BOARD MEETING

Date: Wednesday, 30 August 2017

Time: 1.00pm

Venue: Te Waiora Room, DHB Administration Building,
Corner Omahu Road and McLeod Street, Hastings

Members:
Kevin Atkinson (Chair)
Ngahiwi Tomoana
Dan Druzianic
Barbara Arnott
Peter Dunkerley
Dr Helen Francis
Diana Kirton
Jacoby Poulain
Heather Skipworth
Ana Apatu
Hine Flood

Apologies: Helen Francis; Ngahiwi Tomoana (leaving the meeting around 2pm)

In Attendance:
Dr Kevin Snee, Chief Executive Officer
Sharon Mason, Executive Director of Provider Services
Tim Evans, Executive Director of Corporate Services
Chris Ash, Executive Director of Primary Care
Kate Coley, Executive Director of People & Quality
Tracee Te Huia, Executive Director of Strategy & Health Improvement
Chris McKenna, Chief Nursing Officer
Dr Mark Peterson, Chief Medical Officer, Primary Care
Dr John Gommans, Chief Medical Officer, Hospital
Dr Andy Phillips, Chief Allied Health Professions Officer
Graeme Norton, Chair HB Health Consumer Council
Members of the public and media

Board Administrator: Brenda Crene

Public Agenda

Item	Section 1 : Routine	Ref #	Time (pm)
1.	Karakia		1.00
2.	Apologies		
3.	Interests Register		
4.	Minutes of Previous Meeting		
5.	Matters Arising - Review of Actions		
6.	Board Workplan		
7.	Chair's Report – verbal		

8.	Acting Chief Executive Officer's Report	83	
9.	Financial Performance Report	84	
10.	Board Health & Safety Champion's Update	-	
	Section 2: Reports from Committee Chairs		
11.	HB Clinical Council (including AGM) – Co-Chairs Chris McKenna & Dr Mark Peterson	85	1.40
12.	HB Health Consumer Council – Chair, Graeme Norton	86	
13.	Appointment of Chair to HB Health Consumer Council	87	
14.	Māori Relationship Board - Chair, Ngahiwi Tomoana	88	
15.	Pasifika Health Leadership Group – Barbara Arnott (CPHAC Chair)	89	2.10
	Section 3: For Information		
16.	The Big Listen / Clinical Services Plan - Kate Coley/ Tracee Te Huia / Carina Burgess	-	
17.	Hawke's Bay Drinking Water Governance Joint Committee Terms of Reference Feedback from Havelock North Water Inquiry - Tracee TeHuia / Nicholas Jones	90	2.20
18.	Ngatahi Vulnerable Children Project – Dr Russell Wills	91	2.35
19.	Go Well Travel Plan Update (presentation) – Andrea Beattie	92	2.50
	Section 4: Monitoring		
20.	HR KPIs Q4 Apr-Jun 2017 - Kate Coley	93	2.55
21.	Transform & Sustain Strategic Dashboard - Tracee TeHuia & Kate Rawstron	94	3.05
22.	Annual Māori Plan Q4 Dashboard - Tracee TeHuia / Patrick LeGeyt	95	3.15
23.	Te Ara Whakawaiora / Mental Health - Sharon Mason, Allison Stevenson, Simon Shaw, Justin Lee & Peta Rowden	96	3.20
	Section 5: General Business		
24.	**Section 6: Recommendation to Exclude the Public**		3.30
	Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	Section 7: Agenda Items	Ref #	Time (pm)
25.	Minutes of Previous Meeting		
26.	Matters Arising - Review of Actions		
27.	Board Approval of Actions exceeding limits delegated by CEO - nil	97	
28.	Chair's Update		
29.	Corporate Office Building Lease - Andrea Beattie	98	3.40
	Section 8: Reports from Committee Chairs		
30.	HB Clinical Council - Co-Chairs Chris McKenna and Dr Mark Peterson	99	3.45
31.	Finance Risk & Audit Committee - Chair Dan Druzianic	100	3.55

The next HBDHB Board Meeting will be held at
1.00pm on Wednesday 27 September 2017

Board "Interest Register" - 17 July 2017

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Kevin Atkinson (Chair)	Active	Chair of Unison Networks Limited	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB. Unison leases 3 generators which are located at Hawke's Bay 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.	Chair of FRAC	18.02.09
	Active	Director of Unison Fibre Limited	Non pecuniary interest. Unison is now a provider of high speed broadband to the District Health Board.	Will not take part in any decision or discussions in relation to the provision of high speed broadband to the District Health Board	The Chair of FRAC	17.11.10
	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 discussion in relation to the Trust	The Chair of FRAC	Mar-11
	Active	Board Member of NZ Health Partnership Limited, *effective from 20 March 2017*	Lead, supported and owned by the 20 DHBs, NZ Health Partnerships creates efficiencies in the health sector that allow more to be spent on frontline services.	Will not take part in any decisions in relation to NZ Health Partnerships Limited	The Chair of FRAC	22.02.17
Ngahiwi Tomoana (Deputy 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 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 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 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 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 Chair	01.05.08
Barbara Arnott	Active	Trustee of the Hawke's Bay Air Ambulance Trust	HBDHB has a partnership contract with Skyline Aviation who together operate the HB Air Ambulance Service which is supported by the Trust.	Declare this interest prior to any discussion on the HB Air Ambulance Services and Chair decides on appropriate mitigation action	The Chair	10.05.10
Dr 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

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
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	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
	Active	Member, Hawke's Bay Law Society Standards Committee	Law Society	No conflict perceived	The Chair	20.06.17
	Active	RENEW counselling services	Counsellor	No conflict perceived	The Chair	17.07.17
Dan Druzianic	Active	Director of Markhams Hawke's Bay Limited	Potential Conflict of Interest. Some clients may from time to time be employed by or have contracts with HBDHB	Declare an interest at any time an issue arises concerning a client, and take no further part in any decision or discussion on this matter.	The Chair	7.12.10
Jacoby Poulain	Active	Board Member of Eastern Institute of Technology (EIT)	Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations.	Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT	The Chair	14.1.14
	Active	Councillor Hastings District Council	Potential conflict as potential advocate for Hastings District population whereas HBDHB coveres 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	14.1.14
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; and the Mobility Action Plan (Muscular Skeletal)	Will not take part in any discussions or decisions relating to any actions or contracts with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15 29.03.17
	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
Peter Dunkerley	Active	Trustee of Hawke's Bay Helicopter Rescue Trust	Actual conflict of interest. The Trust provides helicopter patient transfer services to HBDHB	Will not take part in any decision or discussion in relation to any contract or financial arrangement between HBHRT and HBDHB	The Chair	15.05.14
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	5.12.16
	Active	Chair of Directions	Relationship and contractual	Potential Conflict as this group has a DHB Contract	The Chair	5.12.16
	Active	Chair, Health Promotion Forum	Relationship	No conflict	The Chair	5.12.16
Hine Flood	Active	Member, Health Hawkes Bay Priority Population Committee	Pecuniary interest - Oversight and advise on service delivery to HBH priority populations.	Will not take part in any conflict of interest that may arise or in relation to any contract or financial arrangement with the PPC and HBDHB	The Chair	14.02.17
	Active	Councillor for the Wairoa District Council	Perceived Conflict - advocate for the Wairoa District population and HBDHB covers the whole of the Hawkes Bay region.	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.02.17

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 26 JULY 2017, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.00PM

PUBLIC

Present: Ngahiwi Tomoana (Chair)
Dan Druzianic
Helen Francis (left the meeting at 3.25pm)
Peter Dunkerley
Diana Kirton (arrived at 1.45pm)
Heather Skipworth
Jacoby Poulain (arrived at 1.45pm)
Ana Apatu
Hine Flood

Apologies Kevin Atkinson and Barbara Arnott

In Attendance: Tracee TeHuia (Acting Chief Executive Officer)
Members of the Executive Management Team
Dr John Gommans (representing co-Chairs of HB Clinical Council)
Graeme Norton (Chair, HB Health Consumer Council) - left the meeting at 1.55pm
One Media Representative (No members of the Public)
Brenda Crene (Board Administrator)

KARAKIA

Heather Skipworth opened the meeting with a Karakia.

APOLOGY

Apologies had been received from Kevin Atkinson and Barbara Arnott. It was advised that Jacoby Poulain and Diana Kirton would be arriving later in the meeting. Helen Francis advised she would leave around 3.30pm.

3. INTEREST REGISTER

No board member advised of any interest in the items on the days Agenda, however an update had been recorded since the June meeting for Diana Kirton.

4. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 28 June 2017, were confirmed as a correct record of the meeting.

Moved: Dan Druzianic
Seconded: Peter Dunkerley
Carried

5. MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: **Chaplaincy Service Costs –** an update was provided by Ken Foote following on from the letters sent to HB LTAs seeking financial support for Chaplaincy Service Costs. Two responses had been received to date:

- Napier City Council – no support offered
- Central Hawke's Bay – no support offered
- Hastings District Council – yet to be advised
- Wairoa – yet to be advised

Ongoing.

Item 2: **Maori Workforce –** A presentation entitled "Building a Diverse Workforce and Engaging Effectively with Maori had been included on the days agenda. *Actioned.*

Item 3: **Dementia Wing – Glengarry House, Wairoa:** This is being managed by Paul Malan as business as usual. *Actioned*.

Item 4: **Health Literacy – progress update with clear actions and timetable –** A presentation had been included on the days agenda – with presenters Kate Coley and Andre Le Geyt (of Health HB). *Actioned.*

Item 5: **Health & Safety response to Lost Time Injuries query** had been responded to under Matters Arising. *Actioned.*

Items 6, 7 and 8 had all been actioned.

6. BOARD WORK PLAN

The Board Work Plan was noted.

It was noted that the Regional Renal Report (the bigger picture) – would come through the Clinical Services Plan. The Endoscopy Project continues to be updated via the Finance Report (monthly).

There are changes anticipated to the new Endoscopy Unit to clear the way for surgical expansion. A paper will be provided to FRAC in August with a recommendation through to the Board.

Advised that 'Social Inclusion' was on track with stakeholder sign-off progressing.

7. CHAIR'S REPORT

The Chair advised there had been no retirements noted since the June Board Meeting. He also advised that he and Dan Druzianic (FRAC Chair) were in close contact, in Kevin Atkinson's absence.

8. CHIEF EXECUTIVE OFFICER'S REPORT

The Acting CEO Tracee TeHuia provided an overview her report. Comments noted in addition to the report included:

- There was a lot of pressure in hospital system and the health sector generally due to high sickness in the community and amongst health-care staff. Considering this extra pressure our performance against ministerial targets for the quarter ended June 2017, is to be applauded.
- Primary Care have met targets also. A big thank you was conveyed to those in the field for a job well done! The Board especially advised they wished to thank everyone for their efforts. With a wide variety of winter illnesses the whole health system in HB has worked well together.
- Although illnesses were not over yet it was great to see the positive spirits and note it is not too late to get vaccinated! Messaging crucial to the community to help them understand the difficulties being experienced and appreciating their understanding (especially Wairoa).
- Some health care staff had been reoriented and come back to work (from retirement) to help out when we have been under pressure!

Action: Comms Messaging

9. FINANCIAL PERFORMANCE REPORT

Tim Evans (ED of Corporate Services) spoke to the Financial Report for the financial year ending June 2017 (unaudited) which showed a favourable variance of $116 thousand (for the month) with a $3.6m surplus for the year in comparison to the $3.5m forecast. This resulted in $1.4m less than plan, reflecting impact of the gastroenteritis issue which the MoH advised should be funded through a reduced deficit.

Comments noted in addition to the report included:

- Gastroenteritis outbreak contribution: Initially the MoH advised no money would be available f to cover the cost of the outbreak in HB and that they would forgive surplus expectations. A verbal commitment however had since been provided by MoH to the CEO prior to the July Board Meeting.
  This was later followed up and another positive verbal commitment was received. We now await written confirmation, after which the amount advised would be added to the 2017/18 years budget surplus.
- Special budgetary measures were put in place by HBDHB in April (ie, month 9). A lot of hard work had been undertaken since and staff now need to be advised we are back to normal budget control measures.
- Electives have done well and managed to hit 101% of target. Sharon Mason's teams were commended.
- Overall a good finance report.
- The next focus will be the 2.0% savings plan and FRAC will continue to monitor progress.

The Board were pleased with the results advised.

10. HEALTH & SAFETY BOARD CHAMPION'S UPDATE

Helen Francis provided an overview for the month.

- There has been staff turnover in the Health and Safety area. The recruitment process for a replacement Health Advisor had been unsuccessful, however an interim Advisor had been appointed (on Contract) to fill the gap.
- HBDHB's lost time injuries were below most DHBs.
- A Pilot was underway focusing on the "Top 10 Contractors" to ensure health and safety compliance was being met.
- In undertaking her Health and Safety duties, Helen advised she met with staff once/month and in addition undertook several walk arounds.
- The Health and Safety Board Member rotation had been emailed to members and was available on the Diligent Books "Resource Centre" with Peter Dunkerley taking the next roster rotation.

11. CONSUMER STORY

Kate Coley (ED of People and Quality), introduced Angela Fuller (Radiology Manager), and Jenny Sexton (Clinical Nurse Radiology). An incident where busy staff negatively impacted on a patients experience of care, ultimately resulted in a positive improvement strategy being implemented.

Often patients were nervous and the offer of a support person was encouraged. Also headphones could be offered to patients to receive information remotely – this may be a consideration in future.

The timeframe from receiving the initial complaint to resolving it was one week, with the service implementing learnings and improvements to enhance communications (a hand out brochure was also developed).

REPORT FROM COMMITTEE CHAIRS

12. HB CLINICAL COUNCIL & HB HEALTH CONSUMER COUNCIL – JOINT REPORT

Graeme Norton (Chair of Consumer Council) spoke to the report from the joint meeting held 12 July 2017. The joint session commenced with a 90 minute "Workshop" with representatives from Sapere Research Group (tasked with the development of the Clinical Services Plan for the HB Health Sector). Clinical and Consumer members had received a warm-up paper entitled "Our Health System – Changing for the Better". In addition participants were provided with a copy of the Notes from the HB Health Sector Leadership Forum held 15 March 2017.

Health in Hawke's Bay needs to be broader other than just clinical! Collectively members were challenging that by tweaking the status quo (BAU) will not work. We need to do things differently to get a better and more sustainable outcome. It was acknowledged that the "People Strategy" and the "Clinical Services Plan" must work hand in hand. This may not mean it needs to be fixed with money (or bricks and mortar). If there is a requirement for new investment that would be another discussion.

With the best intentions Graeme felt we are not moving fast enough. This discussion was very innovative and challenging, as well as being a relatively new experience for the Consultants.

Other topics/areas discussed at the conclusion of this Workshop were: The Surgical Expansion Project; 2017/18 Budget presentation was received; as well as an Update on the Pharmacy Services Agreement – extended for 12 months to give certainty to the sector as a new contract is developed in readiness for 1 July 2018.

13. HB CLINICAL COUNCIL

On behalf of the co-Chairs, Dr John Gommans spoke to the Clinical Council segment of the meeting held 12 July 2017. He felt the strong partnership between Clinical and Consumer Council was a very powerful way to shape direction. The Sapere Research Group representatives were challenged at the Workshop but it was very clear they were up for the challenge!

14. MĀORI RELATIONSHIP BOARD

Ana Apatu provided feedback from the meeting held 12 July 2017.

- Dr Fiona Cram the new MRB representative (on behalf of the Ahuriri District Health Trust) was proving to be a valuable member.
- MRB was very positive about the Nuka System and the pending Training.
- Members were also pleased to see the focus on Building a Diverse Workforce. The comment around ward nurses being unwelcoming to student nurses (of all ethnicities) had been discussed at MRB. Chris McKenna will respond as there has been no clear evidence to support this claim, but work is being done to ensure that people can talk in a safe environment.

The HB Health Sector Leadership Forum will be held on 6th September (not 9th as reported in the MRB paper).

FOR DISCUSSION / INFORMATION

15. Building a Diverse Workforce

A presentation was provided by Kate Coley, ED People and Quality. This was in response to item 2 of the matters arising. The journey over past years provided the Board with progress made and the next level being to broaden and include all ethnic groups.

Specifically, staff identifying as Maori had risen from 8.7% in May 2012 to 14.1% in May 2017 ie., above the target of 13.8%. MRB had earlier asked for the desired Maori Workforce target to be raised to 25% and this was with EMT for consideration.

Job applications received by ethnicity include the following percentages: 10% Maori, 1% Pacific, 22% Asian and 67% other.

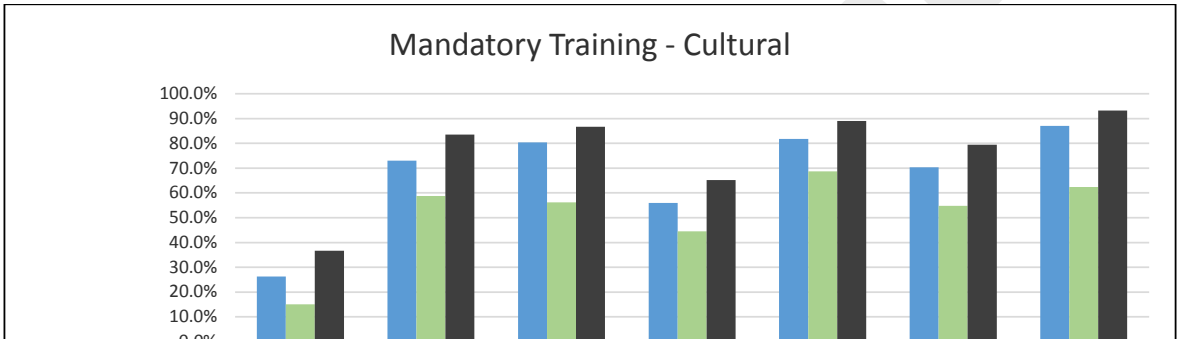
- Blanket targeting should not be seen as the way forward. The targets should be to areas of higher utilisation. A supply (pipeline) is the crucial issue as we need to build depth.
- Tracking students who move out of HB was seen as important. These students need to connect back in some way or they will go further afield.
- This was a big topic and HBDHB are not on their own! The Community Hub at the Sports Park will be a conduit in this area.

Action: **Kate Coley advised a plan would come back in September 2017**

Engaging Effectively with Maori

Kate Coley introduced James Graham, Cultural Competency Advisor, who provided some background.

A Mandatory Cultural Training graph was provided including detail around Engaging Effectively with Maori.



	Medical	Nursing	Allied Health	Support	Mge. & Admin	Total	Managers
EEM	26.2%	73.0%	80.4%	56.0%	81.8%	70.3%	87.0%
TOW	15.0%	58.8%	56.2%	44.6%	68.7%	54.8%	62.3%
EEM or TOW	36.7%	83.5%	86.7%	65.2%	89.1%	79.4%	93.2%

- The board fully supported this training and asked why were we sitting around the table discussing this, if the training is in fact “Mandatory”? Do we need to name and shame?

In response, it was acknowledged that we have not done enough, we need to refresh and manage how this is achieved.

- Why are doctors standing out non-achievers in Cultural Competency Training?

In response Dr John Gommans advised the Medical Council ran a workshop in mid-June 2017. He was not happy to see doctors do the cultural competency courses at in HB, just to tick a box, as many do training in other areas which cover this. RMOs and SMOs turn over within three years. Training of our Junior doctors ensures they come out well versed in this area. It is more the Senior doctors who need this training!

What is helpful is that the Medical Council will soon require annual professional development plans including Health and Disability code of rights and Cultural Competency. This will be a fundamental enabler.

Training records are lacking at HBDHB, as many SMOs are fluent in Te Rao and we don't document what other training is done. We see SMOs going to NUKA training and that speaks volumes!

Whether "mandatory" or "demonstrating" you have done your training by other means needs to be considered.

Action: Kate Coley advised a plan will be developed that fits in with Values and Health Literacy. An update will be provided in September.

16. Health Literacy "Making health care easy to understand"

A progress update presentation was provided by Kate Coley, ED People and Quality together with Andre LeGeyt of Health HB. This related to board action 4. seeking progress update with clear actions and timetable.

An evolving concept about making health easy to understand through **Information, Understanding and Action**. Our Challenge is to help consumers and their whanau achieve their health goals which will require systematic action over the long-term across three main areas:

- health services
- health workforce and
- consumers

This will not be a separate project as it is about building sustainable capability which becomes business as usual.

Initiatives for the next phase:

2017

October	*Health Services* – Implementation of Framework (tool kits for self-assessment; awareness; policies; project ToR).
November	*Health Services* - Medication Safety – Patient Safety week
December	*Workforce* - Relationship Centred Practice Roll-out and introduction of Health Easy to Understand Orientation Programme

2018

February	*Health Services* – Customer Focussed Booking (UBook)
June	*Consumer* - Community Programmes (Bariatric Surgery (more about post understanding and follow up care and counselling); Rangatahi Arotahi Wairoa Project (Play Musical around managing their own sexual healthy); Every Body Get Healthy Project; (Action Research Evaluation Project)

Where to from here:

- Easy to understand and make health easy in everything we do.
- Embed into our values and behaviours.

Feedback:

- Graeme – investment in Navigators but the fundamental change required is to make the system navigable, so the navigators can be moved to other areas!
- Members advised this was a big improvement - well done.
- Great seeing PHO and DHB co-presenting. Thank You.

Action: Regular six monthly progress updates to be scheduled on workplan

Koutou e whakaae, kī mai ae
If you agree say yes

Kāore rānei

If you don't agree, say no

Kua mana
This has been passed

17. Professional Development Policy

Ken Foote (Company Secretary) responded to a request from the Board noted during the May 2017 Board meeting.

A draft Policy had been developed for discussion, comment and potential approval (with or without any amendments). This policy defines the process for identifying and approving relevant training, while ensuring the prudent use of public funds and is a principles based approach.

Feedback:

- It was advised that PHO board members get $1k per year. Others have funds and the HBDHB don't! It was agreed that every board members needs are different. Suggested hat communal training turns into a huge gathering which is not meeting our needs.

  In response: Under this policy, each board member would meet with the Chair to discuss their needs which would be written into the Plan. Some may well be better addressed by having collective training opportunities to best meet the collective needs. The Plan would contain a contingency and there would be flexibility to swap out and swap in - but they would be agreed by the Board as a whole.
- Members who were unsure as to what their training needs may be would be welcome to discuss with more experienced Board members for advice and share experiences. Work as a team, some have more experience than others.
- The Plan would not include compulsory training.
- The Plan, once created belongs to the Board.

RECOMMENDATION

It is recommended that the Board:

1. Discuss the issues raised in this report
2. Approve the proposed policy and / or provide guidance on amendments or the redevelopment of an alternative policy.

Moved **Ngahiwi Tomoana**
Seconded **Dan Druzianic**

Carried

GENERAL BUSINESS

There being no further discussion, the Chair accepted a motion to move into Public Excluded.

RESOLUTION TO EXCLUDE THE PUBLIC

RESOLUTION

That the Board

Exclude the public from the following items:

19. Confirmation of Minutes of Board Meeting
20. Matters Arising from the Minutes of Board Meeting
21. Board Approval of Actions exceeding limits delegated by CEO
22. Chair's Update
23. Cranford Hospice draft Business Case
24. Finance Risk and Audit Committee Report

Moved: **Peter Dunkerley**
Seconded: **Heather Skipworth**
Carried

The public section of the Board Meeting closed 3.25pm

Signed: _____

Chair

Date: _____

BOARD MEETING - MATTERS ARISING
(Public)

Action #	Date Issue first Entered	Action to be Taken	By Whom	Month	Status
1	29 Mar 17 28 June 17 26 July 17	**Chaplaincy Service Costs:** Letters were sent (at end of June) to the four local Council Mayors seeking support with Chaplaincy costs. Update on responses received. Two outstanding: Wairoa and Hastings District Councils.	Board Chair in Ken's absence	Aug	
2	26 July 17	Communicate a big thank you to staff and the Health Sector from the Board	Tracee TeHuia		Actioned
3	26 July 17	**Making Health Care Easier to Understand (Health Literacy):** Six monthly updates to be scheduled (Feb18, Aug, Feb19)	Admin		Actioned
4	26 July 17	**Building a Diverse Workforce and Engaging Effectively with Maori** The Board will be provided with a plan in September (included in the workplan)	Kate Coley	~~Sept~~ Oct	Included on Workplan for October to align with Te Ara Whakawaiora Culturally Competent Workforce (local Indicator).

HAWKE'S BAY DISTRICT HEALTH BOARD – WORKPLAN

Mtg Date	Papers and Topics	Lead(s)
6 Sept	**HB Health Sector Leadership Forum – East Pier, Napier**	
27 Sept	Ka Aronui Ki Te Kounga / Focussed on Quality (final) Implementing the Consumer Engagement Strategy Consumer Experience Results Q4 Waioha Primary Birthing Unit – Benefits Realisation Annual Report (Draft) NZHP Ltd NOS Change Control Report Capital Programme Developments National Oracle System Social Inclusion Position on Reducing Alcohol Related Harm Metabolic (Bariatric) Survey - in the context of a Healthy Weight Strategy for Adults ***Monitoring*** Te Ara Whakawaiora – Healthy Weight Strategy (national Indicator)	Kate Coley Kate Coley Kate Coley Chris McKenna Tim Evans Tim Evans Tim Evans Tim Evans Tracee TeHuia Tracee TeHuia Tracee TeHuia Tracee TeHuia
25 Oct	Establishing Health and Social Care Localities Update Annual Report 2017 (Board and FRAC) Te Ara Whakawaiora / Culturally Competent Workforce incorporating Diverse Workforce PHLG update on the Pasifika Health Navigators and the Pacifika Workforce Strategy	Tracee TeHuia Tim Evans Kate Coley Tracee TeHuia
29 Nov	Recognising Consumer Participation Travel Plan Update Report Surgical Expansion Project People Strategy Update Best Start Healthy Eading & Activity Plan update (6 mthly) ***Monitoring*** HR KPIs Q1 July-Sept 17 HBDHB Non-Financial Exceptions Report Q1 Jul-Sept 17 + MoH dashboard Q4 Te Ara Whakawaiora – smoking (national Indicator) Maori Annual Plan Q1 Dashboard Pasifika Health Plan Q1 Dashboard	Kate Coley Sharon Mason S Mason/Janet Heinz Kate Coley Tracee TeHuia Kate Coley Tim Evans Tracee TeHuia Tracee TeHuia Tracee TeHuia
13 Dec	Audit NZ Final Management Report on the audit of HBDHB for y/e June 2017 Consumer Experience Qtly feedback and Annual Review since inception Transform and Sustian Report (TBC as timelines very tight) Clinical Services Plan presentation of first draft The Big Listen – update (Presentation)	Tim Evans Kate Coley Tracee TeHuia Tracee TeHuia / Carina Burgess Kate Coley

Mtg Date	Papers and Topics	Lead(s)
Jan 2018	**No meeting**	
28 Feb	Transform and Sustain Strategic Dashboard (6 monthly) Quality Annual Plan – 2017-18 6 month progress report People Strategy Clinical Services Plan ***Monitoring*** HR KPIs Q2 Oct-Dec 17 Maori Annual Plan Q2 Dashboard Pasifika Health Plan Q2 Dashboard HBDHB Non-Financial Exceptions Report Q2 Oct-Dec 17 + MoH dashboard Q1	Tracee TeHuia Kate Coley Kate Coley Tracee TeHuia Kate Coley Tracee TeHuia Tracee TeHuia Tim Evans
28 Mar	Establishing Health and Social Care Localities in HB Consumer Experience Feedback Quarterly Report Q2 ***Monitoring*** Te Ara Whakawaiora – Breastfeeding (national indicator)	Tracee TeHuia Chris McKenna Kate Coley
25 Apr	TBA	Tracee TeHuia
30 May	Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-May-Nov18) ***Monitoring*** HR KPIs Q3 Oct-Dec 17 Maori Annual Plan Q3 Dashboard Pasifika Health Plan Q3 Dashboard HBDHB Non-Financial Exceptions Report Q3 Oct-Dec 17 + MoH dashboard Q2	Tracee TeHuia Kate Coley Tracee TeHuia Tracee TeHuia Tim Evans

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 83
	For the attention of: **HBDHB Board**
Document Owner:	Sharon Mason, Acting Chief Executive Officer
Reviewed by:	Not applicable
Month as at	23 August 2017
Consideration:	For Information

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RECOMMENDATION
That the Board

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

INTRODUCTION

This month the quarter four national health target results were released, which show that Hawke's Bay District Health Board (HBDHB) achieved or exceeded all the targets except for Faster Treatment (FCT). It is pleasing to see HBDHB's performance improve for FCT for the last quarter (appendix 1).

It has been a very busy winter month with a nine percent increase in Emergency Department (ED) attendances and 12 percent more acute inpatient admissions compared to July 2016. The main drivers of patient presentations have been respiratory and influenza like symptoms. Primary Care has seen approximately 25 to 30 percent more walk-in patients than what is considered average.

Support from senior leaders and providing afternoon teas and free 15 minute massages for staff have been provided to boost morale and show appreciation to staff for their hard work during the relentless period of demand on our services. We were also delighted to receive a generous donation from Countdown Supermarkets Hawke's Bay of fruit hampers for staff in recognition of the hard work from staff during the winter months.

At the Hawke's Bay Clinical Council Annual General Meeting 9 August 2017, Dr John Gommans (Chief Medical & Dental Officer - Hospital) and Dr Andy Phillips (Chief Allied Health Professions Officer) were elected as the new co-Chairs of the Council. The previous co-Chairs (Chris McKenna and Dr Mark Peterson) will remain members of the Clinical Council. I would like to acknowledge both Chris and Mark for their strong leadership as co-Chairs and for their continued contribution to the Clinical Council in the future.

PERFORMANCE

Measure / Indicator	Target	Month of July	Qtr to end July	Trend For Qtr
Shorter stays in ED	≥95%	91.8%	91.8%	▼
Improved access to Elective Surgery (2017/18YTD) – Results will be populated once plan has been agreed.	100%	-	-	—

Waiting list	*Less than 3 months*	*3-4 months*	*4+ months*
First Specialist Assessments (ESPI-2)	2,576	345	4
Patients given commitment to treat, but not yet treated (ESPI-5)	1,120	107	38

Measure / Indicator	Target	Month of July	Qtr to end July	Trend For Qtr
Faster cancer treatment*	≥85%	66.7% (June 2016)	77.1% (6m to June 2016)	▼
Increased immunisation at 8 months (3 months to end of April)	≥95%	---	94.1%	▲
Better help for smokers to quit – Primary Care	≥90%	90.%	---	▼
Better help for smokers to quit – Maternity	≥90%	---	85.7% (as at 30 June 2017)	▼
Raising healthy kids (New)	≥95% (by Dec 2017)	---	85% (6m to July)	▼
Financial – month (in thousands of dollars)	-159	-60	---	---
Financial – year to date (in thousands of dollars)	-159	-60	---	---

***Based on the expected annual cancer registrations for the DHB supplied by the Ministry, the DHB is expected to identify at least 228 people a year (19 a month) as patients with a high suspicion of cancer.*

Faster Cancer Treatment Expected Volumes v Actual	*Target*	*Month Actual / Expected*	*Rolling 6m Actual / Expected*
	100%	*15/19 = 79.0%*	*96/114 = 84.2%*

Ministerial Targets

The Shorter Stays in Emergency Department (ED) target achieved 91.8 percent for the month of July. The Health Target performance has been compromised by record ED presentation numbers and high levels of inpatient occupancy throughout July.

The Elective Health target plan for 2017/18 has now been agreed, with phasing in the final stages of agreement.

From 1 July the Ministry of Health (MoH) has increased the Faster Cancer Treatment target to 90 percent; our last quarter performance was an achievement of 77.1 percent against the target of 85 percent.

Better Help for Smokers to Quit – Primary Care remains stable at 90 percent.

Financial Performance

The variance from budget for the first month of the financial year is $99 thousand favourable despite the winter pressures on the health system.

I am delighted to advise that we have received correspondence from the MoH confirming that they will provide HBDHB with assistance to cover the costs of the gastro outbreak with an additional $1.0 million in revenue for the 2017/18 financial year.

THE BIG LISTEN AND CLINICAL SERVICES PLAN

Following the presentation to Board in June, which detailed our approach to investing in our staff and building the culture of the sector with the development of a People Strategy, The Big Listen has been developed and launched across the sector. The Big Listen, in simple terms, provides an opportunity through surveys and listening session workshops for our staff and consumers to have their say about their experiences of working in the sector or being cared for in the sector. The Big Listen is very much a bottom up approach to listening to understand what makes a good day and a bad day for staff at work, what are the behaviours we want to see aligned to our values, what are the opportunities to make it a better place to work and an even better place to be cared for.

The Clinical Services Plan (CSP) is well underway and on schedule. The initial stages of engagement have involved general practice, various DHB and PHO committees, pharmacy, aged residential care and DHB health services. More NGOs and health services are planned for engagement in the next few weeks. The consultation and data gathering is starting wide, from a population perspective, to enable us to get a good understanding of the population's needs over the next ten years. We have had a really good level of engagement through these rounds and gathered some valuable feedback.

September and October will be a busy time with activity planning for the CSP and The Big Listen. The two projects are working together to coordinate timelines and communications to reduce the impact on staff, consumers and the community. A presentation on the Big Listen and CSP will be provided to the Board at the meeting.

HAWKE'S BAY DRINKING WATER GOVERNANCE JOINT COMMITTEE

This month hearings for Stage Two of the Government Inquiry into the water contamination of Havelock North have been completed. The final report will be completed by the Inquiry team by December 2017. A paper is being presented to the Board seeking endorsement of the Terms of Reference for the new Hawke's Bay Drinking Water Governance Joint Committee.

NGĀTAHI VULNERABLE CHILDREN'S PROJECT

Ngātahi is a workforce development project for the vulnerable children's workforce in Hawke's Bay. Currently 24 agencies and 450 staff are involved across health, education and social services, government and NGO, mainstream and kaupapa Māori. A competency framework has been agreed by all agencies and is being used to map existing competencies and development needs for the workforce. This phase will be completed by the end of September. We will then use the mapping to develop a training programme over 2018 and 2019.

GO WELL TRAVEL PLAN

Our last update was in March, just after the launch of paid parking, which has now been operational nearly six months. There have been a number of new initiatives introduced and parking availability for patients and visitors remains good with free carparks within the main carpark, at all times of day, which is reflected in the reduction of complaints. Good levels of patient bus ridership continues. In July a bus subsidy was introduced for staff, with staff being able to receive a discount of $1 or $1.50 per trip depending on zone travelled; 420 staff used this in July. In other news with Go Well:

- 86 new parks added to the Hawke's Bay Hospital Campus in the past year
- New motorcycle pad added near the secured bike shed by Pharmacy
- Secured bike shed near AB block now completed
- More secured bike parking being planned
- Wilson House showers now available for use by any staff member using active transport to get to work

In September we will be releasing the 2017 travel plan survey which will allow us to gauge the travel plan's success so far and identify improvements that could be made in future.

HUMAN RESOURCES KPIS QUARTER FOUR

I am pleased to report we achieved the Māori representation target for 2016/17 of 13.75 percent, with 14.25 percent employees identifying as Māori at 30 June 2017. Staff turnover in general was 10.28 percent for the year, which is above the 10 percent annual benchmark. Three main reasons for leaving are staff retirements, staff relocating outside Hawke's Bay and employees moving to positions outside HBDHB. While these reasons give no particular cause for concern, we are completing a full review of how we undertake exit interviews across the whole of the organisation to ensure we more effectively identify the issues and reasons for people leaving while identifying areas for improvement. Annual leave 2+ years is slightly below last year's level and sick leave is slightly higher than last year's level. Note that we will be reviewing and updating the contents of this KPI report to incorporate a broader People and Quality view with the intention to roll these updated KPIs out to the organisation.

TRANSFORM AND SUSTAIN STRATEGIC DASHBOARD
The Transform and Sustain Dashboard continues to identify areas where progress is being made as well as highlighting areas where focus is still required. Faster Cancer Treatment is an area where progress is being made and we have seen improvement in results for the second successive quarter. Māori women smoking during pregnancy remains one of the areas of focus. With results moving further away from target, there are a number of activities being run to address the high smoking rate. I am expecting to present to you the new reporting process for Transform and Sustain in quarter one with alignment to the newly developed System Level Measures.

ANNUAL MĀORI HEALTH PLAN QUARTER FOUR DASHBOARD
HBDHB's Annual Māori Health Plan 2016-2017 quarter four report demonstrates continued improvements across a number of indicators. Ambulatory Sensitive Hospitalisation (ASH) rates for 0-4 year old Māori dropped significantly from 91.7 percent in quarter one to 79.5 percent in quarter four to meet the expected target of ≤82.8 percent. ASH rates for 45-64 year olds also dropped from 196 percent in quarter one to 178.5 percent in quarter four. Child Immunisations (8 month) at 94 percent sit just below the expected target of ≥ 95 percent, PHO Enrolments at 97.9 percent are trending positively towards the ≥100 percent, and the Māori Workforce grew from 12.5 percent in quarter one to 14.3 percent in quarter four to meet the annual target of ≥13.8 percent.

The rates of Cancer Screening for Māori women (Cervical/Breast) and Access to Mental Health and Alcohol and Other Drugs (AOD) Services (0-19 Year Old), although just under expected targets, have remained relatively static throughout 2016-2017. There is still significant work to do to improve rates of Māori under Compulsory Treatment Orders (mental health) and medical staff undergoing Cultural Training.

TE ARA WHAKAWAIOA – MENTAL HEALTH
The Te Ara Whakawaiora report this year points to some improvement on closing the gap between rates of Māori and non-Māori in terms of Compulsory Treatment Orders (CTO), but acknowledges work to close this gap is ongoing with some actions producing results in the longer term. As with other indicators, it is recognised that reducing inequity for Māori in Mental Health requires a sector and system wide approach with the knowledge that improved quality and outcomes for Māori will translate across to improved outcomes for all.

We have made good progress over recent years to improve access to Child, Adolescent and Family Services (CAFS) with reduced wait times and transition plan target indicators showing positive results.

CORPORATE OFFICE LEASE
A paper will be presented for the Board's consideration regarding the Corporate Office lease.

CONCLUSION
This month's report represents a positive performance for quarter four health target results, and a positive start to the year's finical performance, despite the winter pressures in the health system. Underpinning this good performance is a dedicated and loyal workforce.

There are a number of items on the agenda today, which reinforces our commitment to our workforce, whanau, consumers and community. The Clinical Services Plan and The Big Listen will enable us to co-design future health services with the behaviours and values needed to support this.

How is My DHB performing?

MINISTRY OF HEALTH
MANATŪ HAUORA

2016/17 QUARTER FOUR (APRIL–JUNE 2017) RESULTS

www.health.govt.nz/healthtargets

Shorter stays in Emergency Departments

		Quarter four performance (%)	95%	Change from previous quarter
1	West Coast	99		–
2	Wairarapa	97		▼
3	Waitemata	97		–
4	South Canterbury	96		–
5	Bay of Plenty	95		–
6	Nelson Marlborough	95		–
7	Hawke's Bay	95		▲
8	Tairawhiti	95		–
9	Whanganui	95		–
10	Canterbury	94		–
11	Lakes	94		–
12	Taranaki	94		▲
13	Northland	94		▲
14	Auckland	93		▼
15	Counties Manukau	92		▼
16	Hutt Valley	91		▼
17	Southern	90		▼
18	Capital & Coast	90		▼
19	MidCentral	88		▼
20	Waikato	86		▼
	All DHBs	93		▼

Shorter stays in Emergency Departments

The target is 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours. The target is a measure of the efficiency of flow of acute (urgent) patients through public hospitals, and home again.

Improved access to Elective Surgery

		Quarter four performance (%)	100%	Progress against plan (discharges)
1	Northland	123		▲
2	Waikato	114		▲
3	Taranaki	114		▲
4	Waitemata	111		▲
5	Tairawhiti	110		▲
6	Hutt Valley	109		▲
7	Whanganui	107		▲
8	Bay of Plenty	107		▲
9	Counties Manukau	107		▲
10	Nelson Marlborough	105		▲
11	MidCentral	105		▲
12	South Canterbury	104		▲
13	West Coast	104		▲
14	Canterbury	102		▲
15	Lakes	101		▲
16	Hawke's Bay	101		▲
17	Wairarapa	101		▲
18	Capital & Coast	101		▲
19	Southern	99		▼
20	Auckland	98		▼
	All DHBs	106		▲

Improved access to elective surgery

The target is an increase in the volume of elective surgery by an average of 4,000 discharges per year. DHBs planned to deliver 192,237 discharges for the year to date, and have delivered 11,798 more.

Faster Cancer Treatment

		Quarter four performance (%)	85%	Change from previous quarter
1	Waitemata	90		▼
2	Waikato	86		–
3	Canterbury	85		▼
4	Nelson Marlborough	85		–
5	MidCentral	83		▲
6	Auckland	81		▼
7	Taranaki	80		▲
8	Hutt Valley	80		▲
9	Northland	80		▼
10	Capital & Coast	79		–
11	Southern	79		▼
12	Counties Manukau	78		▲
13	Lakes	77		▼
14	Bay of Plenty	77		▼
15	Hawke's Bay	77		▲
16	Wairarapa	76		▼
17	South Canterbury	76		▼
18	Tairawhiti	74		▼
19	Whanganui	64		▼
20	West Coast	56		▼
	All DHBs	81		–

Faster cancer treatment

The target is 85 percent of patients 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. Results cover those patients who received their first cancer treatment between 1 January to 30 June 2017.

Note: From 1 July 2017 the faster cancer treatment target goal will increase to 90 percent. Quarter one 2017/18 results will be against the 90 percent target.

Increased Immunisation

		Quarter four performance (%)	95%	Change from previous quarter
1	Auckland	95		–
2	Hawke's Bay	95		–
3	Canterbury	95		–
4	South Canterbury	95		▼
5	Counties Manukau	94		–
6	Southern	94		–
7	Wairarapa	94		–
8	Capital & Coast	93		–
9	MidCentral	93		–
10	Waitemata	92		–
11	Hutt Valley	92		–
12	Lakes	92		▲
13	Nelson Marlborough	90		–
14	Taranaki	90		▼
15	Waikato	89		▼
16	Whanganui	87		▼
17	Northland	87		▼
18	Tairawhiti	83		▼
19	Bay of Plenty	83		▼
20	West Coast	80		▼
	All DHBs	92		–

Increased immunisation

The national immunisation target is 95 percent of eight-month-olds have their primary course of immunisation at six weeks, three months and five months on time. This quarterly progress result includes children who turned eight-months between 1 April and 30 June 2017 and who were fully immunised at that stage.

Better help for Smokers to Quit

		Quarter four performance (%)	90%	Change from previous quarter
1	Tairawhiti	93		–
2	Counties Manukau	92		▲
3	Auckland	92		▲
4	Hawke's Bay	91		▲
5	West Coast	91		▼
6	Wairarapa	90		▲
7	Waitemata	90		▲
8	Bay of Plenty	90		–
9	Canterbury	90		▲
10	MidCentral	90		▲
11	Lakes	90		–
12	Capital & Coast	89		▲
13	South Canterbury	89		▲
14	Nelson Marlborough	89		▲
15	Waikato	88		▲
16	Hutt Valley	87		▼
17	Taranaki	87		▲
18	Whanganui	86		▲
19	Southern	85		▲
20	Northland	82		–
	All DHBs	89		▲

Better help for smokers to quit

The target is 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.

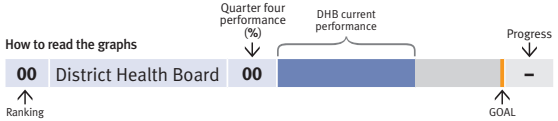
Raising Healthy Kids

		Quarter four performance (%)	95%	Change from previous quarter
1	Waitemata	100		–
1	Auckland	100		–
3	Counties Manukau	98		▲
4	Canterbury	95		▲
5	Hawke's Bay	95		▲
6	Northland	95		▲
7	MidCentral	92		▲
8	Lakes	88		▲
9	Taranaki	88		▲
10	Hutt Valley	87		▼
11	Southern	87		▲
12	Whanganui	84		▼
13	West Coast	81		▲
14	Waikato	81		▼
15	South Canterbury	79		–
16	Capital & Coast	77		▲
17	Bay of Plenty	75		▲
18	Tairawhiti	74		▲
19	Nelson Marlborough	74		▲
20	Wairarapa	74		▼
	All DHBs	91		▲

Raising healthy kids

The target is that by December 2017, 95 percent of obese children identified in the Before School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. Data is based on all acknowledged referrals for obese children up to the end of the quarter from Before School Checks occurring in the six months between 1 December 2016 to 31 May 2017.

How to read the graphs



Health target results are sourced from individual DHB reports, national collections systems and information provided by primary care organisations.

This information should be read in conjunction with the details on the website www.health.govt.nz/healthtargets

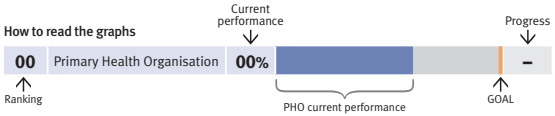
New Zealand Government

How is My PHO performing?

MINISTRY OF HEALTH
MANATŪ HAUORA

2016/17 QUARTER FOUR (APRIL TO JUNE) RESULTS

How to read the graphs



Increased Immunisation

Using Ministry of Health Data

		Quarter four performance	95%	Change from previous quarter
1	Christchurch PHO Limited	99%		▲
2	Cosine Primary Care Network Trust	98%		–
3	South Canterbury Primary & Community	97%		–
4	National Hauora Coalition Limited	96%		▲
5	Compass Health – Wairarapa	96%		–
6	Kimi Hauora Wairau (Marlborough PHO Trust)	96%		▲
7	Well Health Trust	96%		▼
8	Pegasus Health (Charitable) Limited	96%		–
9	East Health Trust	96%		–
10	Rural Canterbury PHO	96%		▼
11	Compass Health – Capital and Coast	95%		–
12	Total Healthcare Charitable Trust	95%		–
13	Central Primary Health Organisation	95%		–
14	Health Hawke's Bay Limited	95%		–
15	WellSouth Primary Health Network	95%		–
16	Procare Networks Limited	95%		–
17	Auckland PHO Limited	94%		▲
18	Ora Toa PHO Limited	94%		▼
19	Alliance Health Plus Trust	94%		▼
20	Te Awakairangi Health Network	94%		–
21	Midlands Health Network – Lakes	93%		▲
22	Waitemata PHO Limited	93%		▲
23	Hauraki PHO	92%		–
24	Midlands Health Network – Taranaki	92%		▼
25	Nga Mataapuna Oranga Limited	91%		▲
26	Midlands Health Network – Waikato	91%		▼
27	Rotorua Area Primary Health Services Limited	91%		–
28	Midlands Health Network – Tairawhiti	91%		▼
29	Nelson Bays Primary Health	91%		▲
30	Manaia Health PHO Limited	90%		▼
31	Whanganui Regional PHO	89%		▼
32	Western Bay of Plenty PHO Limited	88%		▼
33	Te Tai Tokerau PHO Ltd	87%		–
34	West Coast PHO	84%		▼
35	Eastern Bay Primary Health Alliance	82%		▼
36	Ngati Porou Hauora Charitable Trust	80%		▲
	All PHOs	93%		–

Increased immunisation

The national immunisation target is 95 percent of eight-month-olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time. This quarterly progress includes children who turned eight months between April and June 2017, are enrolled in a PHO and who were fully immunised at that stage. Consequently, the All PHOs percentage above will be different to the All DHBs percentage.

Better Help for Smokers to Quit

Using Primary Health Organisation Data

		Quarter four performance	90%	Change from previous quarter
1	Ngati Porou Hauora Charitable Trust	96%		–
2	Nga Mataapuna Oranga Limited	96%		–
3	East Health Trust	95%		–
4	Auckland PHO Limited	93%		▲
5	Total Healthcare Charitable Trust	93%		▲
6	Procare Networks Limited	92%		▲
7	Christchurch PHO Limited	92%		▲
8	Midlands Health Network – Tairawhiti	92%		–
9	Alliance Health Plus Trust	91%		▲
10	Health Hawke's Bay Limited	91%		▲
11	Western Bay of Plenty PHO Limited	91%		▲
12	National Hauora Coalition Limited	91%		▲
13	West Coast PHO	91%		▼
14	Ora Toa PHO Limited	91%		▲
15	Kimi Hauora Wairau (Marlborough PHO Trust)	90%		▲
16	Compass Health – Wairarapa	90%		▲
17	Rotorua Area Primary Health Services Limited	90%		–
18	Pegasus Health (Charitable) Limited	90%		▲
19	Central Primary Health Organisation	90%		▲
20	Compass Health – Capital and Coast	90%		▲
21	Rural Canterbury PHO	89%		▲
22	Midlands Health Network - Lakes	89%		▼
23	South Canterbury Primary & Community	89%		▲
24	Hauraki PHO	89%		▲
25	Te Awakairangi Health Network	89%		–
26	Nelson Bays Primary Health	88%		–
27	Manaia Health PHO Limited	88%		–
28	Waitemata PHO Limited	88%		▲
29	Midlands Health Network – Waikato	87%		–
30	Midlands Health Network – Taranaki	87%		▲
31	Eastern Bay Primary Health Alliance	86%		▼
32	Whanganui Regional PHO	86%		–
33	WellSouth Primary Health Network	85%		▲
34	Well Health Trust	83%		▼
35	Cosine Primary Care Network Trust	78%		▼
36	Te Tai Tokerau PHO Ltd	75%		–
	All PHOs	89%		▲

Better help for smokers to quit

The target is 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.

Health target results use information sourced from national collections and primary care organisations.

More information on the health targets can be found on www.health.govt.nz/healthtargets

New Zealand Government

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report, July 2017** 84
	For the attention of: **HBDHB Board and the Finance Risk and Audit Committee (FRAC)**
Document Owner: Document Author(s):	Tim Evans, Executive Director Corporate Services Phil Lomax, Financial Accountant
Reviewed by:	Executive Management Team
Month:	August 2017
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board and Finance Risk & Audit Committee

1. Note the contents of this report

1. Executive Director Corporate Services' comments

Financial performance

The variance from budget for the first month of the financial year is $99 thousand favourable. This is an early picture. The new financial year's budgets and contracts are bedding in so a significant level of cost is assumed and accrued rather than invoiced and paid. No contingency has been used to support this result.

The biggest variances in month one are around the offsetting effect of receiving $714 thousand funding from the Ministry of Health to pass through to our home support providers in respect of the pay equity settlement to their workforce. Unusually the payable amounts are based on a direct engagement between the Ministry of Health and home support providers. The impact on the DHB is neutral in this year. It is likely that there will be a risk in a future year as this significant resource (around $8.4 million full year effect) and related spend obligation are transferred into baseline Ministry funding.

There is no elective target report this month. Work is being finalised now to create a phased production plan which will be monitored. We are aware that the high level of medical acuity and ED attendance driven by a widespread seasonal flu-like virus has resulted in some cancellation of elective surgical work.

Our major capital scheme, the Gastroenterology unit, is 21% complete and tracking green, except on timescale where the exceptional periods of rainfall this winter have slowed progress on site. Service transition is still planned for late 2018.

We set a universal 2.0% ($10.8 million) recurring Sustain savings target to balance the budget. Specific schemes have now been identified to meet most of this target, a latest update and analysis will be given separately at FRAC.

2. Resource Overview

	July				Year End Forecast	Refer Section
	Actual	Budget	Variance			
	$'000	$'000	$'000	%	$'000	
Net Result - surplus/(deficit)	(60)	(159)	99	62.2%	500	3
Contingency utilised	-	250	250	100.0%	3,000	8
Capital spend	626	1,993	1,367	0.0%	23,920	16
	FTE	FTE	FTE	%	FTE	
Employees	2,250	2,326	76	3.3%	2,318	5 & 7
	CWD	CWD	CWD	%	CWD	

No contingency was released in July.

Identification of efficiencies for the Quality and Financial Improvement (QFI) programme was undertaken in July and will be reported from August. See section 11 for an update on the status of the programme.

The capital expenditure plan was phased evenly across the year, as detailed projected planning was not complete at the time the budget was set. The under-spend in July reflects the early stage of planning and ordering of capital items that should catch up later in the year.

The FTE variance reflects vacancies across a number of areas, and the impact of the high number of medical patients on surgical services.

Case weighted discharges are not available for July and will be updated for the report on performance in August.

3. Financial Performance Summary

$'000	July				Year End Forecast	Refer Section
	Actual	Budget	Variance			
Income	45,474	44,710	764	1.7%	545,339	4
Less:						
Providing Health Services	20,873	20,846	(27)	-0.1%	262,847	5
Funding Other Providers	20,023	19,362	(661)	-3.4%	230,231	6
Corporate Services	4,337	4,305	(32)	-0.7%	47,482	7
Reserves	300	356	56	15.6%	4,278	8
	(60)	**(159)**	99	-62.2%	**500**	

Income
Mainly unbudgeted revenue for the pay equity settlement. Offset under Funding Other Providers below.

Providing Health Services
Vacancies cover efficiencies not yet achieved.

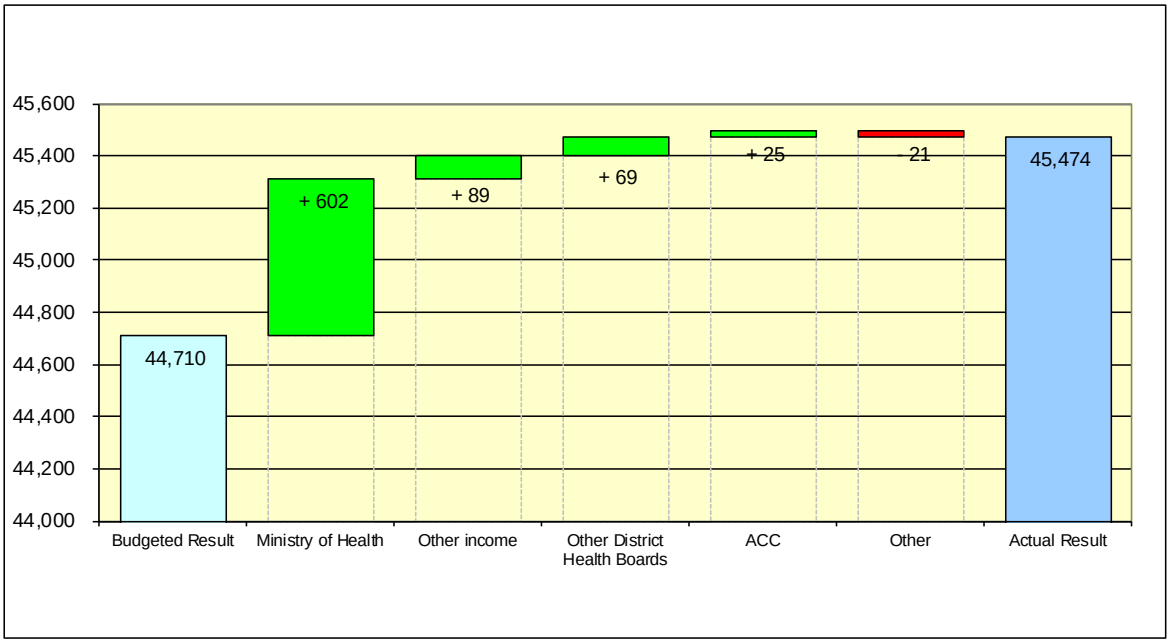
Funding Other Providers
Mainly unbudgeted expenditure for the pay equity settlement. Offset under Income above.

Corporate Services
Depreciation efficiencies not achieved, partly offset by savings elsewhere.

Reserves
Transform and sustain programme costs not incurred as quickly as budgeted.

4. Income

$'000	July Actual	July Budget	July Variance		Year End Forecast
Ministry of Health	43,271	42,669	602	1.4%	520,590
Inter District Flows	693	693	0	0.0%	8,314
Other District Health Boards	402	333	**69**	**20.7%**	3,996
Financing	73	74	(0)	-0.6%	885
ACC	441	415	25	6.1%	5,273
Other Government	55	60	(5)	-8.2%	413
Patient and Consumer Sourced	87	104	(18)	-17.0%	1,406
Other Income	450	361	**89**	**24.6%**	4,394
Abnormals	2	0	2	904.7%	67
	45,474	**44,710**	**764**	**1.7%**	**545,339**



Note the scale does not begin at zero

Ministry of Health (favourable)
Unbudgeted revenue relating to pay equity payments. This revenue is offset by the associated unbudgeted expenditure (see the Funding Other Providers section below).

Other income (favourable)
Special funds and clinical trials income, and unbudgeted Ngā Tahi income.

Other District Health Boards (favourable)
Patient transport recoveries.

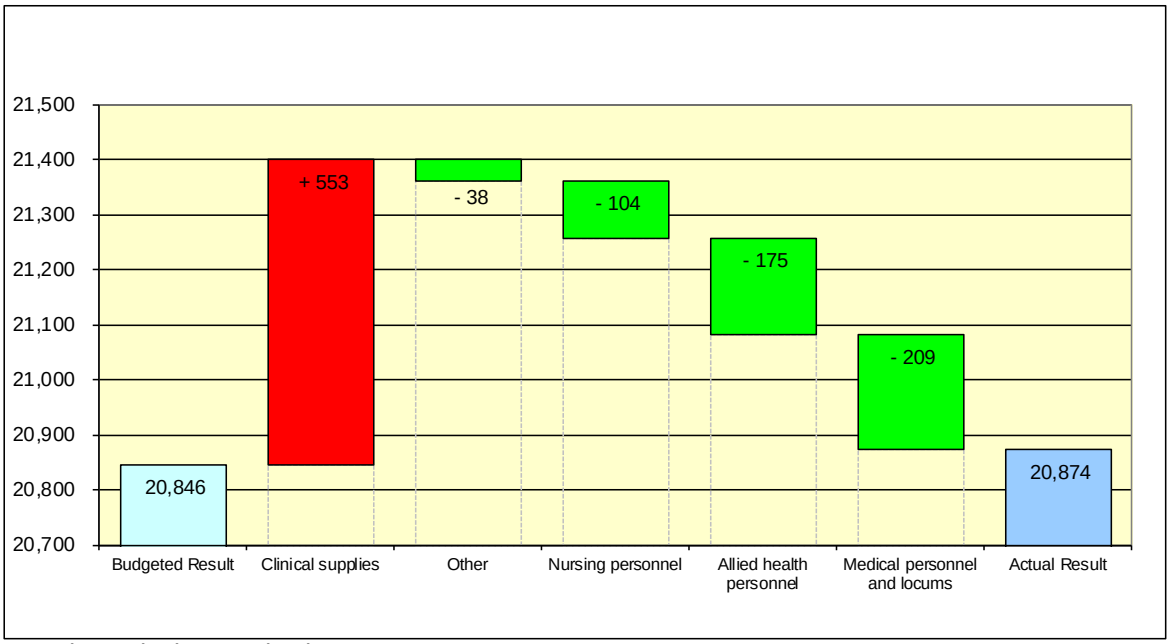
ACC (favourable)
Higher surgery and rehabilitation revenue.

5. Providing Health Services

	July				Year End Forecast
	Actual	Budget	Variance		
Expenditure by type $'000					
Medical personnel and locums	4,472	4,681	209	4.5%	62,154
Nursing personnel	5,924	6,028	104	1.7%	76,184
Allied health personnel	2,729	2,903	**175**	**6.0%**	36,720
Other personnel	1,888	1,928	40	2.1%	23,984
Outsourced services	702	641	**(61)**	**-9.5%**	7,733
Clinical supplies	3,495	2,941	**(553)**	**-18.8%**	35,239
Infrastructure and non clinical	1,665	1,724	60	3.5%	20,834
	20,873	**20,846**	(27)	-0.1%	**262,847**
Expenditure by directorate $'000					
Medical	5,585	5,432	(153)	-2.8%	68,974
Surgical	4,366	4,447	81	1.8%	55,473
Community, Women and Children	3,487	3,465	(22)	-0.6%	42,789
Older Persons, Options HB, Menta	2,650	2,765	115	4.2%	34,925
Operations	3,186	3,124	(62)	-2.0%	38,499
Other	1,599	1,613	14	0.9%	22,186
	20,873	**20,846**	(27)	-0.1%	**262,847**
Full Time Equivalents					
Medical personnel	309.2	324.4	15	4.7%	345.2
Nursing personnel	912.8	940.7	28	3.0%	915.3
Allied health personnel	461.3	479.1	18	3.7%	478.3
Support personnel	132.7	136.0	3	2.5%	136.0
Management and administration	274.1	274.7	1	0.2%	271.7
	2,090.1	**2,155.0**	65	3.0%	**2,146.5**

Directorates

- The Medical result was driven by high patient volume and acuity requiring the use of the overflow ward.
- Older Persons/Options HB/Mental Health was affected by vacancies in mental health.



Note the scale does not begin at zero

Clinical supplies (unfavourable)
Efficiencies achieved elsewhere, patient transport costs, and pharmaceutical costs.

Nursing personnel (favourable)
Lower surgical nursing costs as medical patients filled the overflow ward. Medical nursing costs were affected by vacancies in some senior positions.

Allied health personnel (favourable)
Vacancies, mainly psychologists and MRTs.

Medical personnel and locums (favourable)
Vacancies partly offset by locums, and release of provisions for additional employment related costs.

Full time equivalents (FTE)

FTEs are 65 favourable year to date including:

Medical personnel (15 FTE / 4.7% favourable)

- Vacancies mainly in medical services and mental health.

Nursing personnel (28 FTE / 3.0% favourable)

- Lower staff numbers in the operating theatre, overflow ward and general surgical ward mostly driven by medical acute patients. Lower staffing in acute services, health populations and mental health also contributed.

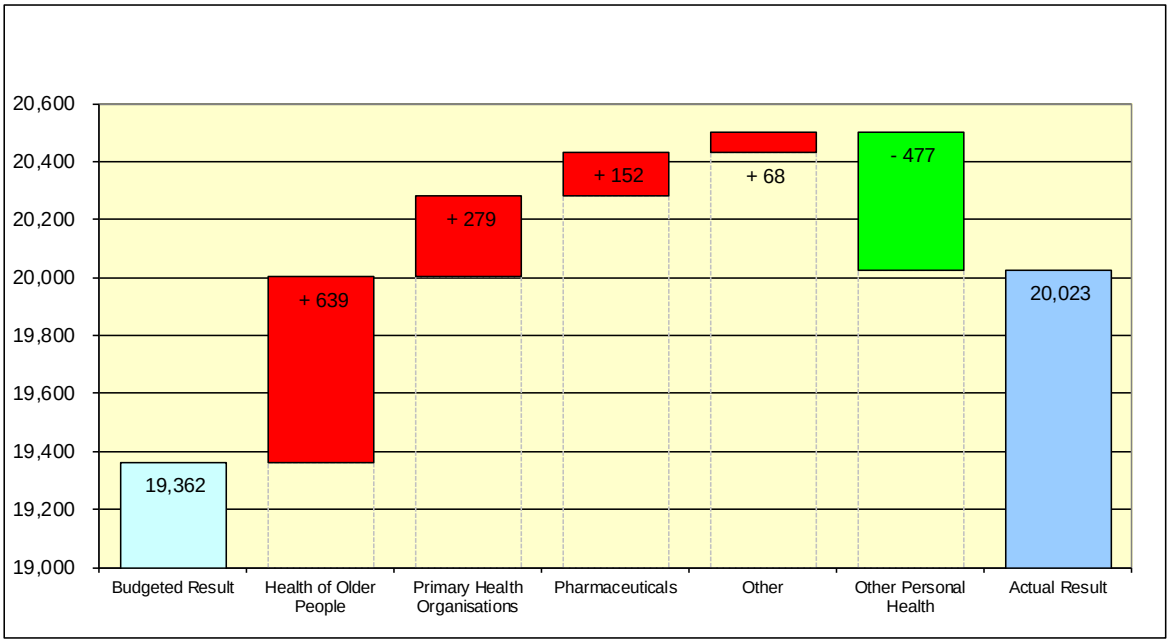
Allied Health Personnel (18 FTE / 3.7% favourable)

- Mostly mental health vacancies including psychologists and therapists.

Elective surgery targets have recently been agreed with MOH, and consequently no report is included this month.

6. Funding Other Providers

$'000	July Actual	July Budget	July Variance		Year End Forecast
Payments to Other Providers					
Pharmaceuticals	3,901	3,749	(152)	-4.1%	45,027
Primary Health Organisations	3,458	3,179	**(279)**	**-8.8%**	36,463
Inter District Flows	4,032	3,979	(53)	-1.3%	47,750
Other Personal Health	1,313	1,790	**477**	**26.7%**	20,942
Mental Health	1,111	1,159	48	4.1%	13,749
Health of Older People	5,797	5,158	**(639)**	**-12.4%**	61,849
Other Funding Payments	411	348	**(63)**	**-18.1%**	4,452
	20,023	19,362	**(661)**	**-3.4%**	230,231
Payments by Portfolio					
Strategic Services					
Secondary Care	3,972	3,827	(145)	-3.8%	45,318
Primary Care	8,117	8,191	74	0.9%	97,105
Chronic Disease Management	-	-	-	0.0%	-
Mental Health	1,218	1,266	48	3.8%	14,890
Health of Older People	5,829	5,195	**(634)**	**-12.2%**	62,011
Other Health Funding	40	33	(7)	-20.0%	400
Maori Health	488	478	(9)	-1.9%	6,053
Population Health					
Women, Child and Youth	254	238	(16)	-6.7%	2,840
Population Health	107	134	27	20.0%	1,612
	20,023	19,362	**(661)**	**-3.4%**	230,231



Note the scale does not begin at zero

Health of older people (unfavourable)
Unbudgeted expenditure relating to pay-equity payments. The expenditure is offset by unbudgeted revenue (see the revenue section above).

Primary Health Organisations (unfavourable)
Higher payments for under sixes.

Pharmaceuticals (unfavourable)
Higher costs than expected for pharmaceutical cancer treatments.

Other personal costs (favourable)
Lower than budgeted respiratory, adolescent dental, and laboratory costs.

7. Corporate Services

$'000	July Actual	July Budget	July Variance		Year End Forecast
Operating Expenditure					
Personnel	1,226	1,276	50	3.9%	15,813
Outsourced services	56	68	11	16.9%	812
Clinical supplies	(115)	(117)	(2)	-1.4%	(657)
Infrastructure and non clinical	1,298	1,292	(6)	-0.5%	9,783
	2,465	2,519	54	2.1%	25,751
Capital servicing					
Depreciation and amortisation	1,167	1,081	**(86)**	**-7.9%**	13,272
Financing	-	-	-	0.0%	-
Capital charge	705	705	-	0.0%	8,459
	1,872	1,786	(86)	-4.8%	21,731
	4,337	**4,305**	**(32)**	**-0.7%**	**47,482**
Full Time Equivalents					
Medical personnel	(0.1)	0.3	0	128.4%	0.3
Nursing personnel	10.7	15.2	5	29.8%	14.9
Allied health personnel	1.0	0.4	(1)	-153.1%	0.4
Support personnel	8.0	8.8	1	8.9%	9.1
Management and administration	139.9	146.1	6	4.3%	146.5
	159.5	**170.8**	**11**	**6.6%**	**171.2**

Depreciation includes efficiencies yet to be achieved.

8. Reserves

$'000	July Actual	July Budget	July Variance		Year End Forecast
Expenditure					
Contingency	250	250	-	0.0%	3,000
Transform and Sustain resource	32	102	70	68.7%	1,227
Other	18	4	(14)	-336.1%	51
	300	**356**	**56**	**15.6%**	**4,278**

No contingency was used during the month.

9. Financial Performance by MOH Classification

$'000	July Actual	July Annual Plan	July Variance		End of Year Forecast	End of Year Annual Plan	End of Year Variance
Funding							
Income	42,718	42,026	693	F	514,556	514,556	-
Less:							
Payments to Internal Providers	23,685	23,685	-		283,900	283,900	-
Payments to Other Providers	20,023	19,362	(661)	U	230,231	230,231	-
Contribution	**(990)**	**(1,021)**	**31**	**F**	**425**	**425**	**-**
Governance and Funding Admin.							
Funding	274	274	-		3,294	3,294	-
Other Income	3	3	-		30	30	-
Less:							
Expenditure	212	242	30	F	3,215	3,215	-
Contribution	**65**	**35**	**30**	**F**	**108**	**108**	**-**
Health Provision							
Funding	23,411	23,411	-		280,606	280,606	-
Other Income	2,753	2,682	71	F	30,753	30,753	-
Less:							
Expenditure	25,298	25,264	(33)	U	311,392	311,392	-
Contribution	**866**	**828**	**38**	**F**	**(33)**	**(33)**	**-**
Net Result	**(60)**	**(159)**	**99**	F	**500**	**500**	**-**

The table above reports the result in the classifications used by the Ministry of Health, and against the projections in the Annual Plan. Those projections differ from the budgets used elsewhere in this report as outlined in the table below.

10. Management Budget Movements

Changes are made to Annual Plan projections so that managers are accountable for budgets that are relevant and up-to-date. The Management Budget is used for internal reporting and the annual plan is used for MOH and statutory reporting. The net result is the same in both budgets.

The major changes between revenue and expense lines are usually due to health provision savings programmes, or unbudgeted new funding received during the year and the associated expenditure.

	July			*End of Year*		
$'000	***Mgmt Budget***	***Annual Plan***	***Movement***	***Mgmt Budget***	***Annual Plan***	***Movement***
Funding						
Income	42,026	42,019	7 F	514,556	514,556	-
Less:						
Payments to Internal Providers	23,685	23,685	-	283,900	283,900	-
Payments to Other Providers	19,362	19,286	(76) U	230,231	230,156	(75) U
Contribution	**(1,021)**	**(952)**	**(69) U**	**425**	**500**	**(75) U**
Governance and Funding Admin.						
Funding	274	274	-	3,294	3,294	-
Other Income	3	3	-	30	30	-
Less:						
Expenditure	242	275	33 F	3,215	3,324	108 F
Contribution	**35**	**2**	**33 F**	**108**	**(0)**	**108 F**
Health Provision						
Funding	23,411	23,411	-	280,606	280,606	-
Other Income	2,682	2,635	46 F	30,753	30,089	664 F
Less:						
Expenditure	25,264	25,255	(10) U	311,392	310,695	(697) U
Contribution	**828**	**791**	**37 F**	**(33)**	**-**	**(33) U**
Net Result	**(159)**	**(159)**	**-**	**500**	**500**	**-**

11. Quality and Financial Improvement Programme

Efficiency targets have been identified during July, and will be reported against from August.

The table below breaks down the efficiency target of $12.776 million into:

- Unidentified savings each service will be required to find or offset during the year of $1.964 million; and
- A general efficiency requiring savings plans incorporated into the budget of $10.812 million.

The general efficiency is further broken down into the amount currently identified in the budget of $10.420 million (the Annualised Efficiency Plans column), and the savings plans yet to be completed of $0.392 million (the Annualised Balance to Find column).

The amount of general efficiency phased to be achieved in July is $0.660 million, and given the surplus for the month, has either been achieved or offset elsewhere.

The full year impact of general efficiencies on the following year, 2018/19 is $10.779 million (the last column). This includes the $10.812 million to be achieved in 2017/18, less the value of one-off plans only achievable in the current year, plus the full year increased value of plans that will be partially completed in the current year.

Efficiency Target 2017/18

Directorate / Service	Total Efficiency ($000)	Unidentified Savings at 22.4% ($000)	General 2% Efficiency ($000)	2017/18 Annualised Efficency Plans ($000)	Annualised Balance to Find ($000)	July 2017 Phased Efficency ($000)	2018/19 Annualised Efficency Plans ($000)
Strategic Planning							
Other Portfolios	3,583	-	3,583	3,244	339	210	2,823
Elective and Acute Portfolio	1,236	219	1,017	1,356	(339)	56	1,356
Total Strategic Planning	*4,819*	*219*	*4,600*	*4,600*	*0*	*266*	*4,179*
Provider Services							
Medical	1,671	381	1,290	1,200	90	108	1,498
Surgical	1,575	477	1,098	795	303	32	1,116
Community, Women and Children	1,156	318	838	838	0	39	1,052
Older Persons, Options HB, Mental Health and Allied Health	1,019	343	676	676	0	57	411
Operations	986	225	761	761	0	60	954
Other	248	- 20	268	248	20	20.67	248
Total Provider Services	*6,655*	*1,724*	*4,931*	*4,518*	*413*	*316*	*5,279*
Strategy and Health Improvement							
Population Health	109	2	107	109	(2)	10	128
Maori Health	181	2	179	181	(2)	40	49
Total Strategic Planning	*290*	*4*	*286*	*290*	*(4)*	*50*	*177*
Corporate Services							
Information Services	202	8	194	202	(8)	-	308
Finance Services	83	4	79	80	(1)	3	127
Governance	33	-	33	33	0	3	34
Quality and People	99	2	97	97	0	8	97
Other (Depreciation etc.)	595	3	592	600	(8)	14	578
Total Corporate Services	1,012	17	995	1,012	(17)	28	1,144
Total Efficiency	12,776	1,964	10,812	10,420	392	660	10,779

12. Financial Position

30 June 2017	$'000	July Actual	July Budget	Variance from budget	Movement from 30 June 2017	Annual Budget
	Equity					
149,751	Crown equity and reserves	149,751	149,751	-	-	149,394
(7,406)	Accumulated deficit	(7,466)	(4,632)	2,834	(60)	(3,973)
142,345		142,285	145,119	2,834	(60)	145,421
	Represented by:					
	Current Assets					
16,541	Bank	17,335	23,071	5,735	795	3,580
1,690	Bank deposits > 90 days	1,654	1,755	101	(36)	1,755
26,735	Prepayments and receivables	22,747	22,390	(357)	(3,989)	22,951
4,435	Inventory	4,396	4,339	(57)	(38)	4,419
625	Non current assets held for sale	625	625	-	-	-
50,025		46,757	52,180	5,422	(3,268)	32,705
	Non Current Assets					
152,411	Property, plant and equipment	151,909	153,175	1,266	(501)	169,324
1,820	Intangible assets	1,778	1,864	86	(41)	5,169
10,580	Investments	10,580	11,123	543	-	12,105
164,811		164,268	166,162	1,894	(543)	186,598
214,836	**Total Assets**	**211,026**	**218,342**	**7,316**	**(3,810)**	**219,302**
	Liabilities					
	Current Liabilities					
35,326	Payables	31,649	35,066	3,417	(3,677)	35,762
34,528	Employee entitlements	34,454	35,473	1,018	(73)	35,381
69,854		66,103	70,538	4,435	(3,750)	71,143
	Non Current Liabilities					
2,638	Employee entitlements	2,638	2,685	47	-	2,739
2,638		2,638	2,685	47	-	2,739
72,491	**Total Liabilities**	**68,741**	**73,223**	**4,482**	**(3,750)**	**73,882**
142,345	**Net Assets**	**142,285**	**145,119**	**2,834**	**(60)**	**145,421**

The variance from budget for:

- Equity reflects the amount the budgeted opening balance differs from the 2016/17 result, and the 2017/18 variance from budget;
- Property, plant and equipment mainly reflect the lower than budgeted capital spend;
- Payables reflects lower funding wash-up accruals from MOH.
- Employee entitlements – see below

13. Employee Entitlements

30 June 2017	$'000	*July* *Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2017*	*Annual Budget*
7,853	Salaries & wages accrued	8,402	8,297	(105)	549	7,756
522	ACC levy provisions	207	532	325	(315)	501
4,869	Continuing medical education	4,688	5,276	588	(181)	5,553
19,819	Accrued leave	19,674	19,714	40	(145)	19,883
4,103	Long service leave & retirement grat.	4,121	4,339	218	18	4,426
37,165	**Total Employee Entitlements**	37,092	38,157	1,065	(73)	38,119

14. Treasury

Liquidity management

The surplus cash of all DHBs is managed by NZ Health Partnerships Limited under a sweep arrangement facilitated by Westpac. The DHB provides forecast cash flow information to NZHPL, to allow them to invest the funds at the most advantageous rates, and uses the same information to ensure the DHB has the funds to meet its obligations as they fall due.

Debt management

The DHB has no interest rate exposure relating to debt.

Foreign exchange risk management

No material transactions occurred during the month. No transactions met the criteria that would trigger the requirement to arrange foreign exchange rate cover.

15. Capital Expenditure

2017 Annual Plan		*Actual $'000*	*Year to Date Budget $'000*	*Variance $'000*
	Source of Funds			
	Operating Sources			
13,625	Depreciation	1,167	1,081	(86)
500	Surplus/(Deficit)	(60)	(159)	(99)
10,166	Working Capital	(490)	1,071	1,561
24,290		616	1,993	1,376
	Other Sources			
-	Special funds and clinical trials	10	-	(10)
625	Sale of assets	-	-	-
625		10	-	(10)
24,915	**Total funds sourced**	**626**	**1,993**	**1,366**
	Application of Funds:			
	Block Allocations			
3,400	Facilities	79	283	204
3,200	Information Services	(38)	267	304
3,400	Clinical Plant & Equipment	86	283	197
10,000		127	833	706
	Local Strategic			
1,082	Renal Centralised Development	133	90	(43)
6,306	New Stand-alone Endoscopy Unit	191	525	334
134	New Mental Health Inpatient Unit Development	43	11	(31)
500	Upgrade old MHIU	35	42	7
243	Travel Plan	48	20	(27)
1,555	Histology and Education Centre Upgrade	33	130	97
3,000	Surgical Expansion	-	250	250
500	Radiology Extension	-	42	42
600	Fit out Corporate Building	-	50	50
13,920		481	1,160	678
	Other			
-	Special funds and clinical trials	10	-	(10)
-	Other	8	-	(8)
-		18	-	(18)
23,920	***Capital Spend***	***626***	***1,993***	***1,366***
24,915	**Total funds applied**	**626**	**1,993**	**1,366**

Monthly Project Board Report
Jul 2017

HAWKE'S BAY District Health Board

Improving Endoscopy Services. Phase 3
Service transition and Facilities Development.

Overall Project Progress	Quality & Safety Risk Status	Time Status	Financial Status
21%	G	Y	G

Project Manager Facilities Development: Trent Fairey

Phase 3: Service transition & Facility Development

Formal approval of the Business Case was received in December 2016 from the Hawke's Bay District Health Board for the construction of a stand -alone Gastroenterology Service building (improving Endoscopy services).
Phase 1 Service & Facility Planning, and Phase 2 Design & Tendering of service facility have been completed on time and within budget.
Phase 3 Service Transition and Facility construction is now underway. This phase concentrates on the construction of the facility to enable the service transition in late 2018.
A fourth and final phase of the project will complete the Improving Endoscopy Services programme, focusing on the development of the service and delivery of the bowel screening programme.

Project Budget Status

Total Approved for Capital Budget	**$ 11,670,000**	Total 17/18 Forecast Spend	**$ 6,300,000**
Total Project Spend to Date	$ 2,432,864	Total 17/18 Spend to Date	$ 191,392
Percentage of Total Spend vs Budget	21%	Percentage 17/18 Spend vs Forecast	3%

Project initiation was completed on the 27th February 2017 on approval of the site specific safety plan. Project total spend is behind projections due to delay with weather and screwpile installation. Contingency funds will be required to support the extensive screw pile failures and the significant changes to the foundation design. At present these changes are contained within the approved funding for the project, the contingency allowed for such issues in the original plan is adequate to cover the projected costs.

Deliverable Dates

Geotechnical design and Testing	Complete	Internal construction - Building Services	Apr-18
Site specific safety plan review and approval	Complete	Furniture , Fittings and Equipment installation	Jun-18
Earthworks and Excavation	Complete	Building services commissioning	Jul-18
Foundation construction	May-17	Facility Sign off & Certificate of Public Use	Aug-18
Structural Steelwork installation	Oct-17	Service Training and Transition to Staged start up	Sep-18
Concrete floor structures	Nov-17	Full operational capacity available and Service Go Live	Oct-18
Exterior and Roof Cladding	Dec-17	Post Implementation Review & Post Occupancy Evaluations	Feb-19

Key Achievements this period

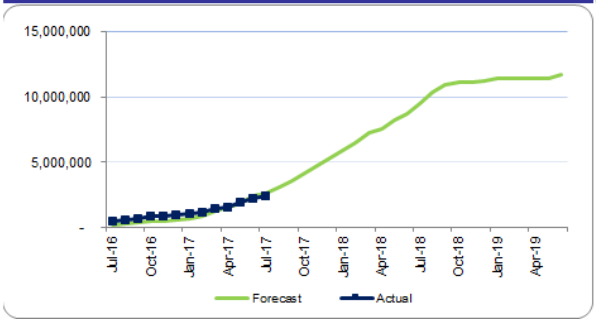
Majority of foundation beams have been poured and backfilled.
Progress on sturctural shop drawings and initiation of structural steel program.
No accidents recorded on site to date, 1st Quarter H&S Audit pass mark of 97%. Introduction of independent H&S auditing for the HBDHB.

Planned Activities next period

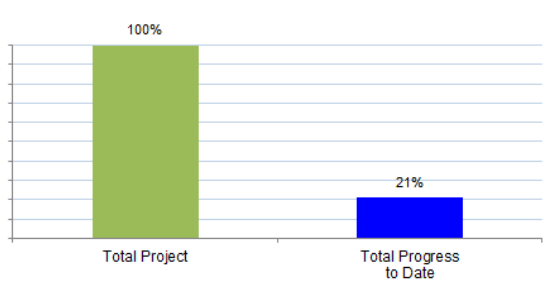
Completion of foundation beams to southern section, manufacture of structural steel frame and BRB braces
Construction of service tunnel between theatre block and Endoscopy building.
Installation of stage 1 structural steel
Installation of foundation walls.

Risks & Issues of Note	Mitigation & Resolutions
Redesign of the Endoscopy Units Level 1 to support the theatre expansion project.	Prompt decision making and design approvals allowing variations to the current contract in a timely manner.
Continued wet weather further delaying the completion of the foundation raft.	Project timeline flex on the HBDHB programme will allow for possible wet weather extensions. Project contract allows for standard wet weather delays, however events like cyclones and unusual weather patterns are genuine extensions of time.
Installation of screw piles to last southern section of site.	Installation of screw piles is now completed, southern section of construction zone required a structural redesign to accept a further 6 screw piles.
Re-calibration of construction programme to recover for lost construction time. Late start up due to unresolved geotechnical conditions , cyclone weather issues and screw pile installation failures.	Ongoing management with GEMCO construction. Review of the original programme has indicated a delay of **21 working days,** until the foundation stage of the project is complete we will not know the full extent that these weather events and screw pile failures have affected the programme, risk around these dates remain. It should be noted that the project programme allows for construction delays, construction completion in late August 2018 is still viable. Staged start up and go live of the facility is planned for spring 2018.

Actual Spend



Total Project Progress



16. Rolling Cash Flow

	Actual	July Forecast	Variance	Aug Forecast	Sep Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast	Jul Budget
Cash flows from operating activities															
Cash receipts from Crown agencies	46,539	44,117	2,422	42,924	43,168	50,176	47,380	43,997	44,036	47,019	44,095	44,020	46,954	47,516	44,365
Cash receipts from donations, bequests and clinical trials	100	-	100	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	1,689	434	1,256	446	440	505	447	445	471	477	471	471	477	472	440
Cash paid to suppliers	(31,014)	(27,155)	(3,859)	(27,047)	(27,183)	(28,487)	(26,808)	(24,272)	(26,568)	(26,472)	(26,792)	(26,705)	(26,735)	(26,646)	(27,740)
Cash paid to employees	(15,299)	(15,688)	389	(20,683)	(15,673)	(15,889)	(18,861)	(15,314)	(23,361)	(16,223)	(16,041)	(16,334)	(19,024)	(16,007)	(15,532)
Cash generated from operations	**2,015**	**1,709**	**307**	**(4,360)**	**752**	**6,306**	**2,157**	**4,857**	**(5,422)**	**4,801**	**1,732**	**1,451**	**1,672**	**5,336**	**1,533**
Interest received	73	74	(0)	74	74	74	74	74	74	74	74	74	74	74	74
Capital charge paid	(705)	(0)	(705)	0	0	0	0	(4,230)	0	0	0	0	0	(4,230)	0
Net cash inflow/(outflow) from operating activities	**1,384**	**1,782**	**(398)**	**(4,286)**	**825**	**6,379**	**2,231**	**701**	**(5,349)**	**4,874**	**1,806**	**1,525**	**1,746**	**1,180**	**1,607**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	2	-	2	-	-	-	-	625	-	-	-	-	-	(0)	-
Acquisition of property, plant and equipment	(625)	(1,655)	1,030	(1,839)	(1,839)	(1,839)	(1,839)	(1,839)	(1,839)	(1,839)	(1,839)	(1,839)	(1,839)	(1,847)	(1,839)
Acquisition of intangible assets	(1)	(338)	337	(154)	(154)	(154)	(154)	(154)	(154)	(154)	(154)	(154)	(154)	(155)	(154)
Acquisition of investments	-	-	-	-	0	-	-	0	-	-	0	-	-	0	-
Net cash inflow/(outflow) from investing activities	**(624)**	**(1,993)**	**1,369**	**(1,993)**	**(1,992)**	**(1,993)**	**(1,993)**	**(1,367)**	**(1,993)**	**(1,993)**	**(1,992)**	**(1,993)**	**(1,993)**	**(2,002)**	**(1,993)**
Cash flows from financing activities															
Equity repayment to the Crown	-	-	-	-	-	-	-	-	-	-	-	-	-	(357)	-
Net cash inflow/(outflow) from financing activities	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**(357)**	**-**
Net increase/(decrease) in cash or cash equivalents	759	(212)	971	(6,279)	(1,167)	4,387	238	(666)	(7,341)	2,882	(187)	(467)	(247)	(1,180)	(386)
Add:Opening cash	18,230	18,230	(0)	18,989	12,711	11,544	15,930	16,169	15,502	14,989	14,699	14,512	14,045	13,798	12,619
Cash and cash equivalents at end of year	**18,989**	**18,019**	**971**	**12,711**	**11,544**	**15,930**	**16,169**	**15,502**	**8,161**	**17,871**	**14,512**	**14,045**	**13,798**	**12,619**	**12,233**
Cash and cash equivalents															
Cash	4	4	-	4	4	4	4	4	4	4	4	4	4	4	4
Short term investments (excl. special funds/clinical trials)	16,007	14,988	1,019	9,680	8,513	12,900	13,138	12,472	5,131	14,840	11,482	11,014	10,768	9,588	9,202
Short term investments (special funds/clinical trials)	2,980	3,026	(46)	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026
Bank overdraft	(2)	-	(2)	-	-	-	-	-	-	-	-	-	-	-	-
	18,989	**18,019**	**971**	**12,711**	**11,544**	**15,931**	**16,169**	**15,503**	**8,162**	**17,871**	**14,513**	**14,045**	**13,799**	**12,619**	**12,233**

The operating forecasts for 2017/18 year are based on the draft budget completed in June 2017 that incorporates the capital plan presented to the Board in June 2017. Changes have been made to the phasing of some major cash-flows based on best estimates of when they will occur e.g. elective services revenue, IDF wash-up and the rest home worker's pay equity settlement. Detailed forecasts of capital expenditure will be updated in August, and is expected to move cash-outflows to later in the year.

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council**	85
	For the attention of: **HBDHB Board**	
Document Owner:	Chris McKenna and Dr Mark Peterson as Co-Chairs	
Month:	August, 2017	
Consideration:	For Information	

RECOMMENDATION

That the Board

Review the contents of this report; and

Note that Clinical Council:

- **Endorsed** the new format for the Quality Accounts
- **Endorsed** the roll out of the Last Days of Life Care Plan and toolkit
- **Noted** the Learnings from ICU Review 2013 report
- **Noted** the Te Ara Whakawaiora / Mental Health report
- **Noted** the Annual Maori Plan Q4 Apr-June 17 / Dashboard
- **Noted** the verbal report from the Clinical Advisory & Governance Group (CAG) Report
- **Note** the update from the Annual General Meeting

Council met on 9 August 2017, an overview of issues discussed and/or agreed at the meeting are provided below.

The following papers were considered:

- **Ka Aronui Ki Te Kounga / Focussed on Quality**

Quality Accounts are a requirement from the Ministry of Health, they are about engaging effectively with our community on the quality and patient safety initiatives that are happening in the sector. This is the fifth year we have published the Quality Accounts. This year the document is a more condensed version of what we have done in the past. Feedback was sought on the format/contents.

Following discussion it was felt that the format was good with some minor improvements suggested. A final version would be presented in September for final endorsement.

The Clinical Council **Endorsed** the new format for the Quality Accounts.

- **Te Ara Whakapiri Hawke's Bay – Palliative Care Outcomes**

Leigh White, Long Term Conditions Portfolio Manager, Strategic Services presented to the meeting the Last Days of Life Care Plan and toolkit and provided an update on the discussion held at the Maori Relationship Board (MRB) about their concerns around evaluation process not including

Maori. A request was also made to include Community Pharmacies as a community provider on the checklist and as part of the notification process when a consumer dies.

A discussion also took place on Advance Care Planning (ACP), it was acknowledged that this is important but it needed to be separate from palliative care so that we do not perpetuate you only need an ACP when you are dying, which is not the case.

The Clinical Council **endorsed** the roll out of the Last Days of Life Care Plan and toolkit, with the adjustments around community pharmacies and the changes requested by the Maori Relationship Board.

- **Learnings from ICU Review 2013**

Kate Coley, Executive Director, People & Quality provided quarerly progress report. The only outstanding item is finalising the job sizing with ICU Consultants, work is underway on the modelling and a meeting has been arranged with the union for the end of the month. All the other recommendations from the 2013 review have been completed and the other recommendations that were identified with the 2015 review have also been implemented.

The Clinical Council **noted** the contents of the report.

Others reports provided for information and discussion included:

- **Te Ara Whakawaiora / Mental Health**

Alison Stevenson, Acting Executive Director, Provider Services, Justin Lee, Acting Service Director, Older Persons, Mental Health, NASC HB and Allied Health Services and Peta Rowden, Acting Nurse Director presented their report to the meeting. It was noted that some improvement had occurred but there are still continuing issues with the rate of Compulsory Treatment Orders (CTO) for Maori; the number of children and youth without a discharge plan and wait times for non-urgent mental health or addiction service

Discussion took place regarding the current situation in mental health services and that it is a whole of sector issue not just health and that we need to work in collaboration with other agencies e.g. CYFS, MSD, justice, education etc.

A suggestion was made that as a governance group Clinical Council needed to set a future date for a workshop to support the work which mental health were doing.

The Clinical Council **noted** the contents of the report.

- **Annual Maori Plan Q4 Apr-June 17 / Dashboard**

Patrick LeGeyt, Acting General Manager Maori Health provided an overview of the report and advised that this would be the final Annual Maori Plan in its current format. In future the Annual Plan and will include 74 indicators for Maori, Pacific and other ethnicities.

The Clinical Council **noted** the report.

- **Clinical Advisory & Governance Group (CAG) Report**

Dr Tae Richardson provided a brief verbal update:

- The committee had the opportunity to meet new members of PHO staff and had a robust conversation around the committee work plan. The PHO quality team is hoping to move towards a proactive rather than reactive mode of governance

- Pharmacy Services in the Community *(this topic was discussed at the Clinical Council meeting in July)*
- Clozapine Contract Renewal – pilot since 2012 to move stable patients receiving clozapine as a treatment to management by their GPs, there is a credentialling process which has been audited, feedback on that audit is that everything is in hand moving forward
- BMI Assessment Tool – information paper on how to embed this into the before school check
- Update on system level measures for Hawke's Bay - draft plan has gone to MoH and the PHO is currently in discussions with stakeholders looking at financial incentives.

Clinical Council's Annual General Meeting:

Following the ordinary meeting the 7th Annual General Meeting of Clinical Council was held.

In summary:

- ***Clinical Governance Structure*** – the final version of the structure was endorsed and brief updates were provided on progress to date for the Clinical Effectiveness & Audit Committee; Patient Safety & Risk Management Committee; Professional Standards & Performance Committee and the Patient Experience Committee.

- ***Annual Information*** – the following was reviewed at the meeting:
  - The last 12 months (2016/17) – year in summary
  - Attendance over the prior 12 months
  - Tenure

- ***Review of Terms of Reference (TOR)*** – discussion took place around the TOR. Noting that the Clinical Council needed to work to the TOR better and make better decisions on what papers came to Council for discussion and information. Noting that at times the agendas can be overwhelming and do not always leave time for robust discussion.

- ***Quality Annual Plan*** – a review was provided on the 2016/17 plan and the work undertaken:
  - Improvement with consumer engagement in the services
  - The Improvement Advisors are working well with the teams across the sector
  - We have attained all the health quality safety markers and have retained our number one position with hand hygiene
  - The Clinical Committees governance structure is now in place
  - There has been a significant amount of work around relationship centred practice
  - An integrated risk management system will be implemented by the end of this year and this will be will shared this with primary care and community providers in the future.
- A dashboard is being developed which will give greater visibility from a quality and safety perspective for Clinical Council.

- ***Election of Chair / Co-Chairs*** - the current Co-Chairs Dr Mark Peterson and Chris McKenna advised that they were standing down. Nominations were sought and were received for Dr John Gommans and Dr Andy Phillips to be Co-Chairs. The nominations were endorsed by Council members.

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Health Consumer Council** 86
	For the attention of: **HBDHB Board**
Document Owner:	Graeme Norton, Chair
Month:	August, 2017
Consideration:	For Information

12

RECOMMENDATION

That the Board

Review the contents of this report; and

Note that Consumer Council:

- **Endorsed** the Te Ara Whakapiri Hawkes Bay – Last Days of Life rollout and toolkit
- **Endorsed** the Ka Aronui Ki Te Kounga / Focussed on Quality (draft)
- **Confirmed** a range of appointments to Clinical Advisory Committees of Clinical Council
- **Finalised** HB Health Consumer Council Annual Plan detail for 2017/18
- **Discussed** the Information Services Plan with Chief Informartion Officer (CIO)

Consumer Council met on 10 August 2017, an overview of issues discussed and/or agreed at the meeting are provided below.

The following papers were considered:

- ***Te Ara Whakapiri – Last Days of Life***

Council provided feedback and endorsed this work done by Leigh (by ovation). Consumer Council were involved in earlier stages in the development of this work.

- ***Ka Aronui Ki Te Kounga / Focussed on Quality (draft)***

Council has had significant input into the development of the annual quality report since its inception. This latest iteration is a positive development hopefully meaning greater readability.

- ***Appointment of members to the "HB Health Sector Clinical Governance Structure"***

The revised committee structure for Committees reporting to Clinical Council, required the appointment of eight members of Consumer Council to the five Clinical Council Advisory Committees. These appointments were made at the meeting.

- ***Consumer Council Annual Plan 17/18***

Whilst the core of the Annual Plan remains the same as last year, the Youth Council has now been formed and is now BAU. Consumer members added their decision to work on enabling a Disability Strategy for the HB health sector. Council will develop a paper and then discuss the next steps with Clinical Council.

- ***Information Services Plan***

Council held a session with the CIO on the Information Services Plan. It was agreed to hold a Workshop to gain more understanding of IS issues and opportunities from a consumer perspective.

OURHEALTH HAWKE'S BAY Whakawateatia	**Chair – Hawke's Bay Health Consumer Council** 87
	For the attention of: **HBDHB Board**
Document Owner:	Ken Foote, Company Secretary, HBDHB
Reviewed by:	Not applicable
Month:	August 2017
Consideration:	For Approval

13

RECOMMENDATION

That the Board

- **Approve** the recommendation of the HBDHB CEO and Health HB Ltd GM, to appoint Rachel Ritchie as Chair of the Hawke's Bay Health Consumer Council, in accordance with the terms and conditions below.

BACKGROUND

Graeme Norton is the current Chair of the Hawke's Bay Health Consumer Council being initially appointed for a 12 month term from 1 May 2013 and subsequently reappointed for a three year term to 31 March 2017. Although indicating an intent to stand down, Graeme has agreed to continue in the role to 31 August 2017, whilst we completed the process to appoint a successor.

An initial request for nominations earlier this year did not identify any suitable candidates so the process was run again in June. From the limited number of nominations received, Rachel Ritchie was identified as a potential appointee.

RACHEL RITCHIE

Rachel has been a valued member of Consumer Council since August 2014, and for the past twelve months has been a member of the Council's informal leadership group, being highly regarded by her peers.

A brief summary of her CV includes:

> *"A motivated and experienced senior leader, with an extensive background working in Board and advisory positons to support both commercial and community based organisations. A background as a qualified lawyer and Senior Associate, practicing in both New Zealand and the UK. Capable of providing an exemplary level of customer service to a commercial client base and building relationships across sectors. Communication skills and both administrative and strategic skills highly developed."*

At the time of her appointment to Council, Rachel identified her motivation for wanting to be involved in the Consumer Council:

> *"Having a young child with Type 1 Diabetes has meant I am a very regular user of health services across the public and private systems and in a number of different areas. As a result of this intensive experience, I have developed an interest in health services and a particular interest around the provision of patient centred care, and the connection between that approach and improved health outcomes for patients. I have been able to articulate the perspective of a regular user with both a child's experience and an adults, particularly around chronic conditions, and am keen to assist the health sector in Hawke's Bay."*

Now Rachel sees an opportunity to apply her strategic, governance, facilitation and communication skills in this leadership role and further contribute to improving the health outcomes and experiences of the Hawke's Bay community.

PROCESS

Rachel was formally interviewed for this role by HBDHB CEO, the current Consumer Council Chair and HBDHB Company Secretary. Her potential appointment was subsequently discussed with HHB Ltd's General Manager.

Following these processes, both HBDHB CEO and HHB Ltd GM, now recommend Rachel be appointed. This recommendation was endorsed by the HHB Board.

TERMS & CONDITIONS

- This appointment will be effective from 1 September 2017 and end on 31 March 2020 ie, within four months after the end of the term of the HBDHB Board, in accordance with the Terms of Reference
- Rachel shall however be eligible for reappointment.
- This appointment will be reviewed after six months to ensure that Rachel is still able and willing to meet the time commitment required.

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board (MRB)** 88
	For the attention of: **HBDHB Board**
Document Owner:	Ngahiwi Tomoana (Chair)
Reviewed by:	Not applicable
Month:	August 2017
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board

Review the contents of this report; and

Note that MRB:

- **Request** for Alcohol Free Health Awards proposal to the Board to make the Hawke's Bay Health Awards an alcohol-free event.

MRB met on 9th August 2017, an overview of issues discussed and recommendations at the meeting are provided below.

The following reports and papers were discussed and considered:

Oral Health Services and Kōhanga Reo
MRB briefly discussed issues with non-Māori speaking providers entering Kōhanga Reo. MRB noted the DHB have a Memorandum of Understanding (MOU) with National Kōhanga Reo Trust Regional Office and **recommend** the HBDHB update the MOU to include the provision of te reo Māori speaking staff when working with Kōhanga Reo as business partners. The DHB confirmed that te reo Māori speaking staff were available and work with Kōhanga Reo.

MRB also suggested that DHB treat all Māori organisations as business partners and as such should support the provision of te reo Māori speaking staff when working with them.

In addition, it was suggested the HBDHB could attract te reo Māori speaking staff with additional remuneration benefits within employment agreements. The DHB confirmed that staff are supported with te reo Māori training including paid training.

Te Ara Whakawaiora - Mental Health (National And Local Indicators)
MRB noted the contents of the report and was supportive of the work being undertaken however would like the DHB Mental Health Services to recognise the importance of addressing the wider determinants of health and the requirement for more involvement in whole of sector approaches. MRB also recommended DHB Mental Health Services develop opportunities to work more with whānau and community groups as part of the whole sector approach to eliminate inequities.
ACTION Mental Health Services to develop proposal, including whānau and community groups, to have greater input into whole of sector approaches, i.e. the Intersectorial Forum.

Health Literacy (Making Health Care Easier To Understand)
MRB **noted** the contents of the report and was very supportive of the work being undertaken.

MRB would like to see the term 'Consumer' changed to 'Whānau' as health and long term conditions impact all whānau rather than solely an individual consumer/patient.

MRB Meeting 7th September
The HB Health Sector Leadership Forum is on 6 September, therefore there was no MRB meeting scheduled for September. However, as there is a number of papers on the agenda for September's mail out MRB **endorsed** an MRB meeting on 7th September at 9am.

Te Ara Whakapiri Hawke's Bay (Last Days Of Life)
MRB **noted** the content of the report and was supportive of the work being undertaken pending further consultation with Patrick Le Geyt and Sharon Mason as MRB highlighted the omission of cultural responsiveness in the evaluation and were surprised this project was not piloted with more Māori.

Acting GM Māori Health and Chief Operating Officer will support Leigh White to make amendments to this care plan with reflection of Māori and bring back to MRB. Leigh is to continue the current work however make appropriate changes to include spiritual aspects to support whānau beliefs and empowering staff around spiritual values. Hine Flood will coordinate with Leigh to present the update plan to Kaumātua in Wairoa for feedback.

Proposal - Request for Alcohol Free Health Awards
MRB noted the contents of the proposal by Heather Skipworth and was supportive. MRB **endorsed** the proposal going to the Board. Refer to Appendix One.

Ngātahi Vulnerable Children's Workforce Development Programme
MRB noted the contents of the report. MRB suggested that the employment of more Māori into the workforce would largely address issues of cultural competency and engaging effectively with Māori. MRB **recommends** cultural expertise be used to develop the training programme for the Ngātahi Competency Framework.

Appendix One

HAWKE'S BAY District Health Board Whakawāteatia	**Request for Alcohol Free Health Awards**
	For the attention of: **Māori Relationship Board**
Document Owner: Document Author:	Tracee TeHuia, ED Strategic Services Heather Skipworth, Deputy Chair MRB
Reviewed by:	N/a
Month:	August
Consideration:	Discussion

14

RECOMMENDATION

That the Māori Relationship Board

Recommend this proposal to the Board to make the Hawke's Bay Health Awards an alcohol-free event.

BACKGROUND

> *How appropriate is it to serve alcohol (a health-harming substance) at an event that celebrates health?*

In consideration of the increasing rates of alcohol related harm in the Hawke's Bay community,[1] it is important that the Hawke's Bay District Health Board (DHB) demonstrate leadership by insisting on alcohol-free environments for staff, visitors and the general public.

In 2016, Hawke's Bay DHB adopted a Position Statement around alcohol with the vision of *"…healthy communities, family and whanau living free from alcohol related harm and inequity".* In adopting this position, the DHB have affirmed that alcohol is a priority health and equity issue in Hawke's Bay. This position statement also makes clear that "...the widespread promotion of and accessibility to alcohol has a significant role to play in people's drinking behaviour."

In addition, the draft Hawke's Bay DHB Alcohol Harm Reduction Strategy 2017-2022 is set to be presented to the Board for approval in September 2017 and, once approved, will reinforce the Health Board's responsibility as a leader in reducing alcohol related harm in the region.

As such, we believe that making alcohol freely available at the upcoming Hawke's Bay Health Awards normalises alcohol use in a health setting and is incompatible with the DHB's commitment to reducing alcohol related harm.

Leadership has already been demonstrated in this area. Ngāti Kahungunu Iwi Incorporated have, since 2014, shown that an alcohol-free stance is both possible and effective. All iwi events—for example, Annual Sports Awards and Waitangi Day celebrations—are alcohol-free and remain

[1] 1 in every 4 adults in Hawke's Bay is a hazardous drinker and Hawkes Bay has higher rates of hazardous drinking that the rest of the country.

popular and well-attended. Their stance has been applauded and received much positive media interest.

It is recommended that the Hawke's Bay District Health Board follow this progressive response and demonstrate to the community and to the wider health sector that protecting our most vulnerable communities from alcohol related harm[2] by reducing availability and denormalising alcohol use requires meaningful reflection on our own practices and leadership by example.

It is our belief that the time is right for the Hawke's Bay District Health Board to become a credible role model and commit to being an alcohol-free organisation.

[2] This includes injury, violence, and exclusion from society, foetal alcohol spectrum disorder, cancer and chronic conditions.

HAWKE'S BAY District Health Board Whakawāteatia	**Pasifika Health Leadership Group** 89
	For the attention of: **HBDHB Board**
Document Owner:	Barbara Arnott, Chair of CPHAC
Document Author(s):	Caren Rangi, Chair of PHLG
Reviewed by:	Tracee Te Huia, Executive Director - SHI Directorate
Month:	August 2017
Consideration:	For Information

15

RECOMMENDATION

That the HBDHB Board

Note the contents of this report.

The Pasifika Health Leadership Group met on 14 August 2017 and an overview of the discussion is provided below.

WORKFORCE DEVELOPMENT

Nuanua Pasifika Health Workforce Collective Hawke's Bay (Nuanua Workforce) is a group of Hawke's Bay Pacific health workers initiated in 2013 by the HBDHB. Pacific workforce is the focus of their work.

Vaevae Tuahine the Chairperson of Nuanua Workforce was invited by Talalelei Tuafale to attend the Creating a Diverse Workforce – Invitation to Workshop" led by Kate Coley. This workshop was attended by portfolio managers across the HBDHB and HR staff. A follow-up meeting is due to take place on 16 August. A presentation was delivered to PHLG by Vaevae Tuahine that outlined Pacifica workforce data across the district health board from this workshop. This data illustrated the need to plan for an equitable workforce to match the population shift of Pacifica ensuring there is a plan going forward for recruitment and retention.

Nuanua Workforce hosted a meeting in August for Pacific workforce in Hastings. This was their first public meeting that included; a Pacific health overview provided by Talalelei Taufale, Vaevae Tuahine outlined Pacific workforce numbers in the HBDHB and Dr Tony Diprose provided a captivating overview of his work in the hospital setting and Pacific communities around the Pacific. Key workforce topics discussed included; recruitment, supply and retention. The feedback on these topics will be used to inform the follow-up meeting for the Creating a Diverse Workforce discussion led by Kate Coley.

ANNUAL PACIFIC HEALTH PLAN QUARTER 4 (April-June 2017)

The Quarter 4 report was tabled and noted with achievements noting:

- B4SC rate - 5% above the equity at 109% (target 104%)
- Increased immunisation rates rose from 94.6% to 100% this quarter

Some areas of progress noted:
ASH rates (0-4) - a decrease from last quarter from 153% to 149.7%.
Breast and Cervical screening – looking at innovative ways to achieve meeting these targets.

Historical data over the last five years has illustrated very little shift in all areas of Pacific targets, however, it was noted there has been real and genuine efforts by stakeholders to improve Pacific statistics.

PHLG commented that workforce strategy would be a good KPI for the HBHDB Board as there is a real need to improve capability and capacity to increase Pacific workforce.

PACIFIC HEALTH UPDATE REPORT

Some highlights noted:

- *Le Va* delivered a 3 day "Engaging Pasifika Workshop" on workforce development that engaged workers from primary care, including a number of clinicians (GPs and secondary care), frontline workers, social workers, receptionists etc. Those that attended spoke on how much they learnt from the workshops and those that were unable to attend have requested Le Va to return to deliver further workshops. Evaluation feedback will be shared with the PHLG.
- *Clinical Services Plan* – Sapere met with the PHLG late July to consult with the group on the CSP. The PHLG felt that there was little time spent on discussion due to the time taken to discuss statistical data, prompting a feeling of mixed messages.
  A meeting is scheduled for 20 September that will focus on a respiratory client's (aged 10-14 years) journey from entry to exit point. PHLG voiced their concern that this would best be facilitated by Pacific representation and requested that Pacific families be included in the patient journey due to complexities and barriers. This feedback has been included into the patient journey and family focus groups being set up.

PHLG REVIEW

The PHLG review will move forward in September, following Ken Foote (Company Secretary's) return from leave.

HBDHB OCTOBER BOARD MEETING

The PHLG look forward to attending the HBDHB October Board meeting to deliver an update on:

- Tupaias[1] (Pacific Health Navigators); and
- Pacific Workforce Strategy

[1] *Tupaia, Captain Cook's Polynesian Navigator*

"THE BIG LISTEN"
AND THE
"CLINICAL SERVICES PLAN"

Verbal

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HAWKE'S BAY District Health Board Whakawāteatia	**Hawke's Bay Drinking Water Governance Joint Committee - Terms of Reference** 90
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Tracee Te Huia, Executive Director SHI Directorate Dr Nicholas Jones, Medical Officer of Health
Reviewed by:	Executive Management Team
Month:	August 2017
Consideration:	For Information and Decision

RECOMMENDATION

That the HBDHB Board :

1. Endorse the Terms of Reference for the new Hawke's Bay Drinking Water Governance Joint Committee.
2. Agrees the nomination of two representatives from the HBDHB Board to join the committee.

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OVERVIEW

During the early stages of the Government Inquiry into Havelock North's Drinking Water (the "Inquiry"), Dr Kevin Snee wrote to the Chief Executives of Hastings District and Hawke's Bay Regional Councils proposing the establishment of a working group of officials from each agency to strengthen collaboration concerning drinking water safety. The Drinking Water Safety Joint Working Group (JWG) was subsequently established and has met regularly since with meetings chaired by Mr Chris Tremain. The JWG has been tasked with responding to a number of recommendations from the Inquiry and has been reporting to the Inquiry panel through the Chair.

At the June hearing of the Inquiry, the panel expressed concern about the sustainability of the JWG and its work programme upon the completion of the Inquiry. It was agreed by the Chief Executives of each agency that sustainability would be strengthened by the establishment of a governance body. Mr James Palmer, CEO HBRC, proposed that the body be established as a joint committee of the Councils and Hawke's Bay DHB, and this concept was supported by the Inquiry panel.

The attached paper is the Terms of Reference (TOR) for the new committee. The TOR is the most recent version incorporating input from the DHB and other parties. The board should note an earlier version of the TOR was endorsed by some of the other councils due to council meeting schedule timing. It is expected that upon the Board's endorsement of the attached those councils will accept the version attached.

The paper seeks endorsement of the Board of HBDHB and calls for nomination of two representatives from the Board to join the committee. The committee will meet six monthly, although may meet more frequently as required.

ATTACHMENT:
Appendix 1 – Terms of Reference

Appendix 1

Hawke's Bay Drinking Water Governance Joint Committee

Terms of Reference

1. Background

1.1. In August 2016 a significant water contamination event occurred that affected the Hawke's Bay community of Havelock North. The Government established an Inquiry into the Havelock North water supply.

1.2. It became apparent during the Government Inquiry that in order to achieve a systematic approach to ensuring safe and reliable drinking water, there was a need to strengthen interagency working relationships, collaboration and information sharing pertaining to drinking water.

1.3. The Inquiry asked a Joint Working Group (JWG) initially comprising staff representatives of the Hawke's Bay District Health Board, Hawke's Bay Regional Council and the Hastings District Council to implement its 17 initial recommendations. As this group has evolved it has become apparent that many drinking water issues will require an ongoing forum for regional collaboration and decision making. Napier City Council have also joined the Joint Working Group.

1.4. Ngati Kahungunu Iwi Incorporated have called for the agencies involved in water management to view water as a taonga, the lifeblood of the land and people. They consider that drinking water should be set as the number one priority for water use in decision-making processes related to water.

1.5. It is within this context that the Hawke's Bay Drinking Water Governance Joint Committee has been established. The principal focus of the Committee is on drinking water, however drinking water cannot be considered in isolation from other fresh water management issues. For that reason the focus of the Committee will be twofold: 1. To provide governance oversight for planning and decision making on regional drinking water matters; and 2. To consider and make recommendations where appropriate to decision-making bodies with responsibility for broader freshwater management issues or planning or infrastructure issues that have implications for drinking water or drinking water safety.

2. Purpose

2.1. The parties agree that water is a taonga, the lifeblood of the land and people. They further agree that the Joint Committee established under this Terms of Reference is intended to give practical meaning and effect to this agreement.

2.2. The Committee is established to provide governance oversight to the existing JWG regarding the implementation of recommendations from the Inquiry Panel and then the evolution of the JWG into a more permanent officials working group.

2.3. In the context of this agreement including 2.1 and 2.2 above, the purpose of the Hawke's Bay Regional Drinking Water Governance Joint Committee is to give governance oversight and direction in respect of the following matters:

2.3.1. Programmes and initiatives to protect and enhance drinking water quality, safety and reliability.

2.3.2. Improving and maintaining effective inter-agency working relationships relating to drinking water, including monitoring the extent and effectiveness of cooperation, collaboration and information sharing between the agencies, monitoring mechanisms to achieve these desired outcomes, and encouraging member parties to give adequate consideration to the safety and reliability of drinking water in the carrying out of their range of functions.

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2.3.3. Provision of governance oversight of strategies, priorities and implementation monitoring related to drinking water management, including drinking water sources, infrastructure matters and drinking water emergency response.

2.3.4. To recommend to relevant bodies and decision making fora (including bodies with responsibility for regional and district level planning) initiatives and priorities affecting drinking water and changes to strategies and work programmes to protect and enhance drinking water quality, safety and reliability, having regard to the needs of the region for adequate and secure water resources suitable for the supply of safe drinking water.

2.4. The geographic scope of the Joint Committee's jurisdiction shall be over drinking water related matters on the land and catchment areas within territorial authorities who elect to be members of the Joint Committee (the participating territorial authorities) plus such other land and catchment areas within the authority of the Hawke's Bay Regional Council that have an impact upon drinking water within the participating territorial authorities.

3. Members/Parties

3.1. If they elect to take up membership and establish the Joint Committee, each of the following shall be a Member of the Hawke's Bay Drinking Water Governance Joint Committee and a party to this document and the establishment of the Joint Committee:

3.1.1. Hawke's Bay District Health Board

3.1.2. Hawke's Bay Regional Council

3.1.3. Central Hawke's Bay District Council

3.1.4. Hastings District Council

3.1.5. Napier City Council

3.1.6. Wairoa District Council

3.2. Each member may appoint two (2) representatives.

3.3. To ensure the work of the joint Committee is not unreasonably disrupted by absences each party may appoint alternative representatives.

3.4. The Joint Committee shall appoint an Independent Chair of the Joint Committee.

3.5. Water is of particular importance to Maori, and Maori have certain statutory rights in respect of decision making relating to water under the Resource Management Act 1991 and the Local Government Act 2002. Some iwi representatives have been involved in discussions leading to the proposal for this Joint Committee but have not determined whether or not they wish to formally participate in the Joint Committee. Provision is made for iwi representation to be added to the Committee should iwi organisations with authority in respect of the geographic areas over which this Joint Committee has jurisdiction indicate that they wish to formally join the Committee.

3.5.1. Notwithstanding any decision by iwi organisations under 3.5 above, the member organisations will take steps to consult with, and take into account the interests of, Maori as appropriate in terms of local authority decision making requirements in respect of matters before the Joint Committee.

4. Name

4.1. The Hawke's Bay Drinking Water Governance Joint Committee shall be known as the **Hawke's Bay Drinking Water Governance Joint Committee (HBDWGJC).**

5. Status

5.1. By agreement of the local authority members, the Hawke's Bay Drinking Water Governance Joint Committee is established as a Joint Committee under clause 30 and clause 30A of

Appendix 1

Schedule 7 of the Local Government Act 2002. It is a Committee of each of the member local authorities.

5.2. By this agreement between the parties, the Committee shall also include members who are not local authorities.

6. Delegated Authority

6.1. The Hawke's Bay Water Governance Joint Committee shall have authority to undertake such steps as are necessary to give effect to the purpose of the Hawke's Bay Water Governance Joint Committee including;

6.1.1. Reviewing and amending as necessary the Terms of Reference for the JWG that comprises officer working for the member organisations.

6.1.2. Receiving reports from and giving direction to the officials Joint Working Group that leads interagency cooperation and work programmes on drinking water quality, safety and reliability and/or the Chief Executives of the member agencies.

6.1.3. Commissioning reports and studies.

6.1.4. Making recommendations to members related to the security, safety and reliability of drinking water.

6.1.5. Making recommendations to members relating to strategies, priorities and work programmes.

6.1.6. Making recommendations to appropriate parties on matters within the purpose of the Joint Committee.

7. Administering authority and servicing

7.1. The members of the Hawke's Bay Drinking Water Governance Joint Committee shall work with the JWG established to lead interagency cooperation and work programmes on drinking water quality and safety. The JWG together with the Chief Executives of the member agencies will provide reports and information to the Joint Committee.

7.2. The Administering Authority of the Joint Committee shall be the Hawke's Bay Regional Council.

8. Remuneration/Costs

8.1. Each member of the Hawke's Bay Drinking Water Governance Joint Committee shall be responsible for the cost of its participation in the Joint Committee.

8.2. The Joint Committee shall agree on the apportionment of the costs of the independent chair on the recommendation of the JWG.

8.3. The JWG shall agree the apportionment of any costs arising from the work of the Joint Committee.

9. Meetings

9.1. The Standing Orders of the Hawke's Bay Regional Council will be used to conduct Joint Committee meetings.

9.2. The Joint Committee shall meet not less than 6 monthly or at such other times and places as agreed for the achievement of the purpose of the joint committee.

10. Quorum

10.1. The quorum at any meeting shall be not less than half of the member representatives on the Joint Committee plus one representative.

11. **Voting**

11.1. The members shall strive at all times to reach a consensus.

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11.2. Each member representative and the independent Chairperson shall be entitled to one vote at any meeting.

11.3. There shall be no casting vote.

12. Chairperson and Deputy Chairperson

12.1. Member representatives shall appoint by agreement an independent chairperson who shall be entitled to a vote.

12.2. The Joint Committee shall also appoint by simple majority vote, from among the representatives, a Deputy Chairperson.

13. **Variations**

13.1. Any Member may propose an amendment (including additions or deletions) to the Terms of Reference which may be agreed to by the Joint Committee as a recommendation for consideration by the member organisations.

13.2. Amendments to the Terms of Reference shall have no effect until each member organisation agrees to the amendment.

14. **Good Faith**

14.1. The parties to this Terms of Reference agree to act in good faith towards each other and to give effect to the purpose of the Joint Committee.

Dated:

Signed on behalf of:

HAWKE'S BAY District Health Board Whakawāteatia	**Ngātahi Vulnerable Children's Workforce Development Programme - briefing paper** 91
	For the attention of: **HBDHB Board**
Document Owner: Document Author:	Tracee Te Huia ED Strategy and Health Improvement, Dr Russell Wills, Project Sponsor
Reviewed by:	Executive Management Team and Māori Relationship Board
Month:	August 2017
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board

- Note the contents of this report.

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OVERVIEW

Ngātahi is a large, cross-sector, workforce development programme for the vulnerable children's workforce, funded jointly by HBDHB, MSD and the Lloyd Morrison Foundation. Dr Russell Wills is project sponsor and Bernice Gabriel (CAFS senior psychologist on secondment) is the project manager. The project currently includes 24 health, education and social sector agencies and services in Hawke's Bay and around 450 staff. Government and NGO, kaupapa Māori and mainstream services are involved.

BACKGROUND

Tamariki of parents with mental illness, addictions, and in violent relationships ("vulnerable children") are at high risk of poor health, education and social outcomes. Māori are highly over-represented among these families/whānau.

Recognising this, Government has embarked on a programme to reform the way these families and whānau are supported, including changes to legislation and accountabilities of Ministry Chief Executives, Child, Youth and Family evolved to Oranga Tamariki, implementation of multi-agency Children's Teams in ten sites, additional funding and changes to expectations and monitoring of all agencies with a part to play in supporting such families.

The workforce serving such families sometimes lacks the skills to identify these families, assess both strengths and risks, formulate an assessment, design and implement a support plan with families and work collaboratively with the agencies involved. It is widely accepted that these skills are necessary but some essential skills may not be taught at undergraduate level and may be weak or missing in some professionals working with vulnerable children and families.

Government's structural changes are essential but will not achieve what is hoped for if the skills required within the workforce are not strengthened. For these reasons the Ministry of Social Development Children's Action Plan Directorate began a programme of work to develop a *Vulnerable Children's Core Competency Framework*, in partnership with sector leaders from education, health and social services. The framework was extended by Child, Youth and Family

(now Oranga Tamariki). It is still in development but sufficiently well-developed to trial in one region (HB).

The Ngātahi project aims to map the skills and learning needs of health, education and social service professionals in Hawke's Bay working with vulnerable children and families, and design, implement and evaluate a development plan for the workforce over three years.

Because the majority of whānau served by the vulnerable children's workforce are Māori, correct tikanga is essential for this programme. Principles such as aroha, tika and pono, rangatiratanga, whakamanawa and kaitiakitanga, cultural competence and cultural safety will be fundamental to the programme. We have agreed to take a *tuakana-teina* (elder sibling/leader - younger sibling/ learner) approach. This allows services and practitioners to take roles, rather than be judged or graded. Most servies have something to offer as a leader and I have asked all services to share staff to teach and resources that will support practice change, such as job descriptions, appraisal forms and teaching packages. I believe most teaching needs at Foundation level should be met within the resources of local services. This saves money but also strengthens relationships, fostering collaborative practice. Services leaders are supportive of this approach.

Progress to date
Bernice Gabriel was appointed in early March as project manager. Bernice is a clinically credible leader, widely respected in the sector, and founded the Fostering Security programme for caregivers of children in CYF care, in partnership with CYF (now Oranga Tamariki).

The first phase of the project was to socialise the concept, seek support and advice from managers and service leaders, gain agreement on the framework and map staff competencies against it. A hui on 4th May brought together leaders of 25 health, education and social sector agencies representing around 450 staff. Leaders agreed on descriptions of each competency and the tiers of competency required by each sector.

We have made several visits to services and there is unanimous support to date. Bernice continues to visit services, particularly to socialise the programme with staff, finalise with leaders the competencies they expect of their staff, support leaders in their competency mapping with staff, and identify who the leaders (tuakana) are.

We expect all competency mapping to be complete (including data entry) by the end of September. This will allow us to plan the training schedule for 2018 including agreeing programme content, teachers (tuakana) and trainees (teina), venues and logistics. The Child, Adolescent and Family Service (CAFS) are slightly ahead of the rest of other agencies, having completed competency mapping and begun approaching training providers. We hope to begin their training programme this year, which will involve specialist trainers from outside Hawke's Bay.

Research and evaluation
Prof Kay Morris Matthews of EIT has been contracted to provide the evaluation of this phase of the project. Kay and her team have begun interviews with CAFS staff on their experience of competency mapping and will extend this to other agencies shortly. The evaluation will demonstrate whether or not competencies improve, if this leads to practice change, and if this leads to improved outcomes. An early paper describing the project is expected.

Next steps
The end product of the first year of the project will be a business case for the development programme in 2018 and 2019.

FINANCIAL IMPLICATIONS OR OTHER KEY ISSUES AS REQUIRED

A business case for staff development in 2018 and 2019 will be prepared following analysis of the competency mapping. This is an entirely voluntary process. We do not yet know what competencies will be prioritised by sector leaders or how much resource (staff time and back fill, tuakana time) they will be able to contribute. The business case will be written in December when these are known.

ATTACHMENTS:

Ngatahi Terms of Reference

Competency Framework

List of services involved

WHAKAWATEATIA
HAWKE'S BAY
District Health Board

Terms of Reference

Project Details

Project Name	Ngātahi Vulnerable Children's Workforce Development
Version	3.0 Final
Date	May 2017
Document Storage Address	I:\Projects\Ngatahi\Project Management\TOR\Ngātahi Terms of Reference v3.0 Final.docx
Project Sponsor	Dr Russell Wills
Project Manager	Bernice Gabriel
Authors:	Dr. Russell Wills and Bernice Gabriel
Endorsed By:	Ngātahi Steering Group and Transform & Sustain Steering Group

18.1

Authorisation

This document authorises the project manager to undertake the delivery of this project. There can be no changes to this document without Project Sponsor sign off of any amendments. This is a formal written process utilising the HBDHB project templates and procedures for change control.

Tracee Te Huia — 12/05/17
Senior Responsible Owner — **Date**

Dr Russell Wills — 11/5/17
Project Sponsor — **Date**

Bernice Gabriel — 11/5/17
Project Manager — **Date**

Kate Rawstron — 12/5/17
Project Management Office Manager — **Date**

Acknowledgments
We gratefully acknowledge the contributions of our funders, the Lloyd Morrison Foundation, Ministry of Social Development and the Hawke's Bay District Health Board

1. BACKGROUND

Tamariki of parents with mental illness, addictions, and in violent relationships ("vulnerable children") are at high risk of poor health, education and social outcomes. Māori are highly over-represented among these families/whānau. Recognising this, Government has embarked on a programme to reform the way these families are supported, including changes to legislation and accountabilities of Ministry Chief Executives, reform of Child, Youth and Family, implementation of multi-agency Children's Teams in ten sites, additional funding and changes to expectations and monitoring of all agencies with a part to play in supporting such families.

The workforce serving such families lack many of the skills to identify these families, assess both strengths and risks, formulate an assessment, design and implement a support plan with families and work collaboratively with the agencies involved. It is widely accepted that these skills are necessary. But often some essential skills are not taught at undergraduate level and are weak or missing in many professionals working with vulnerable children and families.

Government's structural changes are essential but will not achieve what is anticipated if the skills required within the workforce are not strengthened. It is for these reasons the Ministry of Social Development Children's Action Plan Directorate began a programme of work to develop a Vulnerable Children's Core Competency Framework, in partnership with sector leaders from education, health and social services. The framework is still in development but sufficiently well-developed to trial in Hawke's Bay.

The Ngātahi Project is a multi-agency, collaborative project to assess the skills and learning needs of health, education and social service professionals in Hawke's Bay and will leverage the Vulnerable Children's Core Competency Framework. Agencies working with vulnerable children and families will be invited to actively collaborate in designing, implementing and evaluating a development plan for the workforce over three years. In Hawke's Bay, the project involves the Ministry of Social Development (MSD), Ministry for Vulnerable Children Oranga Tamariki (MVCOT), Hawke's Bay District Health Board (HBDHB), Ministry of Education (MoE) Hawke's Bay, The Lloyd Morrison Foundation, Eastern Institute of Technology (EIT) and local services involved in caring for vulnerable children and their families.

All aspects of this project – values, goals, scope, methodology, benefits and measures - will be discussed and agreed with policy decision-makers, funders, local executives, operational leaders and other key stakeholders before the project begins.

Because the majority of whānau served by the vulnerable children's workforce are Māori, correct tikanga is essential for this programme. Principles such as aroha, tika and pono, rangatiratanga, whakamanawa and kaitiakitanga, cultural competence and cultural safety will be fundamental to the programme. A hui was held on Monday 7th November 2016 including members of the Maori Relationship Board and Consumer Council, facilitated by staff of the Hawke's Bay District Health Board Maori. The values and principles outlined below were highlighted as important in underpinning the Ngātahi Project.

Values and Principles

What should be the key foundational Values and Principles of the workforce development programme? *(Facilitator Laurie Te Nahu)*

1. Must be located within the strengths of the Whānau collective.
2. The health, wellbeing and safety of the child is paramount, however, must be considered within the needs of the Whānau.

3. Facilitation skills must coordinate best practice and include enhancing the mana of the Whānau over-all.
4. The intention of facilitating best practice should empower and enable the whole Whānau to participate in finding solutions.
5. The concept of Kaitiakitanga implies a Duty to Act and Care for people.
6. Key aspects of whanaungatanga (Family roles and responsibilities include accountability for the care of the child (ren).
7. A wholistic approach (able to deal with a range of variables/diversities identified through the facilitation process.
8. Honesty (the ability to have the courage to make a stand, and, or go the extra mile in working through difficult situations).
9. Kanohi Ki te Kanohi (the ability to face the difficulties head on in sometimes complex situations).
10. Tika/Pono (remain truthful and righteous particularly working with stretched Whānau dynamics).
11. Hui (full and active participation in decision-making is important).
12. Wānanga (as a place to impart knowledge, skills, and experience in order to gain competency).

Key Note: A key principle should involve the concept of Rangatiratanga: key aspects for the application of the above elements could be encapsulated in; displaying the qualities of a Rangatira including integrity, generosity, bravery, humility, respect, commitment to the Whānau/community, using facts and honest information, as well as legends and stories to make a case, relay a message, or explain things in a way which binds people together, i.e. facilitating rather than commanding.

2. PROJECT GOAL

The aim of this project is to design, implement and evaluate a development and training programme for the vulnerable children's workforce across the health, education and social service sectors in Hawke's Bay.

This project will **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 whanau. We will benchmark skills against the Children's Action Plan Core Competency Framework and relevant registration bodies via a knowledge and skills mapping exercise with each clinician in the vulnerable children's workforce in Hawke's Bay, and aggregate the results up to each service, each sector and as a region. We will then design, deliver and evaluate a training programme to address the skills gaps identified, and assess the impact on outcomes for children and families.

We also aim to **improve relationships and develop a shared language and culture** of "how we do things around here". We will achieve this by:

- Agreeing core values up front – an early goal of the project
- Including relevant stakeholders early, e.g., some unions may wish to be involved
- Joint local governance to model the expected collaborative practice from local leaders and ensure high engagement in the project
- Sharing resources (facilities, people) wherever possible
- Valuing local expertise, e.g., using local trainers wherever possible
- Joint training across services, e.g., practitioners from multiple agencies in one locality attending training together.

3. PROJECT SCOPE

Presently, the sector working with vulnerable children and young people in the Hawke's Bay includes:

- Ministry for Vulnerable Children Oranga Tamariki (MVCOT)
- HBDHB Child, Adolescent and Family Service (CAFS), Child Development Service, Paediatrics, Public Health Nurses, DHB-employed midwives and social workers
- Te Taiwhenua O Heretaunga well child/ tamariki ora team, Family Start, Hinengaro (mental health and addictions) service
- Te Kupenga Hauora Family Start Napier
- Plunket
- NGOs (e.g., Birthright Hawke's Bay, Napier Family Centre, Family Works, Youth Directions, DOVE Hawke's Bay, Women's Refuges)
- Ministry of Education Learning Support
- Resource Teaches Learning and Behaviour
- Primary Health providers (e.g. GP practices)
- Lead Maternity Carers

There are multiple (>12), smaller kaupapa Maori and faith-based health and social service NGOs in Hawke's Bay who may also wish to be involved.

We estimate around 250 staff have working with vulnerable families as the core, or a major part of their workload. Participation in this programme is voluntary for all agencies and therefore an individual agency will need to commit to all aspects of the process from engagement, sharing of skills and knowledge, through to being part of the evaluation process.

Participating agencies will be identified and the first wave (i.e. first year) of agencies will be agreed as part of the initial project activity. Followings waves of agency participants (e.g. in Years 2 and 3) will need to be agreed towards the end of Year 1 however it is the intention of this project to enrol and train as many of the c250 identified workforce as possible during the 3 year period.

Inclusions

No.	Objectives	Deliverables
1.	Map the strengths and gaps in the knowledge and skills of the vulnerable children's workforce in Hawke's Bay: • Assess competencies of all Year 1 agreed vulnerable children's workforce practitioners against the Core Competency Framework • Aggregate competency development needs by agency and regionally • Following waves in Years 2 & 3 to be determined at the end of Year 1	• Core competency mapping for each participating agency • Create an integrated Core Competency Map / Competency Database • Formalised performance plan (e.g. PDR) completed per workforce practitioner

2.	Design and deliver a training and development plan to address identified knowledge and skills gaps (as per the Core Competency Framework mapping) • Child Adolescent and Family Service (CAFS) Year 1	• Workforce development programme -consisting of individual modules (CAFS) • Training plan - CAFS (i.e. trainers, supervision etc) • Workforce Development Plan for Years 2 & 3
3.	Design and implement an Evaluation Framework to assess the outcomes, impact and effectiveness of the workforce development training programme	• Evaluation Framework (tools & processes)
4.	To improve relationships and develop a shared language and culture of "how we do things around here" across agencies working with vulnerable children and families in Hawke's Bay	• Enduring/ BAU Governance Structure • Enduring/ BAU Workforce development programme (including evaluation framework)

Exclusions:

- Practitioners not in the workforce listed above, e.g., other education, health and social service personnel
- Discipline-specific skills / competencies not contained in the Core Competency Framework
- Core training of new workforce practitioners specific to their agency
- Practitioners from outside the HBDHB area

4. BENEFITS

Successful implementation of this project is expected to result in the following high level benefits:

Project Benefits

No.	Benefit	Measure (KPI)
1.	Agreed core competency framework for disciplines across sectors	Framework in use by agency workforce
2.	More connected vulnerable children's workforce across Hawke's Bay	Joint training schedules across the sector and qualitative interviews with participants. Example measures include: • % programmes attended by staff from >1 agency • Self-report from practitioners, e.g., collaborative practice measure • Self-report by managers/ practice leaders of collaborative practice

		• Direct observation by evaluators, e.g., of FVIARS, Strengthening Families, MCWCP, IWS
3.	Vulnerable children workforce across sectors in Hawke's Bay change and improve knowledge and behaviour in identified core competencies • Practitioner skills increased across the Ministry for Vulnerable Children Oranga Tamariki domains specifically; prevention, early intervention, carer support (3 of 5 work streams identified)	Year 1: Baseline measures across sectors – as defined by the core competency framework Years 2 & 3: targeted improvements, to be agreed as part of the performance plans Example measures include: • Courses delivered by type and number of attendees • Self-report (before/after) on completing course • New, evidence-based programmes delivered with fidelity, number of attendees, number (%) completing courses • Manager/ practice leader report that delivering content to standard after agreed time • Direct client feedback, e.g., Marama online tool, fidelity tools for client feedback • Direct observation by evaluators • Confidence level of staff to assess
4.	Benefits to vulnerable children and their families over time	Outcomes seen beyond the life of the project/longer term benefits – longer term measures to be considered as part of the evaluation activity

Benefits Evaluation

Benefits will be demonstrated by an independent evaluation by expert programme evaluators led by Professor Kay Morris-Matthews of the Eastern Institute of Technology. Benefits will be aligned to the indicated Government's work streams for Oranga Tamariki (prevention, intensive intervention, and caregiver support) and family violence and sexual violence work streams.

The focus of this evaluation in year one is the skills mapping processes and early stage implementation of the workforce development programme within Child, Adolescent and Family Services (CAFS) at the HBDHB and across the wider Hawke's Bay vulnerable children's workforce in two related but separate evaluations:

- **Part A** is an evaluation of the implementation of a workforce development programme in CAFS. A skills mapping process is in progress, core and specialist skills that are clinician specific are being identified and training plans for each clinician planned. That is, the CAFS workforce development programme is one step ahead of that of the wider vulnerable children's workforce.
- **Part B** is an evaluation of the wider vulnerable children's workforce core competency skills mapping, training plan and development programme in year one.

The primary research question for both evaluation parts is "*What differences does a skills mapping development programme make for clinicians and front-line professionals who work with vulnerable children and adolescents?* (What do we know so far that leads to practice change and improved outcomes for children and adolescents?) ".
A mixed method approach will be used with both quantitative and qualitative data gathered to support.

Potential Longer-Term Benefits
Hawke's Bay would be the first region to undertake workforce development across the vulnerable children's workforce at this scale so we have agreed to undertake the programme in partnership with the Ministry of Social Development and share the lessons we learn with all relevant ministries and other regions. The original proposal has been discussed with and is supported by leaders in MSD, HBDHB, Special Education and NGO social services in HB working with vulnerable children, who have a well-established history of collaborative working.[1],[2] We believe that this project could become a template for development of the vulnerable children's workforce nationally.

5. STRATEGIC ALIGNMENT

This project strategically aligns as follows:

Strategy Area	Alignment
Better Public Services	The Ngātahi Project is consistent with the aim for government agencies working together and with communities to come up with innovative ways to deliver better public services.
Ministry of Health Strategy	multiple, see also guidance to DHBs for this year's annual plan "identify and address barriers to access to children in the care of Oranga Tamariki
HBDHB Transform & Sustain strategy	**This project supports Whole of Public Sector Delivery, and the multi-agency key intention by establishing a cross-agency programme for workforce development.**
Oranga Tamariki, Expert Advisory Panel final report	The Ngātahi Project supports the new "single point of accountability" model which focuses on five core services: prevention, intensive intervention, care support services, transition support and a youth justice service aimed at preventing offending and reoffending.
Social Inclusion Strategy	It is consistent with government's vision of fairness, opportunity and security for all New Zealanders.
Ngati Kahungunu strategic plan 2016-2017	It supports the Te Ara Toiora o Ngāti Kahungunu - Kahungunu Wellbeing Strategy which focuses on interventions and activities for a strong, vibrant, healthy whānau & hapū – te hau o te mauri, te hau o te ōrā.

18.1

[1] Wills R, Morris Matthews K, Hedley C, Freer P, Morris M. Improving school readiness with the Before School Check: early experience in Hawke's Bay. *NZMJ* 2010; 123: 47-58
[2] Wills R, Ritchie M, Wilson M. Improving detection and quality of assessment of child abuse and partner abuse is achievable with a formal organisational change approach. *J Paed Child Health* 2008;44: 92-98

6. ASSUMPTIONS

- Policy environment and Government priorities - vulnerable children will continue to be a Government priority, Ministers will commit resource and require ongoing collaboration of agencies for vulnerable children
- Relationships and buy-in will continue from:
  - Ministries
  - Local executives
  - Practice leaders and agency managers
  - Practitioners
  - Families, whanau, rangatahi and tamariki
  - Other stakeholders, e.g., trades unions, registration and disciplinary bodies
- Funding and resources will be available from MoE, MSD, HBDHB and philanthropic sources for years 2 and 3

7. INTERDEPENDENCIES

No hard dependencies have been identified at this point however the project will need to be aware of the following in the event a new dependency (or constraint) develops:

- Policy priorities: vulnerable children, family violence, sexual violence
- Local agency priorities, e.g.:
  - HBDHB strategic plan, Transform and Sustain, health and social care networks
  - MSD and Oranga Tamariki, e.g., establishment of new agency, development of funding strategy and local collaborations
  - MOE strategy, e.g., how this project facilitated MOE strategies such as improved ECE enrolment and NCEA L2 achievement
  - NGOs' strategic plans
- Other funders' priorities, e.g., Lloyd Morrison Foundation.

8. DELIVERY APPROACH

This project will leverage the MSD-led intersectoral Core Competency Framework to assess and develop the vulnerable children's workforce capability in Hawke's Bay. The need for training modules will be met through a combination of existing resources from the participating agencies, purchase of new modules not already available locally and some purpose-built training developed utilising regional skills and expertise.

The project has an expected duration of 3 years, but will be planned and delivered in waves with the project scope re-evaluated and agreed at year-end 'stage-gates' for the following year. CAFS will be the main focus of the first year of the project, as the leader of mental health care for children and young people in Hawke's Bay, and will be used to test and refine the programme for further rollout in Years 2&3.
This project can only be successful if done in a staged and collaborative way - done with, rather than to families and whanau, practitioners, services, local and national chief executives and other senior managers, funders and policy makers.

The project will utilise the HDBHB Project Management methodology based on PRINCE2 principles.

<u>Multi-Agency Governance Approach</u>
While there are many effective inter-agency groups in HB, we believe the **High and Complex Needs Local Steering Group (HCN LSG),** which includes leaders from key organisations within the vulnerable children's sector, would be the ideal local operational governance group

for this project in Hawke's Bay. We recommend that governance of the current project be a partnership between the HCN LSG and the Service Director of the HBDHB Mental Health and Addiction Service, Allison Stevenson. Consumer involvement in governance would be sought.

9. COMMUNICATION MANAGEMENT

A communications plan for the project has been developed and includes:

- Key communication points/schedule
- Communications methods (newsletter, direct email, face-to-face meetings with project steering group).

Due to the number of interested parties and stakeholders, and multi-agency focus, support will be sought from the HBDHB Communications Team for communications for the project.

10. REPORTING AND ISSUES ESCALATION

Reporting will be as follows.

- Project Manager will report monthly to the Project Sponsor and Project Management Office using the HBDHB monthly reporting template
- The Project Manager and/or Project Sponsor will report monthly to the Project Steering Group
- The Project Sponsor and/or SRO will providing reporting to the Bilateral Partnership Group.

Risks and issues will be reported to the same groups as indicated above.

11. QUALITY STANDARDS

Consistent with:

- HBDHB Project Management Standards are used to support project delivery
- Best Practice Communication and Engagement approach in engagement with stakeholders including: agendas / minutes etc.
- Information solutions comply with IS infrastructure and development strategy in HB
- Marketing information re hours of service etc. are of a professional standard and align with national messaging etc.

12. PROJECT TIMELINE

High Level Milestones	Date of Completion
Year 1 - Wider Vulnerable Children's Workforce	
• Face-to-face engagement with key stakeholders to ascertain participation in and commitment to project	April 2017
• Socialise and agree core competencies and tiers of competencies	May 2017 - early engagers, and June 2017 for all participating agencies

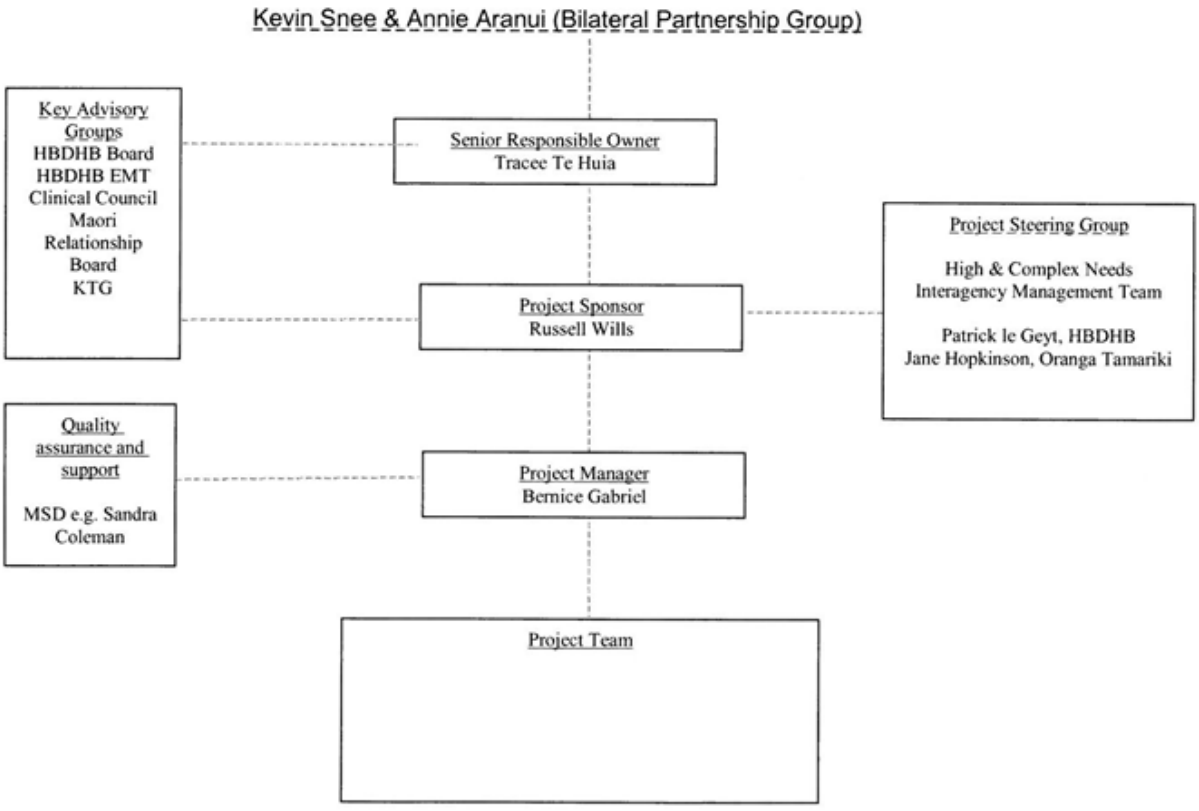
High Level Milestones	Date of Completion
• Agency stocktake/mapping of current and preferred level of competence (according to core competency framework), and mapped with key client issues and needs, submitted to Project Manager • Training and practice change plan developed for individual agencies and across sectors Year 2 • Begin implementing training and practice change plan	September 2017 October & November 2017 February 2018
Year 1- Child, Adolescent & Family Service • Socialise and agree core competencies and tiers of competencies, mapped with key client issues and needs • Stocktake/mapping of current and preferred level of competence (according to core competency framework), and mapped with key client issues and needs, submitted to Project Manager. Training and practice change plan developed • Initial training programmes implemented • Plan for second wave of training for year 2 developed Year 2 • Begin implementing training and practice change plan	May 2017 June 2017 August to November 2017 November/December 2017 February 2018
Year 3 - TBC	TBC
Benefits evaluation/Research • Benefits evaluation framework completed • Baseline data collected • Evaluations alongside training implementation plan • Report completed	 May 2017 June 2017 August to November 2017 January 2018
Project Management Milestones • Business Case / Resource application to deliver the training and practice change plan in Year 2 • Business Case / Resource application to deliver the training and practice change plan in Year 3	 Dec 2017 Dec 2018

13. FINANCIALS

Requirement	Budget – Year 1	Budget Source
Bilateral Partnership Group	$0	N/A
Steering Group	$0	N/A
Y1 workforce development programme for CAFS	$70,000	Lloyd Morrison Foundation
Project Manager – 1.0 FTE	$100,000	MSD
Evaluation	$80,000	HBDHB
Total Y1	**$250,000**	

Other project requirements will be met out of baseline budget.
Funding for subsequent years will be secured through the business case completed at the end of Year 1 (and 2).

14. Project Management Team Structure



See Appendix 1 for project role descriptions.

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15. RISK MANAGEMENT

The purpose of the risk management system is to:

- Effectively and efficiently manage project risk in order that project deliverables may be met within planned schedule, budget and quality requirements.
- Ensure Lessons learned are captured for use in future project activities

The HBDHB Project Support Office guide to Risk Management will be used to capture risk management for this project. Relevant mitigation activities will be included in the project plan.

Preliminary Risk Analysis:

Risk:	Likelihood Hi/Med/Lo	Impact Hi/Med/Lo	Planned Response
If Stakeholders do not engage in the workshop morning session then the competency descriptions will lack legitimacy which will undermine the project.	Medium	High	1. Ensure kaupapa for the day solid. Engage facilitators likely to have credibility with stakeholders more likely to disengage 2. Have a smorgasbord of competency descriptions for attendees to choose from.
If Stakeholders do not engage in the workshop afternoon session then there will not be agreement within sectors about the core competencies, which will negatively affect their ability to assess their skills and deficits in relation to the core competency framework.	Medium	High	1. Ensure kaupapa for the day solid. Engage facilitators likely to have credibility with stakeholders more likely to disengage 2. Have a smorgasbord of competency descriptions for attendees to choose from.
If managers/ practice leaders unable to use the competency framework in an agency stocktake/mapping of skills and deficits then we will not have a reliable baseline of competencies for the project, which will make it impossible to know if there was an improvement in competencies thereafter.	Medium	High	Face to face meetings with managers early in process to gain trust and buy-in. Meet again after workshop to discuss how they will achieve this. Provide coaching on use of core competency for agency stocktake/mapping for those that ask for it. Offer coaching if indicated.
If we cannot identify Tuakana from the sector for key domains or Tuakana unable to teach/ coach then we will need to bring in these skills, which will increase the cost for years 2 and 3.	Medium	Medium	Identify Tuakana/trainers as we go, ensure they are confident in their Tuakana role and provide support. Tuakana/trainers will be offered incentives, for example, recognition of trainer status for inclusion in CV's. Agencies will have tuakana as well as teina, so there will be a chance to 'pay it forward'.
If managers fail to see practitioner deficits and/or rate practitioners and their service higher on core competencies than they should be, the accuracy of the core competency baseline will be unreliable.	Medium	High	Open discussions with managers and practice leaders about the skills sets within their agencies, and the evidence for these.

If the identified staff training needs are greater than our training capacity then expectations will not be met and the success of the project will be negatively impacted.	Medium	Medium	Ensure clear and open communication around likely training capacity from the outset.
If professional and registration bodies do not support the core competency framework we won't be able to enforce workforce expectations and we won't get the trained workforce we require.	Low	High	Taking at face-value that the professional and registration bodies have bought into and signed off the vulnerable children's core competency framework.
If identified skills needs are not communicated in a positive and strengths-based approach with staff this may result in a negative impact on staff morale, union relationships, and undermines the success of the project.	Medium	High	Ensure that discussions with practitioners about the project is done positively, engages them, and is about building strengths and capacity rather than an audit of their performance.

References

Briere, J. & Lanktree, C. (2013). *Integrative Treatment of Complex Trauma for Adolescents (ITCT-A) Treatment Guide 2nd Edition*. USC Adolescent Trauma Training Center.

Fixsen, D., Naoom, S., Blasé, K., Friedman, R. & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

Hawke's Bay Health (2014). *Mai: Māori Health Strategy 2014-2019*. Retrieved from: http://www.hawkesbay.health.nz/file/fileid/49419

Hawke's Bay DHB (2012). *Final Mental Health Model of Acute Care*. Retrieved from: http://www.hawkesbay.health.nz/file/fileid/45451

Ministry of Social Development (2015). *Investing in New Zealand's Children and their Families Expert Panel: Final Report*. Retrieved from: http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/investing-in-children/index.html

Nanni, R. & Uher, A. (2011). Childhood Maltreatment Predicts Unfavorable Course of Illness and Treatment Outcome in Depression: A Meta-Analysis. *American Journal of Psychiatry*, 2011; DOI: 10.1176/appi.ajp.2011.11020335

OurHealth Hawke's Bay, (2013). *Transform and Sustain: The Hawke's Bay Health System*. Retrieved from: http://www.ourhealthhb.nz/assets/Strategy-Documents/Transform-and-Sustain.pdf

Teicher, M. & Samson, J. (2013). Childhood Maltreatment and Psychopathology: A case for ecophenotypic variants as clinically and neurobiologically distinct subtypes. *American Journal of Psychiatry, 2013*; 170: 1114-1133.

Werry Centre (2014). *Real Skills Plus ICAMH/AOD: A Competency Framework for the Infant, Child and Adolescent Mental Health and Alcohol and other Drug Workforce 2014*. Retrieved from: http://www.werrycentre.org.nz/real-skills-plus-camhs

Appendix 1: Project Role Descriptions

Bilateral Partnership Group
Provides *executive leadership*

- Local executive leaders of MSD and HBDHB
- Champions for the project
- Ensures the project is integrated into sector-wide strategies, e.g., the Hawke's Bay Regional Economic Development Strategy and Social Inclusion Strategy
- Ensures the project is integrated into organisational strategies and plans, e.g., HBDHB Transform and Sustain
- Strategic guidance, advice and removal of road-blocks
- Final decision maker Go / No Go decisions at key points and deliverables acceptance
- Available for key meetings to ensure the project momentum.

Project Steering Group (High and Complex Needs Interagency Management Group including Patrick le Geyt, HBDHB, Jane Hopkinson, Oranga Tamariki)
Provides *leadership for practice change*

- Operational champions for the project with leaders and frontline staff of involved organisations
- Provides regular up-dates and review of the status of the project
- Supports the Project Sponsor and Project Manager to manage major project issues and risks
- Contributes to decisions on acceptance of project deliverables and Go / No Go decisions at key points
- Escalates risks and issues as appropriate
- Available for key meetings to ensure the project momentum.

Senior Responsible Owner

- Provides strategic advice and direction to the Project
- Support for Project Sponsor
- Resolution of issues outside of the scope of the Project Sponsor
- Uses executive authority to overcome organisational barriers on behalf of the Project
- Advocates for high level support of the project, including resourcing.

Sponsor

- Guides and controls the project, lead project champion
- Works with Steering Group and advisory groups/ forums
- Holds and allocates project budget
- Change control: ensures all scope, time, cost, quality, risk, and business benefit parameters are met or the project plan is altered
- Key support for Project Manager in relation to the project
- Resolution of issues outside of the scope of the project manager or escalated to Steering Group or SRO as appropriate
- Communicates regular up-dates and review of the status of the project to SRO, Steering Group, or other key stakeholders and staff formally through agreed mechanisms
- Direct and immediate line of contact to project manager.

Project Management Office + Additional Project Assurance Roles

- Engaged by the project sponsor to provide pro-active input to assist and "assure" the project will: achieve planned benefits, meet quality requirements of customers, use best practice processes to create the deliverables and appropriately follow the project management processes.

Project Manager

Facilitates the project management process at all points as per HBDHB project management methodology including:

- Planning - Develops the project plan, stage plans, and detailed project delivery plans using available expertise and lessons learned.
- Delegating – Identifies and secures resources for the completion of all project delivery and ensures allocation of tasks to these resources with supporting work plans that clarify what is required by when.
- Monitoring – Monitors project delivery ensuring that all expectations are met in relation to time, cost, quality, scope, risk, and benefits.
- Controlling the project – ensure all issues and risks to project delivery are identified, analysed and responded to effectively using prescribed escalation routes and change control procedures including provision of information to the Steering Group and Project Sponsor to enable them to perform their function effectively.

Project Delivery Leaders and Provider Resources

- Complete tasks as identified in the agreed scope of work and project plan effectively.
- Work to agreed timeframes
- Report progress and elevates issues to the Project Manager in a timely way
- Effective team members demonstrating pro-active and constructive problem solving.

Ngātahi Core Competency Framework and Domains – April 2017

NGĀTAHI

WORKING AS ONE

HE KAUANUANU • ĀKINA • RĀRANGA TE TIRA • TAUWHIRO

Introduction to the framework

Welcome to the Ngātahi Core Competency Framework (the framework) for the vulnerable children's workforce in Te Matau-a-Māui Hawke's Bay. The framework uses the same six domains and 17 sub-domains of the Core Competency Framework for the Ministry for Vulnerable Children Oranga Tamariki (Oranga Tamariki CCF).

We are practitioners first, and have used a practice lens to group the Oranga Tamariki CCF 17 sub-domains into 11 that we believe

- Make sense in *practice*, e.g., child protection and family violence; adolescent development and mental health
- Are sensibly *taught together*, e.g., consent, privacy and information sharing; reflective practice, supervision and appraisal.

The sub-domains listed below should group together in a way that make it possible

- To clearly define the competencies within each sub-domain in tiers/ roles
- For leaders in each service or group of services to decide which tiers/ roles are appropriate for their practitioners
- To give guidance to leaders to work with their practitioners to appraise their current and desired future competency tiers/ roles
- To identify Tuakana (leaders) who can support others to achieve their desired level of competency
- For services and practitioners that would like to achieve a new tier of competency (Teina) to understand what that looks like and how that competency can be achieved.

We suggest preserving the tiers/ roles of the Oranga Tamariki CCF (Foundation, Practitioner, Leaders of Practice) in the Ngātahi CCF because we believe most competencies are common for all the vulnerable children's workforce, with a few exceptions due to Oranga Tamariki's legislative mandate and role. For a few sub-domains (e.g., assessment of parent mental illness and addictions, intimate partner violence, child development, adolescent mental health) we suggest the practitioner domain may need to separate out where a

practitioner's role is to assess and refer, and where the role includes to provide an intervention.

The framework emphasises the core *values* of the vulnerable children's workforce. They require all of us to consider the best interests of children at all times, ensure that children's voices are heard and included in all decisions affecting them and to ensure that we work in culturally safe ways at all times. The framework should promote collaboration between disciplines and sectors, the sharing of effective practices and improve the capacity of the workforce to work effectively with vulnerable children and their whānau.

In the vulnerable children's workforce roles cannot be rigid or exclusive. All levels require foundation-level competencies. The tiers build on each other and overlap, e.g., foundation level skills imply a basic assessment competency, and an effective intervention requires a competent assessment. However a leader need not have provided (or lead a service that provides) interventions. This emphasises that these are roles, rather than levels.

We recognise the important role of executive-level leaders in the vulnerable children's workforce (e.g., creating the correct policy environment, ensuring realistic caseloads, providing ongoing professional development and quality assurance) however the purpose of the Ngātahi project is to define the competencies for the vulnerable children's core workforce so, for now, we have limited the framework to leaders of *practice*.

Tuakana-Teina (ako) model

In this model, Tuakana (elder siblings) are identified by the community as leaders capable of supporting others to achieve new skills. Teina (younger siblings) self-identify as wanting to learn a new skill. Tuakana support teina to achieve the new level of skill through teaching, demonstrating, mentoring, guiding and appraising. Tuakana and teina are roles - not judgments - and each learns from the other in the process. In a large workforce development project like Ngātahi, most tuakana will also be teina in areas they want to learn in.

Russell Wills
Community and General Paediatrician
Ngātahi Project Sponsor

Bernice Gabriel
Senior Psychologist
Ngātahi Project Manager

Domains and sub-domains

Domain: Act in the best interests of children (Vulnerable Children's Workforce Core Competencies)		
Subdomains	**Our vision**	**Profile of a worker competent in this domain**
Champion the rights and interests of children **Work in a child-centred way** **Professional conduct and continual improvement**	A children's workforce that understands the rights and interests of children, and works in a child-centric way to act in the best interests of children.	• Understands relevant ethical codes, competency frameworks, and legalisation that govern practice and service delivery. • Promotes the rights of children and respects their dignity. • Committed to urgency when responding to children's needs and persistence to achieve outcomes. • Recognises the principle that the welfare and best interests of a child must be the first and paramount consideration when making decisions that may affect their welfare. • Able to put the child at the centre, and demonstrates child-centred decision-making that informs action, including recognising and responding to the vulnerability of children. • Works in a child-centred way. • Applies the least intrusive intervention necessary to protect vulnerable children. • Reflects upon and improves professional practice.

Domain 1: Act in the best interests of tamariki			
Sub-domains	**Foundation**	**Practitioner (plus Foundation)**	**Leaders of Practice (plus Foundation)**
1) Champion the rights and interests of tamariki and work in a child-centred way (including needs assessment, formulation and treatment planning)	• Advocates for the rights of the child, acknowledging their dependency on adults. • Recognises the child's best interests as the paramount consideration for decisions that may affect them. • Engages with and supports children in a manner that promotes their rights and respects their dignity. • Makes decisions that put the child's current and future wellbeing, needs and interests at the centre. • Reflects on and adapts their actions as the child's needs and views change. • Understands who is working with the child.	• Commits to applying the least intrusive intervention necessary to protect vulnerable children. • Motivates and encourages children to achieve their full potential. • Understands key principles of child-centred practice, including early intervention, holistic assessment of needs, promoting the voice of the child, and taking a collaborative approach. • Understands the elements of good quality assessments. • Assesses the holistic needs of children (including ecological, cultural and risk assessment), plans an appropriate response, and reviews the implementation of the planned response to check its effectiveness.	• Champions the use of evidence-based, holistic, and child-centred assessment practice to develop holistic understandings of the needs, strengths and risks of vulnerable children. • Understands the elements of quality assessment of vulnerable children, and can support colleagues in their assessment practice. • Understands how to establish meaningful and measurable goals for children, record these in an appropriate plan, and can support colleagues in this planning process. • Understands the importance of evaluation and review to supporting effective assessment, planning and implementation, and

	• Makes decisions based on child's developmental stage and needs. • Ensures that the child's voice is heard and uses the child's language. • Knows how to do a basic risk assessment.	• Uses evidence-based, holistic, and child-centred assessment practice to develop holistic understandings of the needs, strengths and risks of vulnerable children.	is able to support colleagues in this process. • Recognises training needs of self and colleagues • Participates in case consultations
2) Display professional conduct and seek continual improvement (including reflective practice, professional development, self care, appraisal, supervision, quality improvement, feedback and complaints)	• Understands and works within the legal requirements, policies and systems that govern practice in the sector. • Has a basic knowledge of ethical issues, confidentiality, and boundary issues. • Knows how to access support and knowledge, and how to meet development needs. • Has a basic understanding of linking theory to practice. • Has emerging skills in critical enquiry, reflective practice, and self-evaluation. • Understands the supervision process and uses supervision as needed.	• Uses theory, evidence, research, and experience to reflect upon and improve practice within the cultural context of child and family. • Understands and works within the legal requirements, policies and systems that govern practice in their sector. • Draws upon and supports other's perspectives to challenge personal thinking and improve practice. • Manages ethical dilemmas ~~with~~ through supervision, guidance, ~~or~~ and reference to relevant practice and organisation codes. • Uses self-reflection, critical inquiry and problem solving effectively ~~in~~ to improve professional practice. • Identifies when a working environment is unsafe (i.e. culturally,	• Champions and demonstrates the importance of using critical inquiry, problem solving and evaluation effectively in professional practice and supervision of colleagues, including engaging with evidence and professional literature that reflects best practice. • Ensures that supervision for practitioners occurs either internally or externally. • Supports and guides colleagues in using theory, evidence, research, and experience to reflect upon and improve practice within the cultural context of child and family. • Champions and enables a learning environment through induction of new staff, ongoing professional development, and clear pathways for staff to access support and self-cares.

18.2

	• Has an awareness of own self-care needs and support. • Understands and appreciates the vision and values that underpin working with children.	bullying, not child-centred), raises this with colleagues, and elevates to management when needed.	• Leads self-reflection, critical inquiry and problem solving.

Domain: Be culturally competent (Vulnerable Children's Workforce Core Competencies)		
Subdomains	**Our vision**	**Profile of a worker competent in this domain**
Understand diversity in Aotearoa New Zealand **Work with diversity and difference** **Work with Māori**	A children's workforce that takes into account cultural perspectives, to engage and work with children and their parents, family, whānau and caregivers to understand and respond to their needs.	• Recognises and respects diversity within Aotearoa New Zealand. • Communicates and engages in culturally appropriate and inclusive ways. • Reflects upon own values, and their impact on professional practice. • Cultural awareness and sensitivity underpins culturally competent practice. • Recognises bicultural partnership in Aotearoa New Zealand and is able to reinforce the value, rights and mana of Māori, underpinned by the principles of Te Tiriti o Waitangi.

Domain 2: Be culturally competent			
Sub-domains	**Foundation**	**Practitioner (plus Foundation)**	**Leaders of Practice (plus Foundation)**
3) Work effectively with Māori.	• Recognises bicultural partnership in New Zealand, underpinned by Te Tiriti O Waitangi, and the rights of mokopuna and whānau Māori to participate in their culture, practices and language. • Works in a way that demonstrates high aspirations for mokopuna and whānau Māori, recognises that Māori are not homogenous and that all tamariki and whānau are diverse, and may require different methods of engagement or assessment in order to facilitate a path towards equitable outcomes for all. • Has a broad understanding of local history and is aware of the effects of colonisation on the	• Respects the mana of people, by building respectful relationships with whānau, hapū, iwi and the wider community, acknowledging their expertise and enabling Māori to participate in decisions about mokopuna. • Values whakapapa, cultural narratives, and the cultural wisdom embedded in Māori ideological and philosophical beliefs, to the empowerment of Māori. • Respects and strengthens the voices and aspirations of Māori by championing and modelling the use of Māori cultural practices. • Uses appropriate Te Reo Māori throughout interactions with Māori whānau and or groups and or has the confidence to call upon appropriate Māori cultural support	• Advises colleagues on Māori theories and paradigms that affect positive interactions – for example, tūhonotanga, mana o te ao turoa, and wairuatanga – when working with Māori. • Understands the dynamics of whānau, hapū and iwi, and the relationships between them. • Advises colleagues on incorporating Māori culture (including ngā tikanga-ā-iwi) when engaging with Māori children, their parents, hapū, iwi and communities. • Supports staff to engage effectively with Māori parents, whānau, hapū and the wider community.

	local Māori community (iwi, hapū, marae, whānau) and the implications of this on socio-economic and cultural inequities for local Māori and their overall health and wellbeing today. • Understands the cultural wisdom embedded in Māori ideological and philosophical beliefs, including core values such as manaakitanga, mana whenua, rangatiratanga. • Values whakapapa, understanding the need to include parents, whānau, hapū, iwi and the wider community in decision-making about mokopuna and whānau Māori. • Consults with kaumatua, kuia, cultural advisors, or tohunga (either inside or outside their organisation) to support mokopuna and whānau Māori. • Acknowledges, respects and is inclusive of local marae and the local Māori culture(s) – ngā tikanga-ā-iwi of Ngāti Kahungunu and its many hapū and marae. • Uses Te Reo Māori in interactions with Māori that are	from someone with this capacity in order to facilitate mana enhancing interactions. • Understands and uses mana tamariki and mana ahua eke (the Māori view of child-centred) to guide practice with tamariki mokopuna Māori.	• Supports staff to share, learn, and implement practices which are working in other iwi or Māori organisations to support vulnerable mokopuna and whānau Māori. • Supports and encourages use of Te Reo Māori where appropriate in interactions with Māori.

	mana enhancing for all where appropriate pronunciation of te reo Māori names and places and the use of greetings to open and close interactions is proper, respectful and 'normal'. • Recognises and or acknowledges that there shortcomings regarding personal knowledge and experiences with the above competencies and or that when the unknown arises, they will seek appropriate cultural support and advice in order to progress interactions with whānau. • Utilises existing Māori cultural knowledge and experiences and or organisational cultural frameworks alongside this competency framework to engage with tamariki and whānau in mana enhancing ways.		
4) Work with diversity and difference in Aotearoa New Zealand	• Knows when to consult with cultural advisors (either inside or outside their organisation) to support children and families.	• Engages and communicates in culturally appropriate, inclusive ways.	• Champions the importance or recognising diverse values, beliefs, theories, ideologies, paradigms, frameworks, perspectives, and worldviews.

	• Applies principles of cultural competency in their practice. • Knows when and where to seek help when engaging with people from diverse backgrounds. • Understands that New Zealand is culturally diverse, and that culture extends beyond ethnicity. • Understands that culture and beliefs influence interactions with children and their parents, family, whānau and caregivers. • Understands that positive outcomes for children and their parents, family, whānau and caregivers happen when there is mutual respect and understanding. • Understands that diversity and difference exists at both the group and individual level, and that general cultural information should not lead to stereotyping.	• Recognises, nurtures, and strengthens mana in others. • Identifies cultural issues that may be affecting how children, parents, family, whānau and caregivers engage with a service. • Acknowledges diverse values, beliefs, theories, ideologies, paradigms, frameworks, perspectives, and worldviews. • Reflects on the impact of their background (for example, their culture, values, and beliefs) on their practice, and adopts strategies to manage this. • Takes family and whānau-based approaches where doing so is appropriate. • Engages positively with children, parents, families, whānau and caregivers from diverse backgrounds on topics that may be sensitive or challenging. • Understands the effects of non-verbal communication such as body language, and that different cultures use and interpret body language in different ways. • Engages with children, parents, families, whānau and caregivers	• Encourages colleagues to reflect on the impact of their background on their practice. • Supports colleagues to integrate cultural knowledge and understanding into their interactions with persons from diverse backgrounds. • Advises colleagues on seeking cultural advisors and translators to support clients from diverse backgrounds to engage. • Supports colleagues to reduce inequities within marginalised societies, and promote fair access to entitlements.

		using their preferred language, or seeks the support of an appropriate independent translator if required. • Understands that cultural and historic context affects children, parents, families, whānau and caregivers, and informs effective practice. • Understands the contributors to vulnerability and inequities of diverse populations of Aotearoa New Zealand.	

Domain: Identify needs and respond to vulnerability (Vulnerable Children's Workforce Core Competencies)		
Subdomains	**Our vision**	**Profile of a worker competent in this domain**
Support a culture of child protection **Child protection policies and processes** **Understand child development** **Understand child health**	A children's workforce that recognises vulnerable children's needs and the response that is required to prevent harm occurring, including the implications of the paramountcy principle in practice.	• Considers the holistic wellbeing of the child within its wider ecological context. • Understands the importance of prevention and early intervention, alertness and preparedness to act to protect and improve children's wellbeing. • Identifies indicators of vulnerability and when children are not having their basic needs met. • Acts on unmet needs quickly and effectively and takes concerns seriously. • Committed to child protection culture and continuous improvement based on self-reflection, feedback and consideration of evidence-based practice. • Understands the child protection policies and protocols that govern their organisation and/or profession, including international and national legislation and policy to protect children

18.2

Domain 3: Identify needs and respond to vulnerability			
Sub-domains	**Foundation**	**Practitioner (plus Foundation)**	**Leaders of Practice (plus Foundation)**
5) Support a culture of child protection (including assessment of intimate partner violence), adhere to child protection policy and process	• Recognises that the protection of children is a core duty of all children's workers. • Understands the importance of prevention and that early intervention produces the best long term outcomes for children. • Understands how legislation and policy about the protection of children apply to their practice and knows how to access relevant legislation and policy. • Recognises when something is not right or a child/whānau member is not safe, takes steps to seek advice and support, and responds quickly and effectively when needed.	• Identifies children that are not having their physical, emotional, cognitive and socio-cultural needs met, and responds quickly and effectively. • Recognises their role in modelling a culture of child protection and commits to continuous improvement in their child protection practices. • Understands the particular vulnerability and needs of children with disabilities, and their families. • Considers the wellbeing of children holistically, including their physical, emotional, cognitive, and socio-cultural needs. • Recognises indicators of vulnerability relating to child abuse and neglect.	• Works with colleagues to discuss concerns to promote early intervention and response. • Leads and supports colleagues to respond to concerns, especially in difficult or challenging cases. • Understands the policies and processes of the children's services in the community to support colleagues to make a referral and formulate a plan to follow up on the outcome. • Models and supports colleagues to build effective working relationships with children's services in the community. • Works with colleagues to understand types of abuse and neglect and signs or indicators for each.

	• Commits to following-up after a referral to make sure that the issue is being addressed and children are allocated and don't fall through the gaps. • Maintains appropriate and culturally aware physical, emotional and sexual boundaries in interactions with children and families. • Does not act on concerns alone, and consults with managers, supervisors or a designated person to get support and policy guidance to protect children. • Self-reflects on practice. • Seeks help to prevent problematic professional situations or behaviours.	• Understands connections between child vulnerability and family and intimate partner violence. • Recognises indicators of vulnerability in mother and baby including the unborn child. • Follows national, local and organisational child protection policies and procedures, including knowing who to contact, how to access advice, and how to make an appropriate report or referral with formulated plan and follow-up. • Seeks and uses specialist advice on organisational policies and handling challenging legal and ethical issues.	• Supports colleagues to navigate complex or specialist issues connected to abuse and neglect. • Seeks and provides specialist advice on organisational policies and handling challenging legal and ethical issues.
6) Understand child development and be trauma-informed	• Identifies children that are not having their physical, emotional, cognitive and socio-cultural needs met and responds quickly and effectively. • Is familiar with policies, procedures, regulations and legislation as appropriate to the role and workplace.	• Understands that there are various theories about how children develop, including the degree to which it is influenced by environmental and cultural factors. • Tracks children's development and takes action where there is an indicator of vulnerability.	• Leads, models and supports colleagues to navigate difference, current and evidence-based theories about how children develop. • Listens carefully to colleague's concerns about developmental or behavioural changes, supports analysis of potential issues, and

	• Understands child development and how physical, emotional, sexual, cognitive and socio-cultural development progresses in children. • Recognises that there are various theories about child development, including environmental and cultural influences. • Is aware that trauma can occur in any family or environment and keep an open mind. • Recognises the indicators of trauma. • Interacts with children in ways that support the development of the child's ability to think, learn, and increase competency and/or independence. • Recognises that the child is more than the trauma and disabilities – look for strengths and abilities	• Understands the need for assessment of holistic needs of the child and the support required during key points of transition. • Recognises the indicators of trauma and is well able to respond appropriately and implement recommendations to address the impact of the trauma. • Seeks to remediate trauma that may be experienced by children and support implementation of recommendations. • Increases experiences to aid development and resilience	planning of appropriate responses. • Recognises and addresses the trauma experienced by children and take steps to prevent their re-victimisation. • Supports, appraises, enquires, supervises, and consults with the practitioner.
Understand Child Health – divided into 7) Addressing unmet health needs (including	• Has a holistic approach to case management. • Includes the child's and whānau's assessment of the problems confronting them.	• Identifies signs of unmet health needs (such as common childhood illnesses), and responds appropriately, including making a	• Supports colleagues to understand health issues that contribute to the vulnerability of children

understanding the Health System)	• Has basic computer skills. • Understands the socio-economic and cultural determinants of health. • Understands that health is more than just the absence of disease.	referral to an appropriate specialist or service. • Applies Māori models of health care (e.g. Te Whare Tapa Wha). • Identifies children whose development is delayed or behaviour is disordered, discusses these with parents, and makes appropriate referrals.	• Supports colleagues to recognise unmet health needs and refer appropriately.
8) Adolescent development, mental health and addictions	• Is able to have conversations with children and family members about mental health and addiction issues. • Is able to ask about risk and suicide. • Knows when to share information and escalate issues. • Has an awareness of terminology commonly used. • Has an awareness of limitations of role or scope of practice. • Is able to link mental health and addiction issues with family, cultural and socio-economic context. • Identifies signs of potential substance misuse in youth and responds appropriately,	• Identifies signs of unmet mental health needs in children and responds appropriately, including making a referral to a specialist or service. • Is able to communicate effectively and appropriately with children and adolescents about their mental health and addiction diagnoses, using language that is developmentally appropriate and well-understood. • Has an awareness of the legislation relating to mental health and addiction issues. • Has knowledge of mental health and addiction theories.	• Supports and mentors colleagues to understand health issues (including mental health and substance misuse) that contribute to the vulnerability of children • Is able to undertake a comprehensive assessment of mental health and addiction problems. • Is able to provide evidence-based interventions for high prevalence conditions (e.g. anxiety and depression) appropriate to role and competency. • Is able to assess, undertake case formulation, and provide evidence-based specialist therapies and interventions. • Contributes to the strategic planning for the mental health and

	including making a referral to a specialist or service.	• Has knowledge of mental health and addiction resources and matches resources to client's needs. • Has knowledge of presentation of mental health and addiction issues at different developmental stages. • Is able to do a screening assessment around mental health and addiction needs. • Has an awareness of the diagnostic processes for mental health and addiction problems. • Has dual diagnosis knowledge. • Uses brief motivational interventions. • Has knowledge of the effects of substances and withdrawal. • Understands, assesses, and treats issues from the child's, adolescent's and family's perspective. • Is able to develop a safety plan. • Is able to develop goals collaboratively with child, adolescent and family.	addictions needs of children and adolescents. • Has expert knowledge in the use of outcome measures. • Has expert knowledge of mental health and addiction theories.

Domain: Engage children (Vulnerable Children's Workforce Core Competencies)		
Subdomains	**Our vision**	**Profile of a worker competent in this domain**
Empower children **Communicate effectively with children**	A children's workforce with the interpersonal qualities and communication skills to engage with children in a manner appropriate to their developmental stage and abilities, to build positive and constructive relationships, and to establish a shared understanding of their perspectives in order to plan actions. A children's workforce that operates in accordance with the rights of the people of New Zealand, as defined in relevant legislation.	• Takes account of children's views of themselves, their lives, their future, their family whānau and community. • Uses a developmental perspective with age-appropriate engagement and communication, assessment and actions within each child's cultural context. • Communicate with children at a level appropriate to their developmental stage and ability, using language they can understand. • Listens to children and accurately convey their perspective so that the child's voice is heard. • Balances child-centred practice with other priorities and needs.

Domain 4: Engage Tamariki			
Sub-domains	**Foundation**	**Practitioner (plus Foundation)**	**Leaders of Practice (plus Foundation)**
9) Empower and communicate effectively with Tamariki	• Is committed to giving children a voice in decisions that may affect them. • Recognises that children can communicate even when very young or non-verbal, and treats their communication with dignity, respect, and integrity. • Understands that the behaviours of vulnerable children may be the result of their attempts to cope with trauma and/or disability. • Actively engages and listens in a calm, non-judgemental, non-threatening way using open questions, consistent with the child's developmental stage • Ensures that parents, families, whānau and caregivers are	• Recognises the importance of presenting genuine choices to children, and being honest and open about the weight of their opinions and wishes. • Involves children in decision-making at the appropriate developmental level. • Helps children to express what they are experiencing, feeling and to describe their world. • Engages with vulnerable children using trauma-informed practices and approaches that are culturally responsive and evidence-based. • Understands theories about how children's communication skills develop. • Communicates effectively with children across their developmental	• Understands theories to help describe the child's world and how children's communication skills develop, and can support colleagues with this knowledge. • Supports colleagues to use the most appropriate forms of communication to meet the needs of the individual child. • Supports colleagues to address with children issues that are sensitive, challenging, or subject to stigma. • Knows where information, advice, advocacy and support services for children are available in the community, and supports colleagues to connect children to these services.

	aware of the feedback and complaints channels, and facilitates access as required. • Is receptive to feedback from children to inform continuous improvement and development. • Seeks guidance and support if unsure what to do with information given by children. • Understand principals and expectations of the United Nation's Convention on the Rights of the Child (UNCROC) • Has hope in children.	stages, meeting the needs of the individual child. • Is able to accurately listen, understand, reflect and respond to the child's voice, context, views and feelings. • Actively seeks and is receptive to feedback from children to inform continuous improvement and development. • Has a broad understanding on the ways children communicate and options available to them. • Is able to identify the strengths and potential of children. • Is able to recognise risk of collusion with parents. • Supports colleagues to understand that sometimes it is necessary to go against a child's expressed wishes to act in their best interests.	• Supports colleagues to actively seek feedback from children, through a range of mediums, informing continuous improvement of services and professional development of staff. • Supports colleagues to be courageous in supporting the child's goals and dreams. • Actively keeps up to date with best practice on engagement with children.

18.2

Domain: Work collaboratively and share information (Vulnerable Children's Workforce Core Competencies)		
Subdomains	**Our vision**	**Profile of a worker competent in this domain**
Work collaboratively **Share Information** **Lead and sustain transformational change**	A children's workforce that works together until positive outcomes are achieved for children, as well as their parents, family, whānau and caregivers.	• Has sound knowledge, skills and values, and develops capability in collaborative working. • Understands the different roles, responsibilities and processes in the children's workforce. • Networks and operates effectively and ethically in a cross-agency environment • Committed to a culture of collaboration that enables clear and decisive action for children. • Lawfully shares information in a timely and accurate manner to effectively address the needs of children. • Organisational leaders lead and sustain transformational change in practice to reflect the values, skills and knowledge described in the core competency framework.

Domain 5: Work collaboratively, share information, lead and sustain transformational change			
Sub-domains	**Foundation**	**Practitioner (plus Foundation)**	**Leaders of Practice (plus Foundation)**
10) Work collaboratively	• Recognises they are part of the children's workforce if they plan, manage or deliver services to children, regardless of their role or profession. • Connects and communicates with others in the children's workforce in a respectful, open and honest way and values the expertise others bring. • Understands that the diverse roles in the children's workforce have their own practice frameworks, expectations and standards. • Seeks care for themselves, actively engages in reflective supervision, and seeks expert advice and guidance as needed.	• Recognises the criticality of collaborative working where it is in the best interests of the child. • Recognises that responsibility for children is on-going, carries across the process of referral, but also recognises the ethical and competency boundaries of their role. • Partners with other children's workers to create shared assessments of need, make joint decisions, plan together, and deliver agreed next steps to achieve good outcomes for children. • Understands that there are different perspectives, theories and drivers across the children's workforce, but is confident to challenge situations with considered questions.	• Champions collaborative working so it is in the best interests of the child. • Champions on-going commitment to the children's workforce learning community and collaborative professional learning opportunities. • Supports colleagues to use common tools, processes and procedures for collaborative working. • Leads or supports collaborative, multi-agency and multidisciplinary assessments using relevant, agreed, and common frameworks. • Navigates organisations to support others to access services

	• Responds appropriately and effectively to feedback and complaints, providing a resolution and escalating as required. • Recognises the importance of continual professional development, supports the learning of others, and encourages an environment that promotes learning. • Actively seeks and participates in collaborative professional learning opportunities. • Writes competent referrals to services to address issues confronting the client and their whānau. • Understands the structure of the multiple sectors within the community, including the roles, responsibilities, and obligations of each service. • Understands the legal obligations of all sectors (e.g., right to attend the closest school to where you live, right to be enrolled in a general practice, etc.) • Recognises barriers to successfully working	• Understands children's services in their community, and how to help children and their parents, family, whānau and caregivers to access them (including the appropriate referral pathways). • Uses common tools, processes and procedures for collaborative working. • Understands the assessment framework principles and processes • Networks with other children's workers to grow knowledge and improve practice.	using advocacy, negotiation, facilitation, and mediation skills. • Provides reflective supervision and encourage others to do so. • Supports colleagues when complaints are received, work to provide a resolution or escalate as required. • Is confident to respond to referrals/supports colleagues to respond collaboratively when referrals appear inappropriate. • Supports colleagues to write referrals to other agencies that meet their referral criteria. • Creates an environment/supports colleagues to create an environment where practice that is bullying, culturally unsafe, or not child-centred is not tolerated. • Creates an environment that supports the identification of children with delayed development or disordered behaviour. • Supports policies that encourage collaborative working and breaking down barriers.

	collaboratively and initiates actions for improvement.		
Share information, including working in multidisciplinary, multi-agency teams	• Commits to sharing information to achieve good outcomes for children. • Shares information in a timely, accurate and lawful manner, with support. • Understands how privacy legislation and policies and procedures surrounding confidentiality, consent and sharing are to be applied in their work.	• Champions the sharing of information to achieve good outcomes for children. • Openly and honestly communicates about the sharing of information. • Seeks consent to information sharing appropriately, unless this increases the risk of harm. • Is able to identify when there are too many services, conflicting goals or plans, and whānau are overwhelmed, and arrange an appropriate co-ordination mechanism (e.g. MDT, Strengthening Families meeting).	• Supports colleagues to share information in ways consistent with privacy legislation, policies and procedures, especially in difficult or challenging legal or ethical cases.
Lead and sustain transformational change	• Understands the content of the core competency framework (and role within it), can apply the descriptors in self-assessment, and in conversations with others about continuing professional development • Understands and applies the vision, values and behaviours	• Recognises the value of consistent evaluation and review of practice and services delivered. • Engages constructively with new practice, risk assessment and management frameworks, and other system-level and sector-specific changes.	• Supports colleagues to understand the vision and content of the core competency framework, and apply the descriptors in assessment of their competencies. • Supports colleagues to engage constructively with new practice, risk assessment and management

	related to this domain, i.e. 'A children's workforce that works together until positive outcomes are achieved for children, as well as their parents, family, whānau and caregivers. • Recognises that everyone has a role to play to get better outcomes for vulnerable children.	• Uses outcome measures to capture change.	frameworks, and other system-level and sector-specific changes.

Domain: Engage parents, family, whānau and caregivers (Vulnerable Children's Workforce Core Competencies)		
Subdomains	**Our vision**	**Profile of a worker competent in this domain**
Empower parents, family, whānau and caregivers **Communicate effectively with parents, family, whānau and caregivers**	A children's workforce with the interpersonal qualities and communication skills to engage with parents, family, whānau and caregivers in an honest and open manner to build positive and constructive relationships, establish a shared understanding of their situation, and collaboratively plan actions.	• Recognises parents, family, whānau and caregivers as the child's primary support system. • Uses interpersonal qualities and communication skills to engage effectively with parents, family, whānau and caregivers. • Maintains and strengthens, wherever possible and appropriate, the relationship between a child and their parents, families, whānau and caregivers. • Works in partnership with those that children depend on, including parents, family, whānau and caregivers to retain parental responsibility wherever possible and appropriate. • Able to communicate openly and honestly with parents, family, whānau and caregivers about concerns when this is in the best interest of the child.

18.2

Domain 6: Engage parents, family, whānau and caregivers			
Sub-domains	**Foundation**	**Practitioner (plus Foundation)**	**Leaders of Practice (plus Foundation)**
11) Empower parents, family, whānau and caregivers, including rapport, engagement building working with resistance, courageous conversations, strengths-based practice, family therapy/systems approaches and interventions	• Commits to maintaining and strengthening the relationship between a child and their parents, families, whānau and caregivers. • Values whakapapa – particularly that of parents, families, whānau and caregivers, understanding their lead role and their responsibility for their children. • Understands that the behaviours of parents, families, whānau and caregivers may be the result of their attempts to cope with trauma. • Is able to use plain language and no jargon with families. • Has a clear understanding of role. • Has a solid understanding of the strengths-based model of practice.	• Works in partnership with parents, families, whānau and caregivers to maintain parental responsibility wherever appropriate. • Is able to engage in and lead courageous conversations with parents, families, whānau, caregivers and children to ensure the best interests on the child. • Recognises the right of parents, family, whānau and caregivers to information about their children, unless it is judged to be not in the best interests of the child. • Engages with parents, family, whānau and caregivers using trauma-informed practices and approaches. • Advocates, when appropriate, to other organisations and organisational leaders on behalf of	• Supports colleagues to respond appropriately where parents, family, whānau and caregivers are disengaging from their children, or where barriers to effective engagement are identified. • Supports colleagues to engage positively and constructively with parents, family, whānau and caregivers to address issues they are facing that impact on their parenting capacity. • Supports colleagues to understand issues within the community that may be impacting on parents', family, whānau and caregivers' interactions with services. • Ensures that leaders are modelling strengths-based and empowerment practices within each relationship, in the office and in the organisation.

	• Is committed to engaging in courageous conversations with parents, families, whānau, and caregivers where it is in the best interests of their child to do so. • Builds knowledge about the dynamics of families, how they interact with each other, and how to work with this.	parents, family, whānau and caregivers. • Values whakapapa and understands the role that parents, family, whānau and caregivers have in the decision-making for their tamariki. • Demonstrates the skill of understanding the different family dynamics at play, making an analysis of how this impacts on the wellbeing of the child, and working effectively with this. • Understands and recognises the resilience in children and their parents, families, whānau, and caregivers, and uses it to engage and empower them. • Participates in supervision that explores the impact of working alongside vulnerable families. • Recognises and reflects back the strengths identified in the child and family. Is able to recognise exceptions to the problem and work with them around this. • Is able to clearly explain to a variety of groups (including professionals) who you are, where you work, and what you are there for.	

12) Listen and connect effectively with parents, family, whānau and caregivers, including assessment of, and working with, parents with mental illness and addictions.	• Communicates openly and honestly (includes active listening) with parents, families, whānau and caregivers, treating them with dignity, respect, and integrity. • Communicates in a positive and future-focused manner. • Ensures that parents, families, whānau and caregivers are aware of the feedback and complaints channels, and facilitates access as required. • Actively seeks feedback from parents, family, whānau and caregivers to inform continuous improvement and development. • Has an awareness of mental illness and addiction presentations in children and adults. • Recognises early sources and antecedents of conflict in families.	• Creates positive group dynamics, seeks solutions, and demonstrates the different roles of supporting, leading and facilitating when working with parents, family, whānau and caregivers. • Has conversations with parents, families, whānau and caregivers about personal issues or circumstances where these may be contributing to the vulnerability of their child or children. • Engages with parents, families, whānau and caregivers about potential intimate partner or family violence, connecting this if necessary to the vulnerability of their children.	• Supports colleagues to help parents, family, whānau and caregivers understand and interpret their child's needs. • Supports colleagues to discuss personal issues or circumstances with parents, family, whānau and caregivers where these may be contributing to the vulnerability of their child. • Supports colleagues to sensitively and confidently manage conflicts between the wants of parents, family, whānau and caregivers and what is in the best interests of the child. • Advises colleagues on different ways of communicating and to understand communication barriers that could affect parents, family, whānau and caregivers access to services. • Supports colleagues to actively seek feedback from parents, family, whānau and caregivers, informing continuous improvement of services and professional development of staff. • Develops robust service systems based on current best practices and feedback mechanisms that ensure

			participation and support of family and whānau.

Agencies/Services Participating in the Ngātahi Project

1 HBDHB – Child Development Service (CDS)
2 HBDHB - Child, Adolescent & Family Service (CAFS)
3 HBDHB – Family Violence & Child Protection Programme
4 HBDHB – NASC
5 HBDHB - Public Health Nurses
6 HBDHB – Te Ara Manapou (Parenting & Pregnancy Service)
7 Te Kupenga Hauora
8 Roopu a Iwi
9 NZ Police
10 Youth Horizons
11 Ministry of Education
12 Birthright HB Child & Family Care
13 Napier Family Centre
14 Ikaroa Rangatahi
15 Ministry for Vulnerable Children Oranga Tamariki (Napier)
16 Awhina Whanau Services
17 Open Home Foundation
18 Resource Teachers- Learning & Behaviour (RTLB)
19 Ministry for Vulnerable Children Oranga Tamariki (Hastings)
20 Directions Youth Health Service
21 Dove Hawkes Bay
22 Family Works
23 Te Taiwhenua o Heretaunga (Mental Health, Tamariki Ora, Family Start)
24 Plunket

Agencies still to reply with dates for visit to discuss mapping:

25 Choices

HAWKE'S BAY
District Health Board
Whakawāteatia

GO WELL TRAVEL PLAN UPDATE

Presentation

HAWKE'S BAY District Health Board Whakawāteatia	**Human Resource KPIs (Q4 April-June 2017)** 93
	For the attention of: **HBDHB Board**
Document Owner: Document Author:	Kate Coley, Executive Director of People & Quality Jim Scott, Workforce Analyst
Reviewed by:	Executive Management Team
Month:	August 2017
Consideration:	Monitoring

RECOMMENDATION

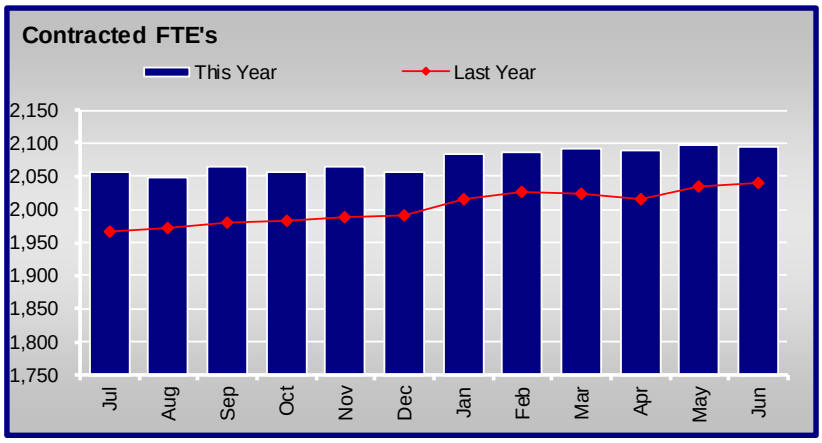
That the HBDHB Board:

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

20

Headcount and positions

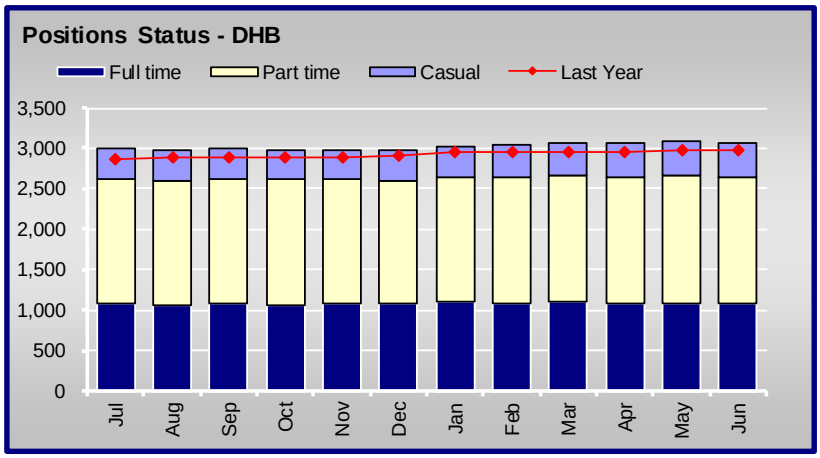
Reporting on headcount/ positions is a snapshot in time rather than an average for the month or year.



Contracted FTEs
2092.9 at 30 Jun. 2017
2038.6 at 30 Jun. 2016
= 2.7% increase

Overall increases/ (decreases)

	FTE	
Medical	8.4	3.5%
Nursing	14.5	1.7%
Allied Health	16.8	3.9%
Support	1.5	1.2%
Mge. & Admin	13.1	3.4%
Total	**54.3**	**2.7%**



Positions filled:
3073 at 30 Jun. 2017
2982 at 30 Jun. 2016
= 3.1% increase (91 positions)

Of the 3073 positions (last year in brackets):
35% are full-time (36%)
51% are part-time (51%)
14% are casual (13%)

Overall increases/ (decreases) – breakdown of 3.1% increase

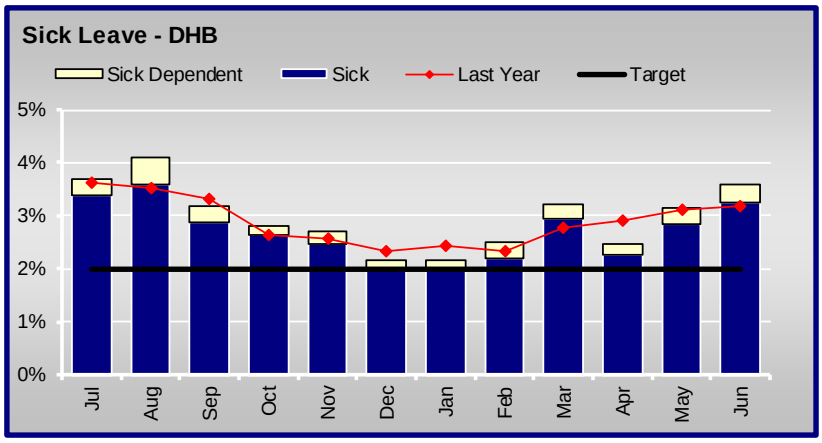
	Full time	Part time	Casual	Total	% change
Medical	15	(8)	2	9	3.2%
Nursing	(1)	20	31	50	3.3%
Allied Health	12	1	1	14	2.5%
Support	2	1	(1)	2	1.1%
Management & Admin	(1)	20	(3)	16	3.5%
Totals	**27**	**34**	**30**	**91**	**3.1%**

Sick Leave

The percentage of sick leave taken hours (paid and unpaid) to accrued FTE hours.

Note: as this KPI is reported early in the month, not all sick leave for the previous month has been recorded as yet. Figures and the graph will be adjusted in the following month.

Target is 2.00%



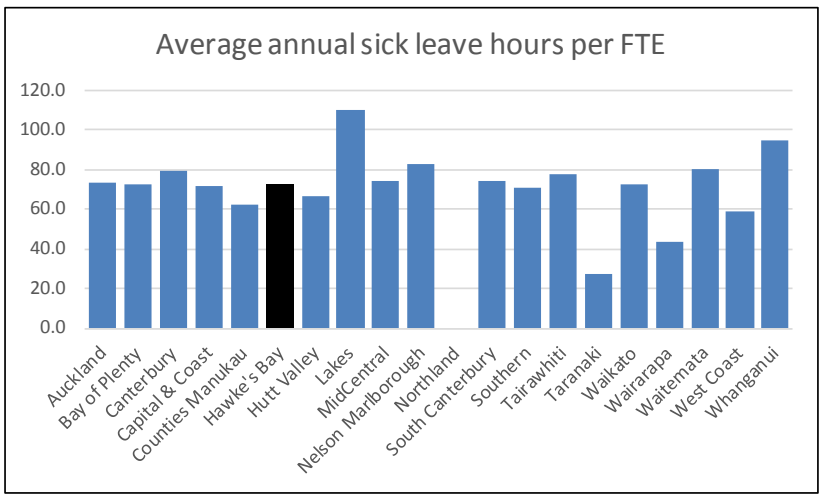
Jun 2017 = 3.59%
Jun 2016 = 3.18%

YTD Jun '17 = 2.98%
YTD Jun '16 = 2.90%

DHBSS have taken over reporting of the 20 DHB Comparisons and report on the average annual sick leave hours per FTE (to 31 March 2017). Hawke's Bay DHB rank:

9th lowest of 19 DHBs.

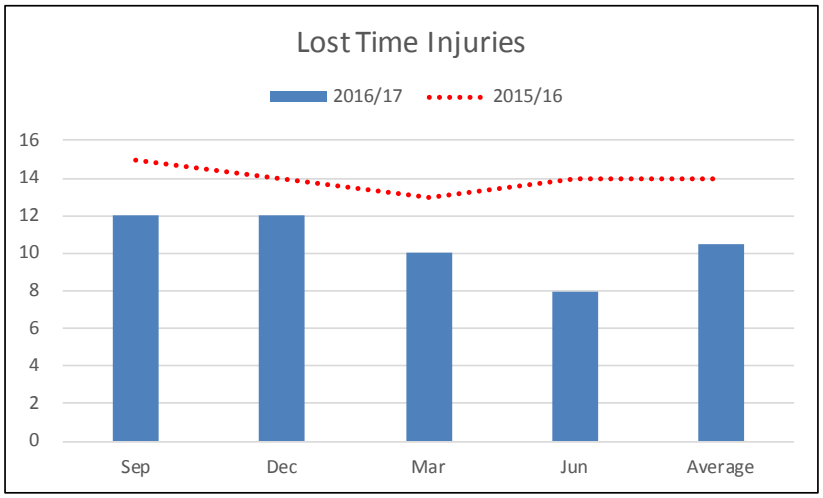
2nd lowest of the 5 mid-sized DHBs



20

Lost Time Injuries

Measure the incidences of work time lost due to injury or occupational illness associated with the workplace.



Breakdown by quarter:

	2016/17	2015/16
Sept	12	15
Dec	12	14
Mar	10	13
Jun	8	14
Total	**42**	**56**
Average	*11*	*14*

Average days lost:
2016/17 = 13.1 days
2015/16 = 22.8 days

Breakdown by Occupational Group:

	2016/17	2015/16
Medical	1	0
Nursing	24	45
Allied Health	4	2
Support	9	6
Management & Admin	4	3
Total	**42**	**56**

Breakdown by reason for injury:

	2016/17	2015/16
Being hit by object	1	2
Being hit, struck or bitten by person	4	5
Falls	8	8
Hitting objects	4	5
Muscular stress	22	33
Other	3	3
Total	**42**	**56**

The reduction of lost time injuries is a significant positive for DHB staff. This has been achieved through

- The introduction of a 'hands on' musculoskeletal Physiotherapist has meant:
  - early intervention in the workplace.
  - reduction of financial barriers to early treatment, as there is no surcharges associated with this.
- The reintroduction of regular fortnightly doctor on site, providing the same benefits as above as well as:
  - early diagnosis, and referral to appropriate services
- A change in Case Manager for work injuries has improved the efficiency between the DHB and WellNZ.
- A positive change in the culture of managers with regard to accommodating staff on gradual return to work programmes – most now see staff who are able to do some hours as a bonus rather than a burden.

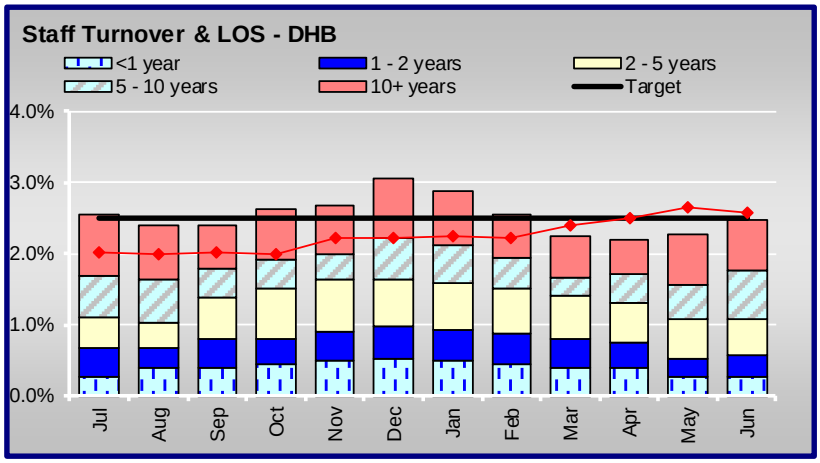
Staff Turnover

Incidence of staff resignations in an organisation. #Voluntary resignations ÷ Total headcount at the beginning of the period. Period is a rolling 3 Months

Note: Junior Doctors (RMOs), Temporary (fixed term) employees and casual employees are excluded from this measure. Employment terminations due to redundancy, death, dismissal and medical grounds are excluded.

A table has been included in the notes for each section to show total headcount at the beginning of the period, new starts, resignations, transfer and changes of status to reconcile to total headcount at the end of the quarter.

Target is 2.50% per quarter.



3 months ended Jun '17 = 2.46% which is within the target of 2.50%.

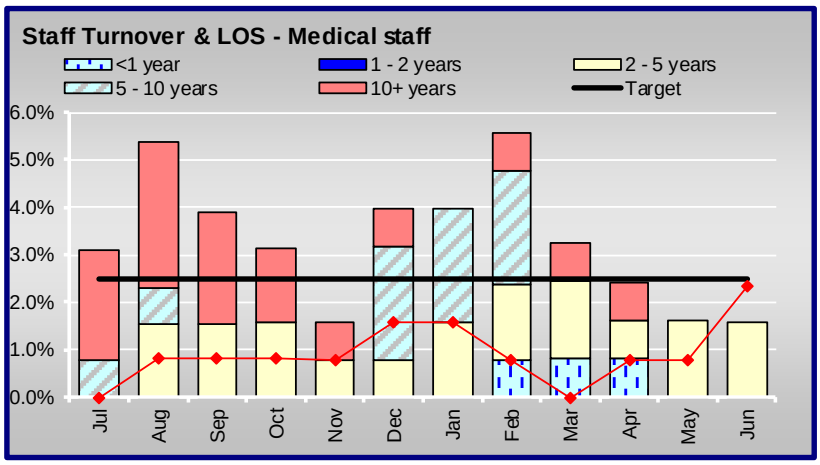
12 months to Jun '17 = 10.28% which is above the 10% annual target. See reasons below.

2319	Staff at 1 Apr '17
45	New Staff
(60)	Staff resignations
(3)	Change of status – mostly permanent to fixed term
2301	Staff at 30 Jun '17

Reasons for leaving included in Staff Turnover	Quarter	Last 12 months
Moving to a position outside HBDHB	16	67
Relocating outside HB	4	32
Retirement	14	48
Not returning from parental leave	0	6
Personal	6	18
Family reasons	2	6
Further education	0	3
Other reasons	11	35
Unknown reason	4	16
Total	**57**	**231**

Note difference to staff resignations figure above is due to non-voluntary resignations (medical grounds, redundancy etc.)

Staff Turnover – Medical Staff



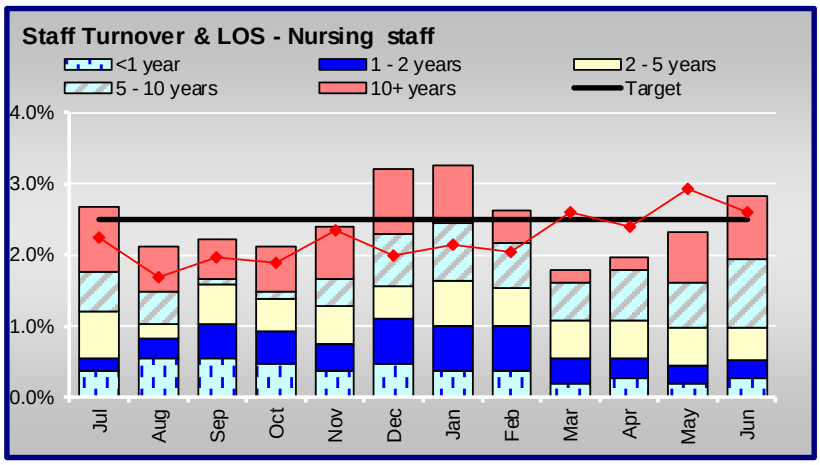
3 months ended Jun '17 = 1.57% which is within the 2.50% target.

12 months to Jun '17 = 12.40% which is above the 10% annual target. See reasons below.

127	Staff at 1 Apr '17
0	New Staff
(2)	Staff resignations
0	Change of status – casual to permanent
2	Trf other staff group
127	Staff at 30 Jun '17

Reasons for leaving included in Staff Turnover	Quarter	Last 12 months
Moving to a position outside HBDHB	1	8
Relocating outside HB		2
Retirement		3
Personal	1	2
Other reasons		1
Unknown reason		0
Total	**2**	**16**

Staff Turnover – Nursing Staff



3 months ended Jun '17 = 2.82% which is above the target of 2.50%.

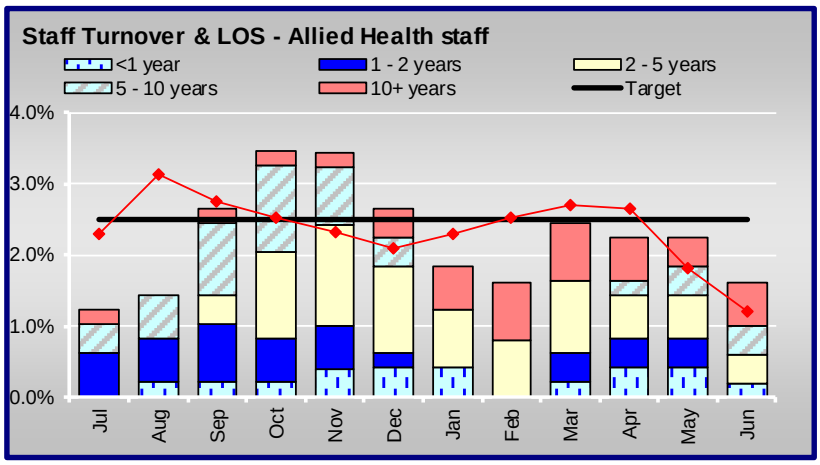
12 months to Jun '17 = 10.27% which is above the 10% annual target.

1135	Staff at 1 Apr '17
20	New Staff
(33)	Staff resignations
(4)	Change of status – mostly permanent to fixed term
0	Trf other staff group
1118	Staff at 30 Jun '17

Reasons for leaving included in Staff Turnover	**Quarter**	**Last 12 months**
Moving to a position outside HBDHB	9	27
Relocating outside HB	2	17
Retirement	6	23
Not returning from parental leave	0	4
Personal	3	8
Family reasons	1	2
Other reasons	7	20
Unknown reason	4	10
Total	**32**	**111**

Note difference to staff resignations figure above is due to non-voluntary resignations (medical grounds, redundancy etc.)

Staff Turnover – Allied Health Staff



3 months ended Jun '17 = 1.61% which is below the 2.50% target.

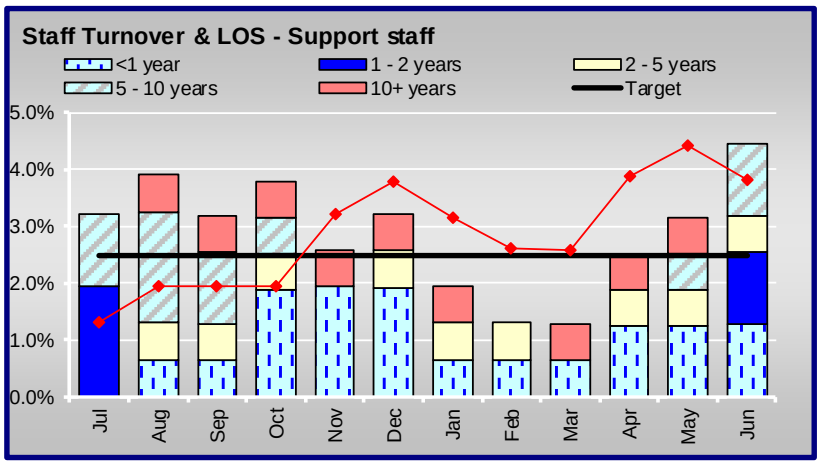
12 months to Jun '17 = 9.39% which is below the 10% annual target.

496	Staff at 1 Apr '17
9	New Staff
(9)	Staff resignations
2	Change of status – fixed term or casual to permanent
(3)	Trf other staff group
495	Staff at 30 Jun '17

Reasons for leaving included in Staff Turnover	Quarter	Last 12 months
Moving to a position outside HBDHB	2	11
Relocating outside HB	1	9
Retirement	3	6
Not returning from parental leave	0	2
Personal	0	4
Family reasons	0	2
Further education	0	1
Other reasons	2	9
Unknown reasons	0	2
Total	**8**	**46**

Note difference to staff resignations figure above is due to non-voluntary resignations (medical grounds, redundancy etc.)

Staff Turnover – Support Staff



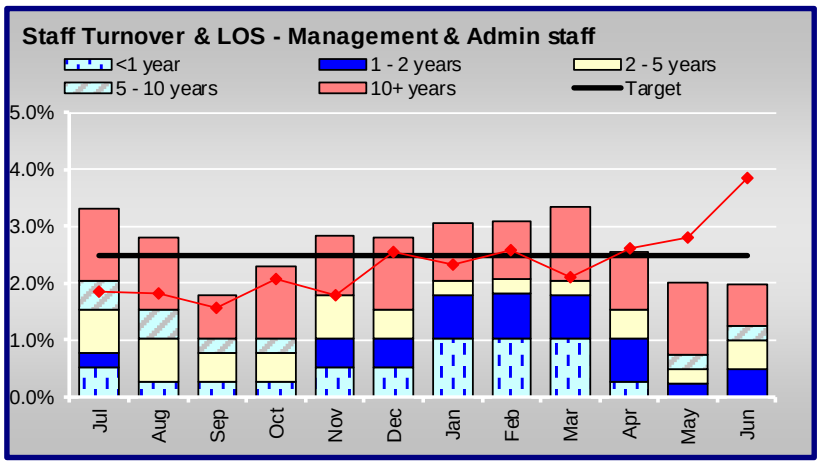
3 months ended Jun '17 = 4.46% which is above the 2.50% target.

12 months to Jun '17 = 12.10% which is above the 10% annual target. See reasons below.

157	Staff at 1 Apr '17
8	New Staff
(7)	Staff resignations
(1)	Change of status – permanent to fixed term
0	Trf. other staff group
157	Staff at 30 Jun '17

Reasons for leaving included in Staff Turnover	Quarter	Last 12 months
Moving to a position outside HBDHB	2	8
Relocating outside HB	1	1
Retirement	3	5
Not returning from parental leave		0
Personal	1	2
Family reasons		1
Further education		0
Other reasons		0
Unknown reason		2
Total	**7**	**19**

Staff Turnover – Management & Administration Staff



3 months ended Jun '17 = 1.98% which is below the 2.50% target.

12 months to Jun '17 = 10.03% which is above the 10% annual target. See reasons below.

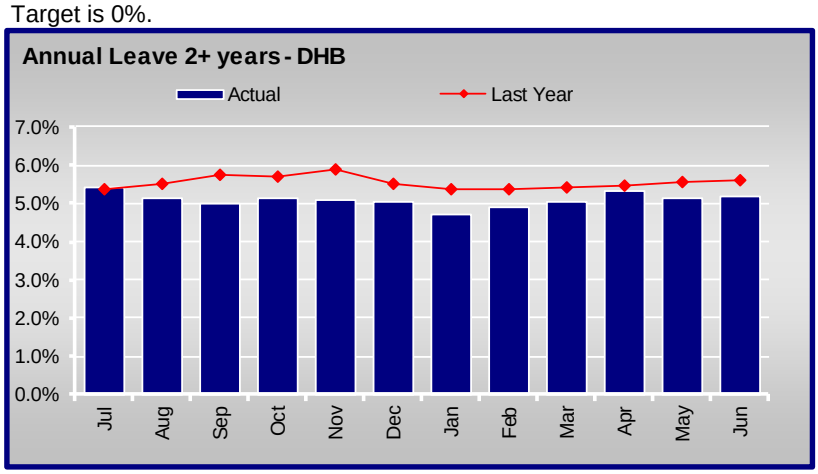
404	Staff at 1 Apr '17
8	New Staff
(9)	Staff resignations
0	Change of status – mostly fixed term to permanent
1	Trf from other groups
404	Staff at 30 Jun '17

Reasons for leaving included in Staff Turnover	Quarter	Last 12 months
Moving to a position outside HBDHB	2	13
Relocating outside HB	0	3
Retirement	2	11
Personal	1	2
Family reasons	1	1
Further education	0	2
Other reasons	2	5
Unknown reason	0	2
Total	**8**	**39**

Accrued Annual Leave (2+ years)

The percentage of employees where accrued annual leave balance is greater than 2 years annual leave entitlement.

Target is 0%.



Jun '17 = 5.16% (137 staff)
Jun '16 = 5.63% (146 staff)
Decreased by 9

The total liability at 30 June 2017 was $19.474m compared to $18.776m at 30 June 2016. This $698k deterioration is made up of:

1. ($540k) unfavourable driven by an increase in the hours owing.
2. ($158k) unfavourable driven by an increase in the average rates.

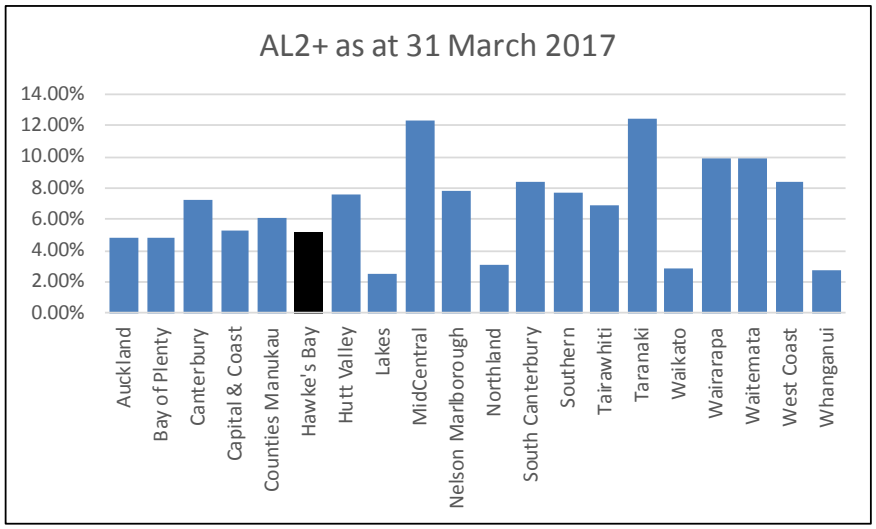
The total leave hours owed (includes statutory lieu leave etc.) has increased in the last year as has the number of employees and the average leave balance:

	Total Hours Owed	Employees with leave balance	Average Leave balance (hours)
June 2017	461,296	2657	173.62
June 2016	447,934	2597	172.48

DHBSS have taken over reporting of the 20 DHB Comparisons and report on the annual leave percentage of employees with 2+ years of annual leave owing (at 31 March 2017). Hawke's Bay DHB rank:

7th lowest of the 20 DHBs.

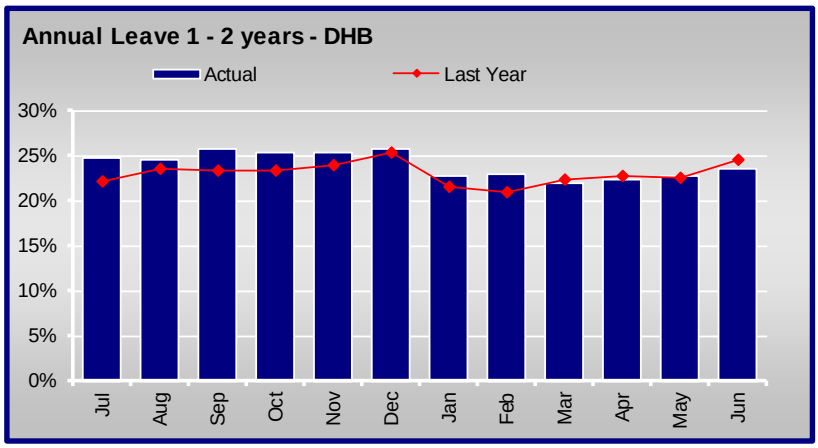
3rd lowest of the 6 mid-sized DHBs



Accrued Annual Leave (1 – 2 years)

The percentage of employees where accrued annual leave balance is between 1 and 2 years annual leave entitlement.

Target is 15%.



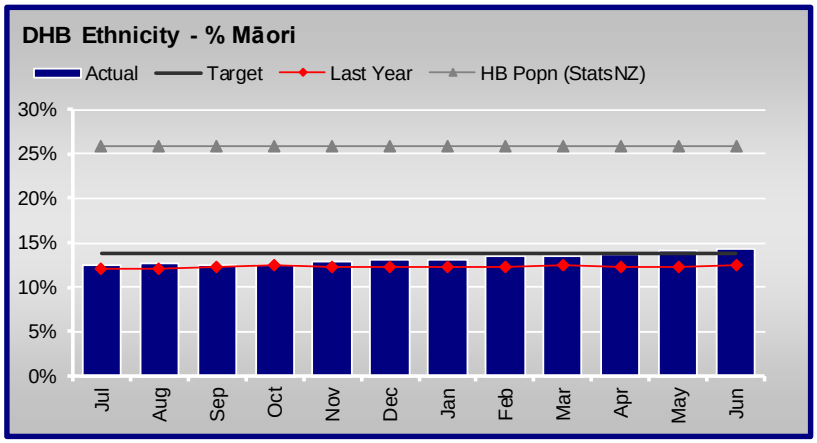
Jun '17 = 23.51% (624 staff)
Jun '16 = 24.43% (634 staff)
Slight decrease (10) in number of employees and also slight decrease in percentage of total staff with 1 to 2 years owing.

Staff Ethnicity

Measure the number of positions at HBDHB where the incumbents identify themselves as Māori

Target is set at 10% improvement on previous year. 2016/17 target = 13.75%. The Māori population for HB is 25.9%

Note - We generally report on positions so we can break our numbers down for reporting purposes by Occupational Group, Service, and Department etc. Some employees have more than one position in more than one Department, Service or occupational group



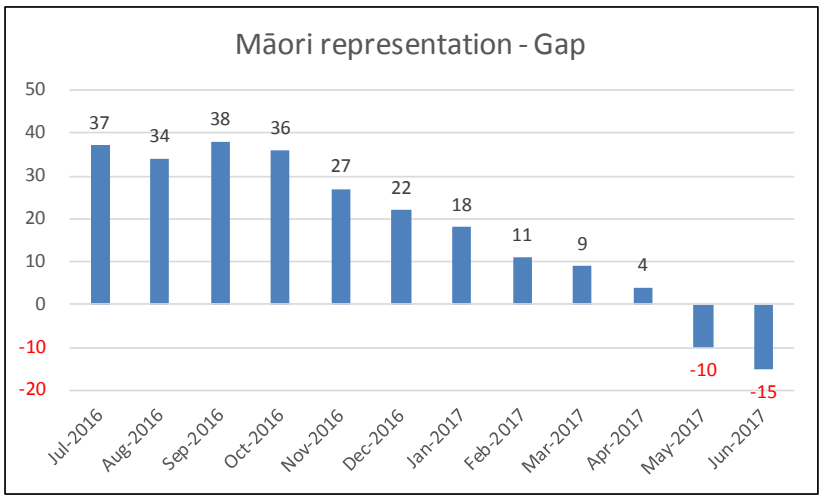
Note – at 31 December 2011 the percentage of Māori staff was 8.8% compared to 13.0% at 31 December 2016.

Māori staff representation in the Workforce:

	People	Positions
Jun. '17	14.64%	14.25%
Jun. '16	12.95%	12.47%

June 2017 breakdown:

	Positions filled	% of Total
NZ & European	2264	73.68%
Maori	438	14.25%
Pacific Islands	32	1.04%
Other	272	8.85%
Not known	67	2.18%
Total	**3073**	



Support staff (31.58%), Allied Health staff (14.29%) and Management & Admin staff (19.87%) exceed the DHB target.

Medical (5.19%) and Nursing staff (12.10%) are below the target.

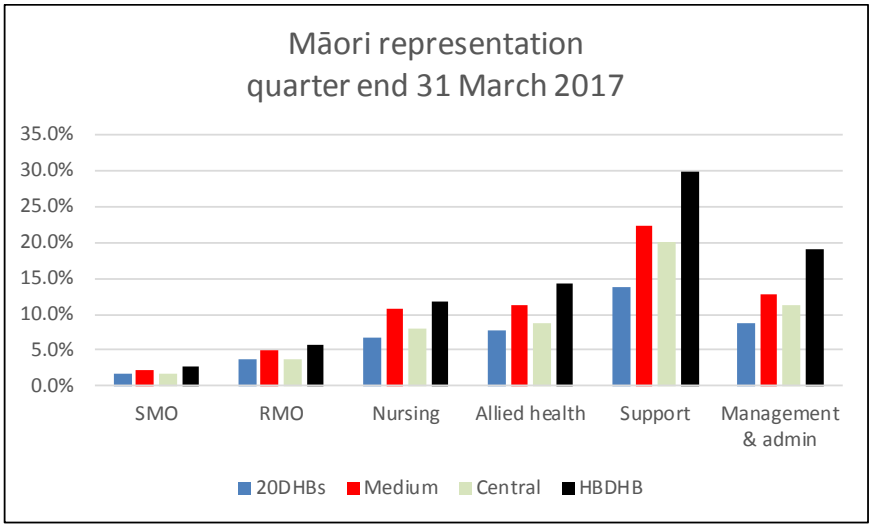
We have exceeded the 2016/17 target by 15 positions at 30 June 2017.

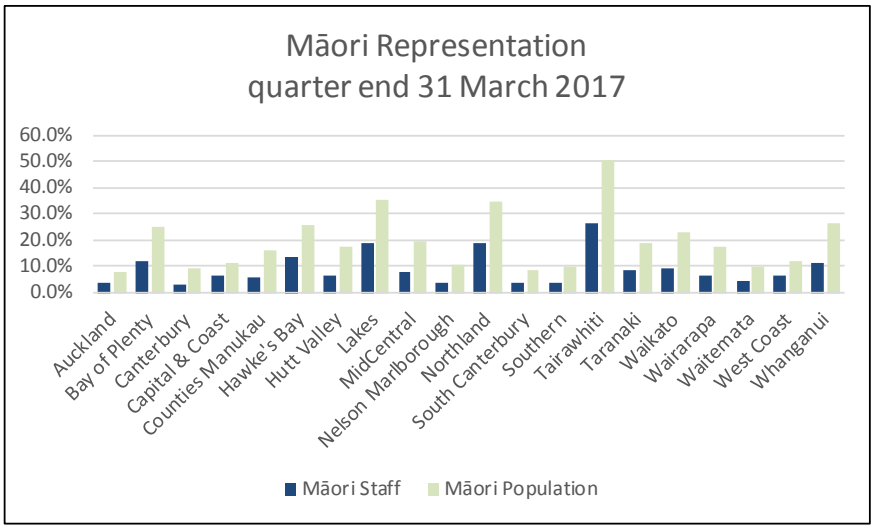
412	Māori Staff - 1 Apr. '17
25	New Staff
(7)	Staff resignations
8	Changes to ethnicity
438	Māori Staff – 30 Jun. '17

20

DHBSS have taken over reporting of the 20 DHB Comparisons and report on Ethnicity figures (to 31 March 2017). The first chart shows that Hawke's Bay DHB compares favourably against:

- 20 DHB average
- Medium sized DHBs
- Central Region DHBs





The above chart shows how DHB staffing compares against the Māori population. At 31 March 2017 Hawkes' Bay DHB had 13.5% of employees identifying as Maori against the HB Māori population of 25.9%

Looking at DHBs with the highest Māori Population we rank 5th highest behind Tairawhiti, Lakes, Northland and Whanganui. Looking at DHBs with the highest Māori staffing percentages we rank 4th behind Tairawhiti, Northland and Lakes.

Just to explain the figures a bit more. Firstly these figures are as at 31 March 2017 so are not quite up to date.

Rank	DHB	Maori Staff	Maori Population	Maori Representation
1	Northland	18.9%	34.7%	54.5%
2	Capital & Coast	6.2%	11.5%	54.1%
3	Lakes	18.9%	35.3%	53.5%
4	West Coast	6.2%	11.8%	52.8%
5	Tairawhiti	26.3%	50.3%	52.4%
6	Hawke's Bay	13.6%	25.9%	52.3%
7	Bay of Plenty	12.3%	25.2%	48.7%
8	South Canterbury	4.0%	8.4%	47.9%
9	Taranaki	8.9%	19.0%	46.8%
10	Waitemata	4.5%	10.0%	45.2%
11	Auckland	3.6%	8.2%	43.7%
12	Whanganui	11.3%	26.6%	42.3%
13	Waikato	9.2%	22.9%	39.9%
14	MidCentral	7.9%	19.9%	39.8%
15	Southern	4.0%	10.1%	39.5%
16	Hutt Valley	6.7%	17.4%	38.6%
17	Nelson Marlborough	4.0%	10.4%	38.2%
18	Wairarapa	6.3%	17.6%	35.5%
19	Counties Manukau	5.6%	15.9%	35.3%
20	Canterbury	3.0%	9.2%	32.4%

20

As you can see there is quite a variation in the levels of Māori staff and also quite a variation in levels of Māori Population. Table above shows how close each DHB is to their Māori Population.

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Transform & Sustain Strategic Dashboard Q4 June 2017** 96
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Tracee Te Huia, GM Maori Health Peter Mackenzie, Business Intelligence Analyst
Reviewed by:	Executive Management Team
Month:	August, 2017
Consideration:	For Monitoring

BACKGROUND

The Transform and Sustain Strategic dashboard has been developed to measure our Vision and Values and progress towards long term Transform and Sustain strategic objectives. In December FRAC and the Board endorsed the reorganisation of strategic non-financial reporting to better reflect the strategic roles between the two committees. It was agreed that the Transform and Sustain Dashboard would be presented to the Board quarterly.

Current results are colour coded to Red if significantly below target, Amber if below target but close to achieving target and Green if achieving target. There is also a trend line against each vital sign and dimension, this shows the trend over time and how each indicator is tracking to target. As this is the first issue of the dashboard not all indicators have a clear trend line but in future issues the trend line will start to become clearer and help to predict future trajectories.

Provided on the back of the dashboard are definitions of each measure.

ONGOING REVIEW OF REPORTING

A review of the Transform and Sustain Strategic Dashboard in relation to programs of work and other relevant quarterly reporting is currently underway in order to better align with the organisations performance. The main outcomes of the review are focusing on:

- Better aligning the dashboard with the efforts of the Transform and Sustain Strategy.
- Making the reporting clearer for the less technically competent.
- Moving to exceptions reporting.
- Considering our current reporting against the planning advice changes from the ministry for 2017/18 financial year.

EXCEPTIONS AND AREAS OF FOCUS

Cornerstone Accreditation

Three practices have changed ownership in the last quarter and one is closing (Dr Jolly's). HHC have bought Dr Wakefield's and The Doctors Napier have bought Dr Craig's, they are now both going through the process of Cornerstone Accreditation. Carlyle Medical, Central Medical and Tuki Tuki have been assessed and just waiting for their formal accreditation' 100% of Foundation Standards have been accredited.

Faster Cancer Treatment:

Further improvements have been made to reduce waiting times for diagnostic intervention, both internally and with external providers. Similarly, there have been marked reductions in waiting times for surgical treatment internally despite strong pressure on HBDHB surgical services. There continue to be challenges in securing treatment of Hawkes Bay residents in other DHBs within the required timescales. There is work underway to agree waiting times for surgical and radiotherapy treatment at tertiary centres. Unfortunately these delays in gaining treatment at external providers impacted on compliance with the Health Target which stands at 67% or 10/15 patients treated within 62 days in June, all of which breaches have been lung cancer. Of the 5 patients who breached, only 2/15 breached due to capacity reasons and so compliance by the new MoH rules to be introduced from July would be 87%. Following this result there have been a number of actions put in place to urgently improve waiting times for patients with lung cancer including organising one stop diagnostic clinics, changing external provider for specialised laboratory tests, implementing new triage process. A retrospective audit has now been completed and many lessons learnt with improvements made. The electronic record has been retrospectively altered to ensure compliance with the MoH business rules. Correction of the electronic record will result in a marked improvement of the HBDHB performance over the past 6 months. Partnership with Improvement Advisors has identified a number of Opportunities for Improvement across pathways and a number of these are being immediately actioned. Following meetings between the CEO and Clinical leads of tumour streams, the Faster Cancer treatment Action Plan has been refreshed. This includes an emphasis on one stop shops for diagnosis and treatment, reduced waiting times for diagnostic tests, improved triaging from clinical

teams, design of electronic systems to replace paper processes and agreement of waiting times with external providers.

Maori women smoking during pregnancy:
There are a number of activities run by the smokefree team and Ata Rangi Maternity to address the high smoking rate in Maori and Pacific birthing women.
Close work with Information technology team to make sure we pull out the correct data. Incentivized cessation provided not only to pregnant and postnatal women but to their whanau too since July 2016. The smokefree team has sourced more funding for baby carbon monoxide monitors to be purchased for use within the DHB but also in the Napier Midwifery Resource Centre, as well as a couple of monitors for the community based cessation providers. All three cessation providers in the area are Maori providers with a high ratio of Maori to non-Maori staff. This should strongly support the cultural needs of our non smokefree women and their whanau.

Rheumatic Fever Hospitalisation Rates:
All stakeholders that are working in the community with community engagement contracts continued to meet monthly to get Rheumatic Fever messages out as part of our community awareness raising strategy. Highlights were Te Taiwhenua O Heretaunga's launch of their video about one of their families rheumatic fever journey and Hawkes Bay Samoan rugby's video in English and Samoan ,both have been featured in Friday Fever over the past month.

Work continues in primary schools in Flaxmere with a community awareness implementation plan delivering the 5 key messages that the MOH has advised. Linked to the national campaign with a local flavour. HBDHB to support the campaign with video clips on TV waiting rooms, messages on the HBDHB Facebook page which has shown increased traction through likes, comments and shares on the RF posts over the past 3 months of monitoring.

HEALTHY HAWKE'S BAY

NZ TRIPLE AIM

TRANSFORM & SUSTAIN

VITAL SIGNS

SUPPORTING DIMENSIONS

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 Whakawateatia

Improved quality and safety of care	Best value for public health system resources	Improved health equity for all populations
Delivering consistent high-quality health care	Being more efficient at what we do	Responding to our population

		Baseline	Previous	Current	Target
Patient experience	Patient Experience Survey Score	8.5	8.3	8.6	≥ 8.5
	*Communication				
Better access to specialist outpatients	Did not attend (DNA) rate across first specialist assessments	6.10%	5.10%	5.20%	≤ 7.50%
A safer hospital	Standardised Hospital Mortality Rate	101	108	103	≤ 100
Higher Quality General Practices	General Practices with Cornerstone Accreditation	50.0%	79.0%	88.0%	≥ 100.0%
All General Practices meet Foundation Standard	General Practices that meet Foundation Standards	0.0%	62.0%	100.0%	≥ 100.0%
Reduced readmissions	Hospital Standardised Readmission Rate	7.5%	7.3%	7.3%	≤ TBC
A culturally responsive workforce	Percentage of DHB Staff Ethnicity who are Māori	11.6%	13.5%	14.3%	≥ 13.8%
Emergency Department Waits	Patients waiting less than 6 hours in ED	91.5%	93.8%	94.7%	≥ 95.0%

		Baseline	Previous	Current	Target
Resource sustainability	Financial Surplus DHB $'000		-$1,778	-$1,433	≥ $0
	Breakeven PHO			On track	
Older people living independently	Over 85s Living Independently	78.4%	78.4%	78.5%	≥ 80.0%
Improved hospital workforce productivity	Case Weight per Health Service FTE	3.04	3.12	3.55	≥ 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%	10.30%	10.3%	Between 9.5% and 10.5%
Care close to home	Strategic Spending Shift	-0.3%	0.1%	-	≥ 0.2%
More Treatments Out of Hospital	Ambulatory-sensitive Hospital Admissions (0-4 yr olds)	76.0%	78.0%	76.0%	≤ TBC

		Baseline	Previous	Current	Target
Live healthier and longer lives	Difference in Maori Death rates (Below 50 years of age)	16.3%	8.0%	17.0%	≤ 14%
Reduced infant mortality	Infant Mortality Rate	4.41	2.79	2.9	≤ 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%	10.5%	8.2%	≤ 8%
More heart and diabetes Checks	Diabetes and Cardiovascular Services Checks	88%	89%	88%	≥ 90%
Faster cancer treatment	Faster Cancer Treatment	62%	72%	77%	≥ 85%
Fewer women smoking in pregnancy	Maori Women Smoking During Pregnancy	44%	46%	49%	≤ 22%
Reducing Rheumatic Fever	Rheumatic Fever Hospitalisation Rates	0.6	1.8	2.48	≤ 1.5

	Indicator Origin	Measure	Definition	Frequency
Patient Experience	National	Communication	Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4	Quarterly
		Partnership	Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4	Quarterly
		Co-Ordination	Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4	Quarterly
		Physical and Emotional Needs	Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4	Quarterly
Better Access to Specialist Outpatients	Local	Did not attend (DNA) rate across first specialist assessments	Patients who do not show up to an outpatient appointment without any prior notice	Quarterly
A Safer Hospital	Local	Standardised Hospital Mortality Rate	Ratio of actual to expected hospital deaths	Annually
More Very Higher Quality General Practices	Local	General Practises with Cornerstone Accreditation (Practices with Population >3,142)	GP's with Cornerstone accreditation (CORNERSTONE is an accreditation programme specifically designed by the Royal New Zealand College of General Practitioners for general practices in New Zealand) it allows GP's to measure themselves against a defined set of standards.	Quarterly
All General Practices are Demonstrably Good	Local	General Practices that meet Foundation Standards	The Foundation Standard represents what is considered to be the minimum legal, professional, and regulatory requirements for general practice	Quarterly
Reduced Readmissions	National	Hospital Standardised Readmission Rate	Patients re-admitting to the hospital within 28 days of being discharged. MOH target.	Quarterly
A Culturally Responsive Workforce.	Local	Percentage of DHB Staff Ethnicity who are Maori	The % of staff employed at the DHB that identify their ethnicity as Maori	Quarterly
Emergency Department Waits	National	Patients waiting less than 6h in ED	Health Target. Patients waiting less than 6 hours in the ED department	Quarterly

Resource Sustainability	Local	Financial Surplus DHB	$0 or + variance to budget	Quarterly
	Local	Breakeven PHO	Financial result = $breakeven	Quarterly
Older People Living Independently	Local	Over 85s Living Independently	The proportion of 85years who are not living in Age Residential Care	Annually
Improved Hospital Workforce Productivity	Local	Case Weight per Health Service FTE	Numerator: Total caseweights. Denominator: Total Doctor and Nursing FTE. Improve productivity by either increasing case weights or decreasing	Quarterly
Better Staff Engagement	Local	Staff Engagement Survey Satisfaction Rate	% engaged employees at HBDHB based on the Engagement questions in the staff engagement survey	Annually or longer
More Efficient Buildings	Local	Buildings Infrastructure Efficiency	Numerator : Total Infrastructure costs (everything to do with buildings & facility costs e.g. buildings, lease, maintenance, depreciation, rates . Denominator: Infrastructure costs weighted output e.g. service weights which is everything we do e.g. caseweights, contacts, face to face, tests, appointments	Quarterly
Better Staff Retention	Local	Staff Turn-over	Turn-Over of HBDHB employees	Quarterly
Care Closer to Home	Local	Strategic Spending Shift	To shift resources from hospital and IDFs to Primary and Community by 0.5% p.a.	Annually
More Treatment Out of Hospital	National	Ambulatory-sensitive hospitalisations	HBDHB ASH rate 0-4 year olds relative to the national Rate as a percentage. (the Ministry of health have recently updated the indicator and are currently collecting baseline data. A target will be set as part of the 2016/17 planning process).	Six Monthly

Live Healthier and Longer Lives	Local	Premature deaths under 50 years	The number of deaths under the age of 50 as a percentage of all deaths. Gap between Maori and Non-Maori.	Annaully or longer
Reduced Infant Mortality	Local	Infant Mortality Rate	HB Children who die from any cause under the age of 1 / total number of live births in the year	Annually
Fewer Premature Deaths	Local	Maori All Cause Mortality < 75	The age standardised rate of death for Maori people under the age of 75. per 100,000	Annually or longer
Healthier Weight	Local	Obesity Rate	Prevalence of Maori children having a B4shcool check who are obese according to the international obesity task force.	Annually
More Heart and Diabetes Checks	National	Better diabetes and cardiovascular services	Health Target. Enrolled people in the PHO who are eligible for a CVD risk assessment who have had a CVD risk recorded within the last 5 years.	Quarterly
Faster Cancer Treatment	National	Faster Cancer Treatment	62 Day FCT Health Target	Quarterly
Fewer women smoking in pregnancy	Local	Maori Woman Smoking During Pregnancy	% All Maori Women who are recorded as smoking at the birth of their baby.	Quarterly
Reducing Rheumatic Fever	National	Rheumatic Fever Hospitalisation Rates	Rate per 100,000 TBC	Quarterly

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Māori Plan Q4 (Apr- Jun 2017) Dashboard Report** 95
	For the attention of: **HBDHB Board**
Document Owner(s):	Tim Evans, Executive Director, Corporate Services Tracee Te Huia, Executive Director, Strategy & Health Improvement
Document Author(s):	Patrick LeGeyt, Acting GM Maori Health; Justin Nguma, Senior Health & Social Policy Advisor Māori Health; and Peter Mackenzie, Business Intelligence Analyst
Reviewed by:	Executive Management Team, Clinical and Consumer Council
Month:	August 2017
Consideration:	For Monitoring

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report.

CONTENTS OF THE REPORT

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

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

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

KEY FOR DETAILED REPORT AND DASHBOARD

Baseline	Latest available data for planning purpose
Target 15-16	Target 2015/16
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target
Trend direction ▲	Performance is improving against the previous reporting period or baseline
Trend direction ▼	Performance is declining
Trend direction -	Performance is unchanged

2016-2017 ANNUAL MĀORI HEALTH PLAN QUARTER 4 PERFORMANCE HIGHLIGHTS

Achievements

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

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

Areas of progress

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Challenges

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

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

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

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

Please note:

- Unless otherwise stated the results presented in this dashboard are for Māori.
- The approximated gap to achieving target numbers stated may only be one of a range of possible values that could deliver the targeted level/result.

ANNUAL MĀORI HEALTH PLAN, QUARTER 4 APRIL – MAY 2017 DASHBOARD REPORT

Immunisation

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Immunisation at 8 Months (3m)	92.6%	95.4%	94.0%	95.6%	≥ 95%	-3		↑
65+ Influenza (12m)	68.0%	21.0%	54.0%	59.0%	≥ 75%	-578		↑

Rheumatic Fever

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Total	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Hospitalisation rate (6m)	2.48	7.23	9.64	3.1	≤ 1.5	-1		↓

Breastfeeding

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Total	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
QIF Data (6m)								
At 6 Weeks	58.0%	66.0%	No new data, waiting for the publication of the QIF		≥ 75%	-		↑
At 3 months	46.0%	39.0%			≥ 60%	-		↑
At 6 months	46.0%	50.0%			≥ 65%	-		↑

ASH Rates

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
0-4 years (6m)	82.1%	84.9%	79.5%	66.9%	≤ 82.8%	-		↓
45-64 years (6m)	172.0%	211.3%	178.5%	67.6%	≤ 138%	-		↓

Cancer

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Cervical screening (25-69 yrs) (3m)	74.1%	73.1%	73.0%	75.2%	≥ 80.0%	-644		↑
Breast screening (50-69 yrs) (3m)	68.4%	66.7%	66.2%	74.9%	≥ 70.0%	-135		↑

Maori Workforce

Indicator	Baseline	Prior period result	Actual to date Maori	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	2.9%	4.7%	5.2%	≥ 13.8%			
Management & Administration	16.5%	19.1%	19.9%	≥ 13.8%			
Nursing	10.6%	11.6%	12.1%	≥ 13.8%			
Allied Health	12.6%	13.2%	4.3%	≥ 13.8%			
Support Staff	28.2%	29.3%	31.6%	≥ 13.8%			
Māori staff - HBDHB (3m)	12.3%	13.5%	14.3%	≥ 13.8%	-		↑

Oral Health

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Pre-school enrolment rate (12m)	65.3%	72.7%	Reported Annually in Q3		≥ 95%			↑
% Caries Free at 5yrs (12m)	36.0%	44.0%			≥ 67.0%			↑

Tobacco

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Smokefree 2 weeks postnatal (6m)	53.0%	65.6%	No new data, waiting for the publication of the QIF					↑

Mental Health & Addictions

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Mental Health Act community treatment orders (per 100,000) (3m)	196	175.9	175.1	61.5	≤ 81.5	-		↓

Access to Care

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
PHO Enrolment (3m)	97.2%	97.5%	97.9%	98.1%	≥ 100%	-890		↑

The number in brackets identifies the frequency at which data is updated:
(3m) 3 months
(6m) 6 months
(12m) 12 months

Cultural Responsiveness

Indicator	Baseline	Prior period result	Actual to date	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	19.2%	37.5%	36.9%	≥ 100.0%			
Management & Administration	79.1%	88.5%	89.4%	≥ 100%			
Nursing	70.0%	85.6%	86.0%	≥ 100%			
Allied Health	77.3%	89.9%	90.8%	≥ 100%			
Support Staff	35.6%	64.9%	64.4%	≥ 100%			
HBDHB (3m)	65.6%	80.9%	81.5%	≥ 100%	-		↑

*Obesity still to be confirmed

Alcohol and Other Drugs

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
% of 0-19 year olds seen within 3 weeks of referral (3m)	63%	74.1%	78.0%	72.6%	≥ 80%	-		↑
% of 0-19 year olds seen within 8 weeks of referral (3m)	86.5%	92.0%	92.8%	89.7%	≥ 95.0%	-		↑

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

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora – Mental Health** 96
	For the attention of: **HBDHB Board**
Document Owner:	Sharon Mason – Executive Director Provider Services
Document Author(s):	Justin Lee – Acting Service Director; Simon Shaw – Medical Director; Peta Rowden – Acting Nurse Director
Reviewed by:	Executive Management Team, Māori Relationship Board, Clinical & Consumer Council
Month:	August 2017
Consideration:	For Discussion

RECOMMENDATION

That the HBDHB Board:

Note actions being taken to address continuing issues in

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

OVERVIEW

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

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

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

UPCOMING REPORTS

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

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

WHY ARE THESE INDICATORS IMPORTANT?

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

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

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

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

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

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

First Indicator : Rate of Section 29 Compulsory Treatment Orders

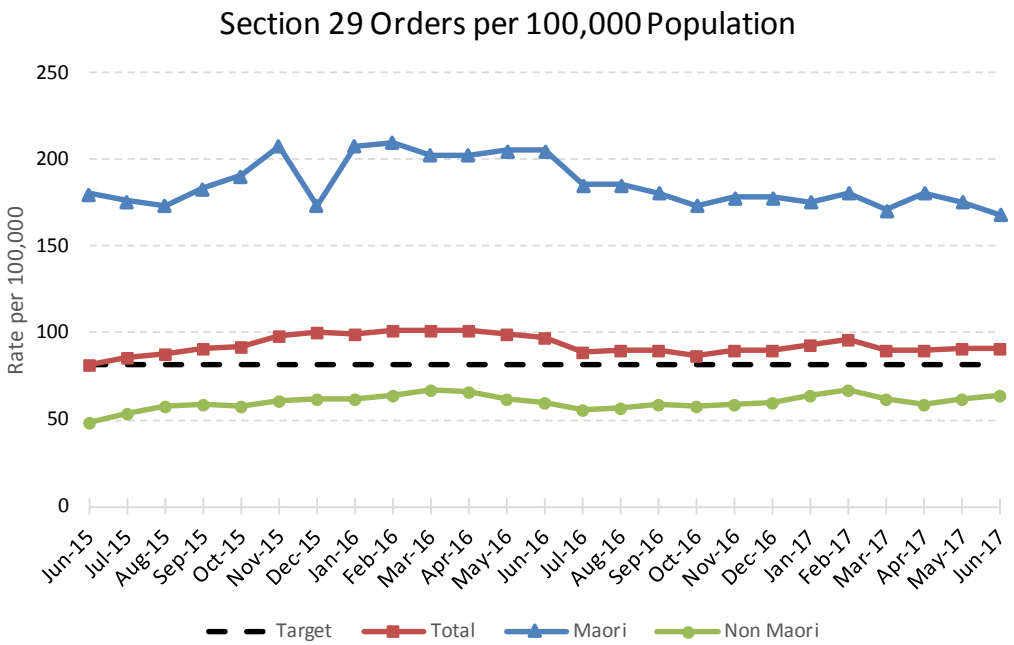
The Office of the Director of Mental Health reports annually on rates of Section 29 use by DHBs. The report comments that Māori have 3 - 4 times higher rates of use of Section 29 compared to non-Māori on average.

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

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

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

HBDHB Section 29 Orders – June 2016 to June 2017



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

COMMENTS:

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

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

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

Actions being taken to achieve plan include:

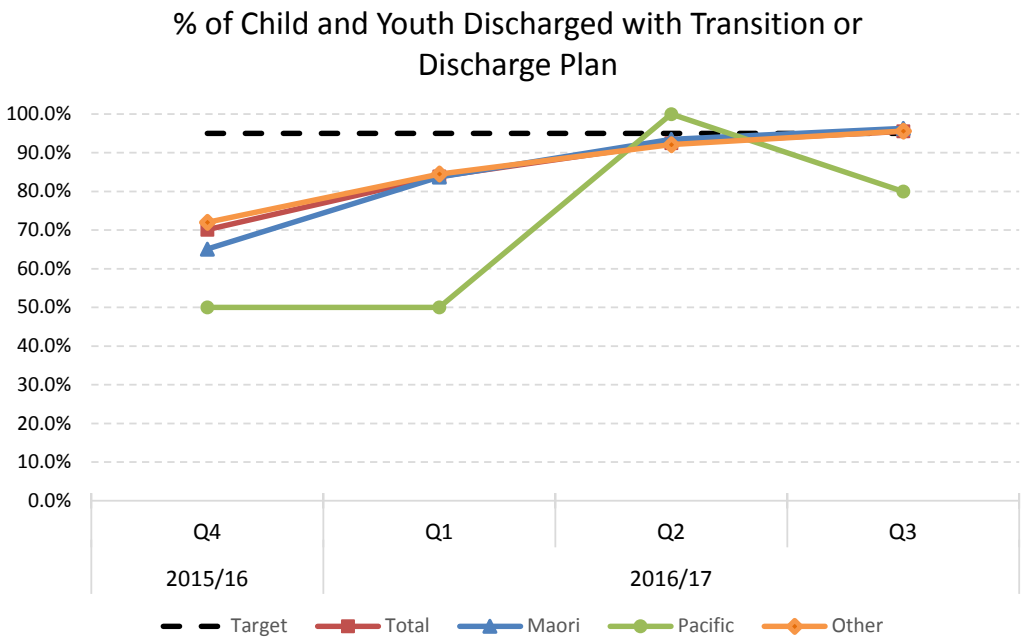
- Home Based Treatment team to provide services closer to home, to prevent mental health conditions worsening and reduce the need for people to be admitted to Nga Rau Rakau when acutely unwell, hence reducing the need for compulsory treatment.
- Provision of Acute Day Service for the community, based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

Second Indicator

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

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

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



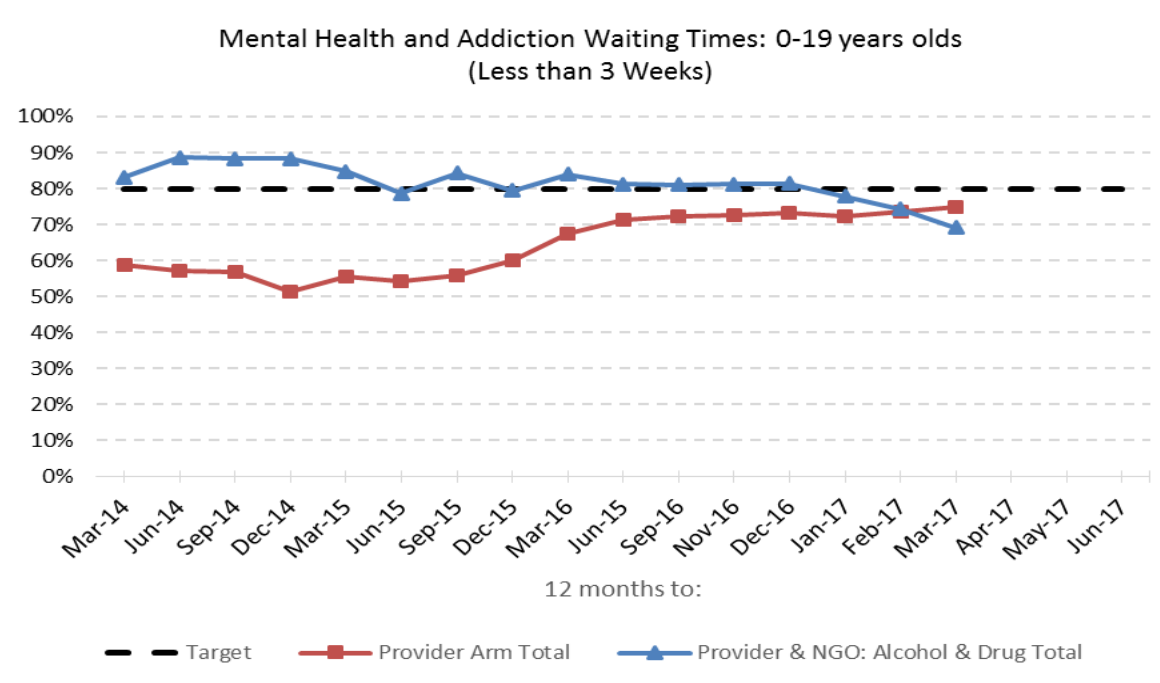
Third Indicator

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

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

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

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



Note: the table below reports data to March 2017.

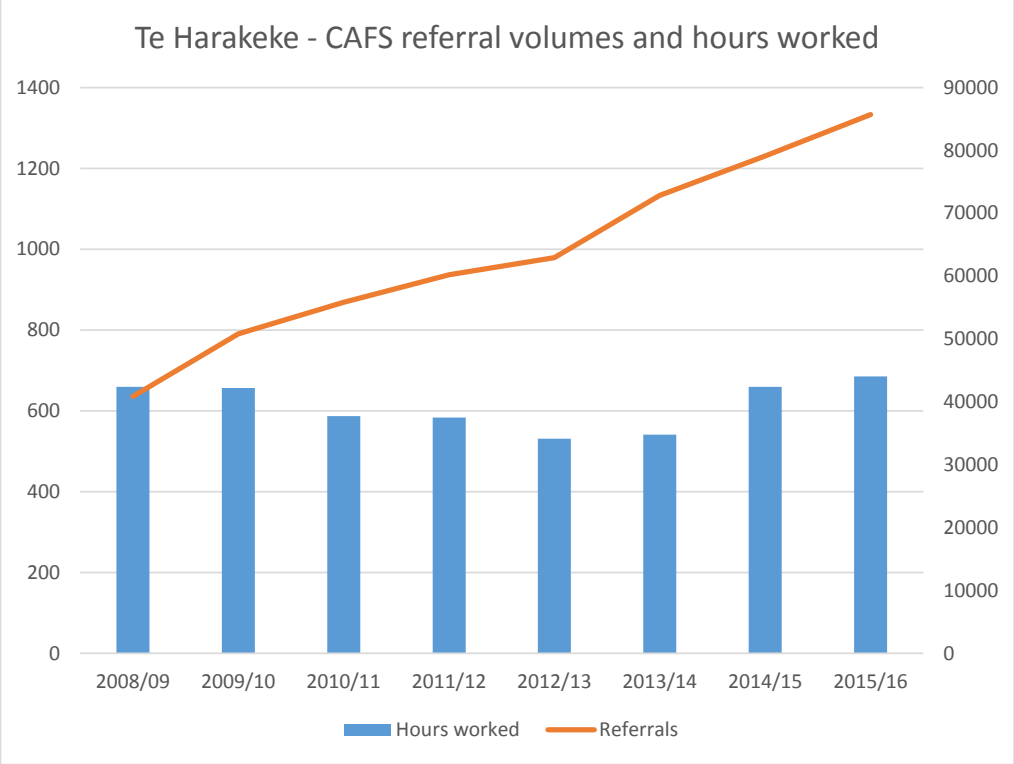
	Mental Health Provider Arm									
	<3 weeks					**<8 weeks**				
12 months to Mar-17	Target	Provider Arm Total	Māori	Pacific	Other	Target	Provider Arm Total	Māori	Pacific	Other
	80.0%	74.8%	78.0%	72.2%	72.6%	95.0%	90.9%	92.8%	88.9%	89.7%

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

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

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

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



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

CHAMPIONS REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THIS INDICATOR

Compulsory Treatment Orders

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

From Annual Plan 2016/ 2017

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

Transition and Discharge Planning

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

23

From Annual Plan 2016/ 2017

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

Reducing Waiting Times

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

From Annual Plan 2016/ 2017

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

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

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

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

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

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

.

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

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

RECOMMENDATIONS FROM TARGET CHAMPION

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

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

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

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

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

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

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

REFERENCES

[i] Kake, Arnold and Ellis. Estimating the prevalence of schizophrenia among New Zealand Māori: a capture-recapture approach. Aust NZ J Psychiatry. 2008 Nov: 42(11):941-9

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

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

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

HAWKE'S BAY
District Health Board
Whakawāteatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

25. Confirmation of Minutes of Board Meeting
    - Public Excluded

26. Matters Arising from the Minutes of Board Meeting
    - Public Excluded

27. Board Approval of Actions exceeding limits delegated by CEO

28. Chair's Update

29. Corporate Office Building Lease

30. HB Clinical Council

31. Finance Risk & Audit Committee

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

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.

- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.

- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).