 years. There are valuable interventions that can be routinely provided in both primary and secondary care.

These targets are designed to prompt doctors, nurses and other health professionals to routinely ask the people they see whether they smoke. The health professional is then able to provide brief advice and to offer quit support to smokers. There is strong evidence that brief advice from a health professional is highly effective at encouraging people to try to quit smoking, and to stay smokefree. Research shows that one in every forty smokers will make a quit attempt simply as a result of receiving brief advice. In the Health Equity Report 2014, tobacco use was highlighted as the single biggest underlying cause of inequity of death rates and ill health in Hawke's Bay.

CHAMPION'S REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THESE INDICATORS?

95% of all patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking

During the period 28/5/2015 to 25/06/2016, 98% of patients aged 15 years and over coded as given brief advice and help to stop smoking. The Smokefree team continue to provide ABC, Helping People Stop Smoking, Nicotine Replacement Therapy (NRT) educational support to clinical staff ward by ward, in the hospital. It is important that patients who smoke within the hospital setting are:

- Charted NRT to manage their addiction
- Offered a referral for cessation and behavioural support on discharge

90% of PHO enrolled patients who smoke have been offered help to quit by a health care practitioner in the last 15 months

		Target	Total	Maori	Pacific	Other	Non Maori
2015/16	Q1	90.0%	81.2%	80.8%	75.7%	75.8%	81.5%
	Q2	90.0%	75.0%	74.5%	70.7%	75.8%	75.4%
	Q3	90.0%	77.6%	76.4%	71.9%	79.1%	77.6%
	Q4	90.0%	81.3%	80.3%	75.3%	83.1%	81.3%

During the period 1 July 2015 – 30 June 2016, 81% PHO enrolled smokers were given brief advice and help to quit. The likely reasons for not achieving this target are:

- Incorrect patient contact details
- Timeliness of ABC conversations. Due to workloads and/or patient priorities, the ABC is not done
- ABC completed verbally, ABC documentation not completed
- No confidence in carrying out ABC
- Few clinical staff have completed the "Helping People Stop Smoking" MoH training

The Smokefree Community Systems Coordinator 0.7 FTE supports the PHO and General Practices in finding solutions to achieve the 90% PHO enrolled smokers; provided with brief advice and help to quit target. There had been a three month period whilst this role was recruited to which left a gap in support to the PHO and General Practices. However, this position has now been filled and will work closely with both the PHO and General Practices to provide sustainable solutions for our whānau and communities.

90% of pregnant women who identify as smokers upon registration with a Lead Maternity Carer are offered brief advice and support to quit smoking

	Month (3 months to)	Target	Total	Maori
2013/14	Q1	90.0%	93.2%	0.0%
	Q2	90.0%	96.3%	94.3%
	Q3	90.0%	87.9%	85.4%
	Q4	90.0%	94.5%	95.2%
2014/15	Q1	90.0%	100.0%	100.0%
	Q2	90.0%	98.1%	100.0%
	Q3	90.0%	98.6%	97.9%
	Q4	90.0%	96.9%	95.2%
2015/16	Q1	90.0%	90.3%	87.7%
	Q2	90.0%	96.5%	95.2%
	Q3	90.0%	88.6%	86.2%
	Q4	90.0%	89.0%	81.1%

Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death at infancy.

Encouraging pregnant women to stop smoking during pregnancy may also help them to kick the habit for good and provide health benefits for the mother and reduce exposure to second-hand smoke by the infant.

91.1% of all pregnant women in Hawke's Bay who identified as smokers were offered smoking brief advice and support to quit (1 July 2015 – 30 June 2016). In the same period, pregnant Māori women who identified as smokers passed the target in one quarter and were below 90% in three quarters. Therefore, overall in the year for Māori, 87.55% were offered smoking brief advice and support to quit.

90% of young pregnant Māori women are referred to cessation support

There is no specific data on referrals of young Māori women to cessation support other than what is collected in (3) above HBDHB and Choices Kahungunu Health Services continue to support Wāhine Hapū and their whānau to be smokefree in the Increasing Smokefree Pregnancy Programme (ISSP). ISPP newly named Wāhine Hapū results for January to December 2015 were:

- There were 502 not smokefree pregnant women booked to HBDHB service, 69% were Māori, 28% European, 2% Pacific island and 1% other.
- Total of 318 stop smoking referrals were made for antenatal women (238), postnatal women (34) and whānau (46). 212 (67%) identified as Māori.
- Of the 318 referrals received to stop smoking services, 103 opted on to a three month stop smoking programme. 63 identified as Māori. 31 (30%) of those who opted on to the programme were smokefree at 4 weeks and 27 (26%) remained smokefree at 12 weeks.

As noted above the ISPP now has incentives to encourage whānau members of the pregnant, postnatal women to increase the chances of the women to be smokefree and to improve the health outcomes of foetus and baby. In conjunction, opportunistic peer to peer support is provided to midwives and lead maternity carers on the ward to increase their confidence with smoking cessation. House Officer and Registrar smokefree training occurs twice a year.

In addition, the Smokefree Māori Support Worker is working with young people to encourage smokefree lifestyles before pregnancy.

95% of Māori women who are smokefree at 2 weeks post-natal

	Target	Total	Maori	Pacific	High Deprivation
Jul - Dec 13	86%	79.0%	58.0%	94.0%	68.0%
Jan - Jun 14	86%	79.0%	62.0%	96.0%	70.0%
Jul - Dec 14	86%	73.0%	53.0%	81.0%	64.0%
Jan - Jun 15	86%	79.9%	65.6%	97.7%	72.6%

Data for Māori women smokefree at 2 weeks is sourced from. To ensure considerable opportunity is given to women to be smokefree, the ISPP includes postnatal women and their whānau. Although most women referred to the ISSP are pregnant, 11% of women are postnatal.

CHAMPION'S REPORT OF ACTIVITY THAT WILL OCCUR TO INCREASE PERFORMANCE OF THESE INDICATORS?

The tobacco control realignment saw the end of 32 Aukati Kai Paipa in New Zealand on 30 June 2016. Hawke's Bay was successful in the bid to be one of the new Stop Smoking Services in New Zealand. Te Haa Matea is a partnership between Te Taiwhenua o Heretaunga (Lead), Te Kupenga Hauora o Ahuriri, Choices Kahungunu Health Services and HBDHB. It is estimated Hawke's Bay has approximately 23,000 smokers in the region. To be able to achieve less than 5% of smokers by 2025, Hawke's Bay needs to help 1,337 people stop smoking each year. This is the goal of Te Haa Matea – to enrol 1,337 people per year and encourage and support as many as possible to be smokefree in 4 weeks.

Te Haa Matea is committed to working together to achieve this goal by:

- Hospital referrals to the Te Haa Matea Hub for follow-up.
- Support PHO and General Practices.
  - Working with the PHO to add a Te Haa Matea referral pathway to Med Tech. (Quitline currently is the only referral pathway).
  - Te Kupenga Hauora is working with Maraenui Medical Centre in helping patients to stop smoking. Te Haa Matea wants to work with other General Practices.
- Expanding the ISPP from an initiative between Choices Kahungunu Health Services and HBDHB to Te Haa Matea partners. This means all partners can work with Wāhine Hapū and her whānau to create a smokefree home environment and better health outcomes for all. The ISPP provides incentives at 1, 4, 8 and 12 weeks validation smokefree of nappies for the Wāhine Hapū and food vouchers for her whānau. By expanding ISPP to Te Haa Matea, we want to achieve a wider coverage of smokefree whānau.
- Te Haa Matea Stop Smoking Practitioners are holding smokefree clinics in youth training establishments e.g. Trade and Commerce, Hastings.

HBDHB along with various stakeholders continues to implement the Regional Tobacco Strategy with particular focus on young Māori women smoking rates and looking at opportunities to work better together with hauora providers.

RECOMMENDATIONS FROM TARGET CHAMPION

There needs to be ongoing focus on achieving the targets for PHO enrolled smokers and Māori pregnant women. The Smokefree Systems Coordinator role that had been vacant for three months has now been filled and this role needs to continue to work closely with the PHO and general practices to support practices to achieve this target.

Ongoing work with LMCs and general practices needs to ensure that there is equity in referring pregnant women to cessation services.

More work is required to define the target group of "young Māori pregnant women" and ensure appropriate services. The expansion of the Increasing Smokefree Pregnancy Programme has potential to be effective but this needs to be evaluated and other programmes considered as required.

Most of the indicators for this area are process indicators – the exception being the percentage of Māori women postnatal who are smokefree. These process indicators are based on the assumption that by inquiring about smokefree status and making referrals to cessation services there will be a reduction in smoking rates. We must ensure that these process targets are being met but also that a wide population health approach is also being taken to reduce smoking rates in our priority groups. This approach is outlined in the Regional Tobacco Control Plan.

CONCLUSION

Achieving these targets continue to be challenging. However I am excited with the development of Te Haa Matea in Hawke's Bay and note the increased focus on working together and support for primary care and smokefree pregnancies. Working collaboratively in all settings will help us achieve the Aotearoa Smokefree 2025 goal.

OURHEALTH HAWKE'S BAY Whakawateatia	**Improvement Plan for System Level Measures DRAFT**
	For the attention of: **Māori Relationship Board, HB Clinical Council and HB Health Consumer Council**
Document Owner: Document Author(s):	Tim Evans, GM Planning Informatics and Finance Carina Burgess, Head of Planning; and Wayne Woolrich, Business Services Manager (Health Hawke's Bay)
Reviewed by:	Executive Management Team
Month:	November, 2016
Consideration:	For Approval subject to changes required by MoH

RECOMMENDATION

That MRB, Clinical and Consumer Council:

1. Note the System Level Measures Framework and what is required from the DHB and Health Hawke's Bay
2. Note the process carried out to formulate the draft
3. **Provide any comments or feedback on the draft to carina.burgess@hbdhb.govt.nz**
4. Approve the contents subject to any changes required.

20

OVERVIEW

The Systems Level Measures Framework has been introduced to encourage the Health System to work as one team to achieve outcomes. Hawke's Bay DHB and Health Hawke's Bay are required to develop a joint Improvement Plan for the 2016/17 year. The draft plan is attached which has been developed following two joint primary and secondary workshops and subsequent meetings to refine the plan. The Plan has been submitted to the MoH for review. Early feedback suggests that changes are required in the Patient Experience of Care section. A verbal update will be provided once more detail is known.

BACKGROUND

The System Level Measures (SLM) Framework has evolved from the Integrated Performance and Incentive Framework (IPIF). Unlike IPIF, SLM is focused on whole system outcomes.

System Level Measures for 2016/17

The SLMs were announced on the 1st April 2016. These were set by the Ministry of Health after consultation with the sector.

The four new System Level Measures to be implemented from 1 July 2016 are:

1. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0 – 4 year olds (i.e. Keeping children out of the hospital)
2. Acute hospital bed days per capita (i.e. Using health resources effectively)
3. Patient experience of care (i.e. Person centred care)
4. Amenable Mortality rates (i.e. Prevention and early detection)

The following two System Level Measures will be developed during 2016/17 including definitions and identification of data sets:

5. Number of babies who live in a smokefree household at six weeks post natal (i.e. Healthy start)
6. Youth access to and utilisation of youth appropriate health services (i.e. Teens make good choices about their health and wellbeing).

IMPROVEMENT PLAN

The DHB is required to jointly develop an improvement plan which outlines the activities and contributory measures that will lead to achieving the targets on the System Level Measures. The draft has been developed following two joint primary and secondary workshops. Subsequent meetigns took place to refine the information gathered during those sessions. Targets, contributory measures and activity are set by the DHB/PHO but the System Level Measures are non-negotiable. The improvement plans are to be signed off by District Alliances

INCENTIVE PAYMENT

The MoH give Health Hawke's Bay a sum of money if, as a system, we achieve the locally set SLM targets (excluding amenable mortality) as well as two Health Targets: Better Help for Smokers to Quit – Primary Care and Increased Immunisations. How this funding is then devolved to Primary Care is a local decision.

Two capacity and capability payments and one 'at risk' performance payment will be paid to PHOs:

- Payment 1: 25% capacity and capability payment up front in quarter one (15 July 2016)
- Payment 2: 50% capacity and capability payment in quarter two once the Ministry approves the district alliance's improvement plan (15 December 2016)
- Payment 3: 25% performance payment in quarter one 2017/18 based on quarter four 2016/17 performance (15 September 2017).

ATTACHMENT

DRAFT Hawke's Bay System Level Measures Improvement Plan 2016/17

APPENDIX

Hawke's Bay System Level Measures Improvement Plan 2016/17

DRAFT

20

Insert Note of agreement from HHB and HBDHB

1. Background

The Integrated Performance and Incentive Framework (IPIF) began in 2012. The aim of IPIF was to drive stronger integration across the health system, improve quality and ensure long term system sustainability. IPIF was implemented in 2014 with primary care financial incentives directly linked to performance against the primary care National Health Targets (Better help for smokers to quit, Immunisation and More Heart and Diabetes Checks) and the cervical screening coverage.

The development of the overall IPIF framework was paused during the refresh of the Strategy. In May 2015 the Minister of Health decided not to introduce new performance measures in 2015/16 as he wanted more aspirational measures developed that looked at the performance of the system rather than just primary care. The Minister also wanted to change the focus from looking at outputs and processes to outcomes. The refresh of the Strategy provided the opportunity for this work and has built the case to extend and evolve the IPIF concept of System Level Measures.

The Ministry of Health (the Ministry) has been working closely with the sector to co-develop a suite of System Level Measures that provide a system wide view of performance. These measures have evolved from an initial list of over 100. The new measures engage the health sector more broadly (professions, settings and health conditions) than the previous measures.

The performance of individual clinicians and/or provider organisations, through health activities and processes, are measured by contributory measures. These individual groups must work as one team to improve system level performance. The System Level Measures for introduction in 2016/17 also resonate with the care closer to home, people powered and smart system themes of the Strategy.

The System Level Measures to be introduced rely on the contribution of a wider group of providers. In 2016/17, the focus is on the contributions and performance of DHBs and PHOs. The contribution of the wider groups will be seen over the next 18 months as the Ministry and the DHBs include System Level Measures in a wider range of contracts.

Health Hawke's Bay and the District Health Board are required to work together to develop an improvement plan for the System Level Measures Framework and report against it throughout the year.

2. Development of the Improvement Plan

20

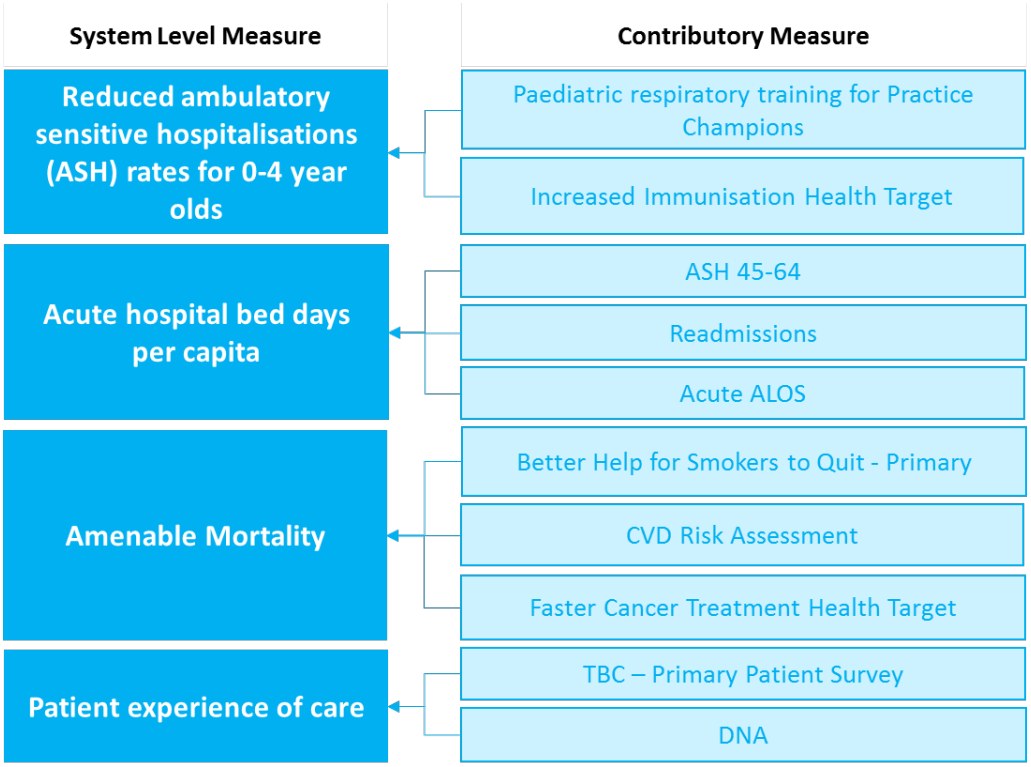
Health Hawke's Bay ran two workshops in conjunction with the Hawke's Bay District Health Board which were attended by both primary and secondary managers and clinicians. The first was also attended by Dr Peter Jones and Kanchan Sharma from the Ministry of Health who explained what SLMs were and what was expected in 2016/17.

The workshops delivered clear themes which were further refined with representatives from primary and secondary care and various governance committees.

In the first year, our aim is to get everyone on board with the concept of System Level Measures and the idea of working together as a whole system. As we move forward we will look to challenge the system more to achieve the desired outcomes.

3. System Level Measures and Contributory Measures

Below is a diagram outlining the System Level Measures and Contributory Measures agreed by Health Hawke's Bay and Hawke's Bay District Health Board. The activities and targets are detailed in the section below.



4. Detailed Improvement Plan

Keeping Children out of Hospital

Measure	Ambulatory Sensitive Hospitalisation 0-4
Target	TBC
Baseline	12 months to March 2016 Total = 4,725, Māori = 5,336, Other = 3,768

Contributory Measures

Paediatric respiratory training for Practice Champions

Measure	% of Respiratory Practice Champions attending Paediatric Respiratory training offered by DHB		
Target	100%		
Baseline	0%		
Numerator	Number of respiratory practice champions that have attended training		
Denominator	Number of respiratory practice champions (n=35)		
Data Source	PHO		
Rationale for Inclusion	Respiratory infections and Asthma are the most common causes of ASH in 0-4 year olds. The gap between Māori and non-Māori ASH rates for Asthma is increasing. Ensuring appropriate support and treatment at a young age sets a foundation for future healthy lungs.		
Activities	**Activity**	**Lead**	**By when**
	DHB to provide training on paediatric respiratory conditions to respiratory practice champions in primary care.	Service Director WCY	End Q4
	Hawke's Bay's existing respiratory programme to expand to include children as well as adults	HHB Health Programmes Manager	Ongoing
SLM Funding Arrangement	TBC		
SLM Proportion of Funding	TBC		
Milestones			
Q1	Agreed Improvement Plan		
Q2	Systems in place to deliver training		
Q3	50%		
Q4	100%		

20

Increased Immunisation Health Target

Measure	% of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.		
Target	≥95%		
Baseline	Oct 2015 to Dec 2015 Total = 93.3%, Māori = 92.6% Pacific = 100%		
Numerator	Health Target Definition		
Denominator	Health Target Definition		
Data Source	Data supplied from Ministry from NIR		
Rationale for Inclusion	Improved immunisation coverage leads directly to reduced rates of vaccine preventable disease, and consequently better health and independence for children, particularly for the most vulnerable groups. The changes which are required to reach the target immunisation coverage levels will lead to more efficient health services for children, because more children will be enrolled with and visiting their primary care provider on a regular basis. It will also require primary and secondary health services for children to be better co-ordinated.		
Activities	**Activity**	**Lead**	**By when**
	Continue to facilitate successful Hawke's Bay Immunisation steering group quarterly and use this group to monitor coverage rates, equity and outreach activity.	DHB Imms Coordinator	Quarterly
	Continue to implement strategies in the Immunisation Action *Plan 'Improving Childhood Immunisation On Time Rates in Hawke's Bay'*. - Identify overdue children through access to Dr Info, monthly Karo reports and quarterly benchmarking across practices. - After three recall attempts, refer children to outreach immunisation services - Check immunisation status for all children presenting at paediatric inpatients and outpatients, and offer immunisation where required.	DHB Imms Coordinator	Quarterly
	Use Datamart reports regularly to measure the coverage rates by ethnicity and deprivation status, identifying increasing numbers of declining or opt-offs or other gaps in service delivery. Tailor the response to data appropriately using the variety of access options available.	DHB Imms Coordinator	Quarterly
	Health Hawke's Bay to support practices to review, audit and manage their Patient management systems for the systematic and timely review of children.	PHO Performance manager	Quarterly
	Health Hawke's Bay and HBDHB to work collaboratively on promotion of Immunisation week in Q4 2017	DHB / PHO	Q3
	Immunisation team to maintain working relationships with age appropriate services such as Tamariki Ora, Plunket, community oral health services and Before School Checks to ensure efficient use of resources for tracking children and appropriate service provision.	DHB Imms Coordinator	Quarterly
SLM Funding Arrangement	TBC		
SLM Proportion of Funding	TBC		
Milestones			
Q1	Agreed Improvement Plan		
Q2	95%		
Q3	95%		
Q4	95%		

Using Health Services Effectively

Measure	Acute Bed Days Per Capita
Target	<350.6
Baseline	12 months to March 2016 Total = 350.6, Māori = 338.5, Other = 356.2

Contributory Measures

Readmission Rates

Measure	Waiting on MoH to confirm the Measure for 2016/17		
Target	TBC		
Baseline	TBC		
Numerator	TBC		
Denominator	TBC		
Data Source	TBC		
Rationale for Inclusion	An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system. Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of care, in the hospital and/or primary care, ensuring that people receive better health and disability services. Readmission rates should be monitored along with average length of stay when aiming to reduce bed days		
Activities	**Activity**	**Lead**	**By when**
	4000 bed days activity - TBC		
SLM Funding Arrangement			
SLM Proportion of Funding			
Milestones			
Q1	Agreed Improvement Plan		
Q2	TBC		
Q3	TBC		
Q4	TBC		

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Average Length of Stay

Measure	Inpatient Average Length of Stay (ALOS) for acute admissions		
Target	≤2.35		
Baseline	12 months to Dec 2015 Total – 2.55		
Definition	The standardised ALOS for acute discharges in any medical or surgical specialty, expressed as the ratio of the observed (actual) to predicted ALOS, multiplied by the nationwide acute inpatient ALOS. The DHB observed ALOS, and the nationwide acute inpatient ALOS, are both defined as the total bed days for acute medical or surgical inpatients discharged during the 12 months to the end of the quarter, divided by the total number of discharges for acute inpatients during the 12 months to the end of the quarter.		
Data Source	National Minimum Dataset (NMDS), Ministry of Health		
Rationale for Inclusion	By shortening hospital length of stay, while ensuring patients receive sufficient care to avoid readmission, the DHB will impact on the Ministerial priority of improved hospital productivity. This will be achieved through freeing up beds and other resources so the DHB can both provide more elective surgery and reduce length of stay in the emergency department.		
Activities	**Activity**	**Lead**	**By when**
	Improve communication to patients about their admission and things they need to know, to ensure family / support people are involved and engaged in the process.	Improvement advisor Team Leader	
	Improve patient information in all adult wards including CHB and Wairoa.		
	Electronic Whiteboards in all adult inpatient areas.		
	Criteria Based Discharge - Promote timely discharge, reduce delays across the seven day week. Currently formally introduced in one medical ward this now needs to be enhanced to include a seven day week service and to be introduced to surgical areas and across all medical areas.		
	Increase Knowledge/ access to EngAGE intermediate beds and flag early.		
	Communicate to multidisciplinary teams options for supported discharge via one document and flowchart		
	Identify solutions to gaps if identified.		
SLM Funding Arrangement	Nil		
SLM Proportion of Funding	Nil		
Milestones			
Q1	Agreed Improvement Plan ≤2.52		
Q2	≤2.46		
Q3	≤2.41		
Q4	≤2.35		

ASH 45-64

Measure	Ambulatory Sensitive Hospitalisation rate per 100,000 population for 45-64 year olds		
Target	≤3,510		
Baseline	October 2014 to September 2015 Total = 3,510, Māori =6,310, Other = 2,812		
Numerator	Number of ASH admissions for 45 - 64 year olds		
Denominator	Number of 45 - 64 year olds		
Data Source	Data will be released by the Ministry of Health quarterly		
Rationale for Inclusion	Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prophylactic or therapeutic interventions deliverable in a primary care setting. Determining the reasons for high or low ASH rates is complex, as it is in part a whole-of-system measure. It has been suggested that admission rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor care coordination or care continuity, or structural constraints such as limited supply of primary care workers. ASH rates are also determined by other factors, such as hospital emergency departments and admission policies, health literacy and overall social determinants of health. This indicator can also highlight variation between different population groups that will assist with DHB planning to reduce disparities		
Activities	**Activity**	**Lead**	**By when**
	Develop a clinical pathway for Cellulitis to standardise practice by Q1	CPO coordinator (HHB)	Q1
	Implement and socialise the recently developed clinical pathway for Congestive Heart Failure by Q2	Manager – Cardiology (DHB)	Q2
	Secure sustainable funding to continue to provide nurse led respiratory clinics. The clinics are a joint Health Hawke's Bay and HBDHB initiative which has proven to be effective at encouraging self-management resulting in clinical, financial and organisational efficiency. A reduction in hospital admissions resulting from acute exacerbations of chronic respiratory disease has been noted and may be attributable to the respiratory project. This is currently a pilot so sustainable funding will embed the programme into the community.	Strategic Service Manager – Primary Care (DHB)	Q1
	Develop a reporting structure by Q2 which provide reports to general practices to show their admission rates to hospital and emergency department attendances. This will allow the DHB and PHO to identify practices where admission rates for particular conditions are high and work with the practice to identify causes and solutions.	Strategic Service Manager – Primary Care (DHB)	Q2
	Following allocation of funding through new investment prioritisation process, appoint a Congestive Heart Failure nurse practitioner to work in the community alongside primary care with the aim of supporting Heart failure patients to self-manage and avoid hospitalisations	Manager – Cardiology (DHB)	Q4
	Clinical Nurse Specialist and Breathe HB will provide two Respiratory training sessions in Primary Care by Q4	Strategic Service Manager – Primary Care (DHB)	Q4
SLM Funding Arrangement	TBC		
SLM Proportion of Funding	TBC		
Milestones			
Q1	Agreed Improvement Plan		
Q2	≤3,510		
Q3			
Q4	≤3,510		

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Prevention and Early Detection

Measure	Amenable Mortality
Target	Reduce
Baseline	Amenable mortality deaths, age standardised rates, 0-74 year olds 2013 (provisional) = 102.3

Contributory Measures

Better Help for Smokers to Quit - Primary

Measure	% of PHO enrolled patients who smoke that have been offered help to quit smoking by a health care practitioner in the last 15 months		
Target	≥90%		
Baseline	Jul 2014 to Sep 2015 Total = 81.2%, Māori 80.8%, Pacific 75.7%, Other 75.7%		
Numerator	Health Target Definition		
Denominator	Health Target Definition		
Data Source	Supplied to the Ministry of Health through the PHO performance programme (PPP) system		
Rationale for Inclusion	Tobacco is a key contributor to health inequity in Hawkes Bay. Our prevalence of tobacco use is higher than the national average and we believe that reducing tobacco consumption remains the best opportunity to improve Māori health, improve equity and reduce amenable mortality.		
Activities	**Activity**	**Lead**	**By when**
	Continue to offer GP Practices and their staff training, support and guidance on Smokefree systems, processes and policy development	DHB Smokefree manager	Q4
	Provide benchmarking data and audit support for high level leadership and governance structures to manage performance of the 'Better help for smokers to quit' Health Target in primary care. Encouraging the identity and development of Smokefree champions in practices where appropriate.	DHB Smokefree manager	Quarterly
	Review the forms used in the primary care Patient Management System to explore the possibility of mandatory Smokefree fields.	PHO Performance manager	Q4
	Fund independent nurses to contact patients and offer them smoking brief advice and cessation support.	PHO Performance manager	ongoing
	Fund general practices for additional resource to contact patients and offer them smoking brief advice and cessation support.	PHO Performance manager	ongoing
	Coordinate and fund a 'text to remind' campaign with Vensa Health	PHO Performance manager	Q3
SLM Funding Arrangement	TBC		
SLM Proportion of Funding	TBC		
Milestones			
Q1	Agree Improvement Plan 90%		
Q2	90%		
Q3	90%		
Q4	90%		

Cardiovascular Disease Risk Assessment

Measure	% of the eligible population who have had their cardiovascular risk assessed in the last five years.		
Target	≥90%		
Baseline	5 years to Dec 2015 Total = 90.3%, Māori 86.3%, Pacific 87.0%, Other 91.7%		
Numerator	PP20 Definition		
Denominator	PP20 Definition		
Data Source	Supplied to the Ministry of Health through the PHO performance programme (PPP) system		
Rationale for Inclusion	According to our Health Equity Report, ischaemic heart disease is the leading cause of avoidable mortality in Hawke's Bay across all ethnicities. However, the potential years of life lost rates for Māori and Pasifika are four and three times higher respectively than the non-Māori, Non-Pasifika population highlighting a significant equity issue. To reduce the risk of developing CVD, five yearly risk assessments should be carried out on the eligible population.		
Activities	**Activity**	**Lead**	**By when**
	Support practices to carry out PMS audits with a particular focus on those who are coming due for Cardiovascular Risk Assessment (CVRA). Including those coming into the cohort, those that are due and those that will require rescreening	PHO Performance manager	Quarterly
	Provide data to assist Practices to manage the total cohort of their screened population and allow internal benchmarking. Where appropriate, the General Practice facilitation team will work with practices to improve those outliers' performance	PHO Performance manager	Quarterly
	Specific outreach nursing services will target workplaces where there is a high volume of Māori men in the work place and offer incentives such as prize draws.	PHO Performance manager	Quarterly
	Meet with key high needs community stakeholders to develop a plan to increase CVDRA for Maori, Pacific and quintile 5.	PHO Performance manager	Q3
SLM Funding Arrangement	TBC		
SLM Proportion of Funding	TBC		
Milestones			
Q1	Agree Improvement Plan		
Q2	90%		
Q3	90%		
Q4	90%		

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Faster Cancer Treatment Health Target

Measure	% of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by June 2017.		
Target	≥90%		
Baseline	6 months to Dec 2015 Total = 77.6%, Māori 78.6%, Other 76.7%		
Numerator	Health Target Definition		
Denominator	Health Target Definition		
Data Source	Data to be supplied by DHBs		
Rationale for Inclusion	Cancer is one of the leading causes of amenable mortality. Cancer services span the continuum from prevention and screening, through treatment and follow-up care. The National Health Target 'Faster Cancer Treatment' (FCT) takes a pathway approach to care, to facilitate improved hospital productivity by ensuring resources are used effectively and efficiently. Cancer treatment is provided by HBDHB through our own provider and in collaboration with a number of other providers. For example, all radiation treatments are provided for Hawke's Bay patients by MidCentral DHB, while some surgical treatments are outsourced from Capital & Coast, Hutt Valley and Auckland DHBs. There is local provision of outpatient-based chemotherapy plus coordination of all Hawke's Bay patients across and through all networked services. This requires a high level of inter-district collaboration to ensure that services are integrated and seamless for patients.		
Activities	**Activity**	**Lead**	**By when**
	Participate in and comply with reviews of current service provision against the tumour standards within the Central Region. Implement any recommended actions from the reviews.	Manager – Oncology	Ongoing
	Work with the local radiology department to support implementation of regional or local outcomes of their review.	Manager – Oncology	Ongoing
	Review the Breast cancer referral pathway to reduce time delays within referral management	Manager – Oncology	Ongoing
	Work with Central Cancer Network (CCN) to investigate and scope future development of multi-disciplinary meetings and processes. Project report to be prepared June 2016.	Manager – Oncology	Ongoing
	Implement the prostate cancer management and referral guidance by Q4	Manager – Oncology	Q4
	Work with the central region to standardise data interpretation	Manager – Oncology	Ongoing
SLM Funding Arrangement	Nil		
SLM Proportion of Funding	Nil		
Milestones			
Q1	Agree Improvement Plan		
Q2	≥90%		
Q3	≥90%		
Q4	≥90%		

Person & whānau Centred Care

Measure	Implement the Patient Experience of care survey in at least 3 practices by end of June 2017
Target	≥3 practices
Baseline	0 practices

Contributory Measures

National Enrolment Service

Measure	Percentage of general practices live on National Enrolment Service (NES) by end June 2017		
Target	90%		
Baseline	11%		
Numerator	Number of general practices live on National Enrolment Service (NES) by end June 2017		
Denominator	Number of general practices (n=29)		
Data Source	PHO		
Rationale for Inclusion	The NES has been developed to provide a single definitive source for all national enrolment and identity data. The NES is an enabler for the Patient Experience Survey.		
Activities	**Activity**	**Lead**	**By when**
	Dedicated Health Hawke's Bay personnel allocated to be responsible for on-boarding practices in tranches as advised by the MoH.	Health and Social Care IT Liaison (HHB)	Q1
	Health Hawke's Bay provide General Practice with NES and PES education		Ongoing
	Practices on boarded at the rate recommended by the MoH.		Ongoing
	Health Hawke's Bay maintains an active risk management plan to mitigate against any risks associated with not reaching its target of 90% of practices on boarded		Ongoing
	Health Hawke's Bay works with the MoH, patients first and the HQSC to ensure that the PES software is tested and available to General practice in a timely manner		Ongoing
	Risks are escalated to Health Hawke's Bay Clinical and Governance Advisory Group for advice.		Ongoing
SLM Funding Arrangement	TBC		
SLM Proportion of Funding	TBC		
Milestones			
Q1	Agree Improvement Plan		
Q2			
Q3	50%		
Q4	90%		

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DNA

Measure	Did Not Attend (DNA) Rate		
Target	≤7.5%		
Baseline	October 2015 to December 2015 Total = 8.1%, Māori = 14.9%, Pacific = 18.3%, Other = 5.3%		
Data Source	Internal		
Rationale for Inclusion	Māori and Pacific people have DNA rates that are 3-4 times higher than those of other people in Hawke's Bay and therefore are not gaining the benefit of timely health advice or treatment. These rates have remained stubbornly poor both locally and nationally for many years despite numerous initiatives to make a difference. A high DNA rate suggests there are significant numbers of people whose health may be adversely affected through not receiving timely and appropriate health care advice or treatment. It may also indicate access, systems or other reasons that may be limiting people's ability or willingness to attend. DNA is an important measure of person centred care.		
Activities	**Activity**	**Lead**	**By when**
	TBC		
SLM Funding Arrangement	Nil		
SLM Proportion of Funding	Nil		
Milestones			
Q1	Agree Improvement Plan		
Q2	≤7.5%		
Q3	≤7.5%		
Q4	≤7.5%		

5. Beyond 2016/17

Ambulatory sensitive hospitalisation rates for 0-4 year olds

Dental conditions are one of the leading causes of ASH 0-4. In 2016/17 we will form a working group to look into possible joint initiatives to reduce the number of children being hospitalised for dental conditions. If successful, this could lead to a possible contributory measure in the coming years.

Acute hospital bed days per capita

We have a programme of work being coordinated in the DHB to reduce bed days. Over the year the DHB will further align with primary care in this initiative.

Patient experience of care

From 1st July 2017, the Patient Experience Survey will be carried out in Primary care so we will have GP practices on boarded and data to analyse.

Amenable mortality

During the SLM workshops there were discussions on how we could measure CVD risk management rather than just assessment. This will be further explored in 2016/17.

Youth access to and utilisation of youth appropriate health services and Number of babies in smoke-free households at six weeks post-natal

We will continue to engage in discussions on the development of these SLMs over 2016/17