Māori Relationship Board Meeting

Date:	**Wednesday, 14 February 2018**
Meeting:	**9.00am to 12.00pm**
Venue:	**Tukituki Boardroom, Ngāti Kahungunu Iwi Inc. Office, 304 Fitzroy Avenue, Level 1, Takira House, Hastings**

Board Members:

Ngahiwi Tomoana (Chair)
Heather Skipworth (Deputy Chair)
George Mackey
Na Raihania
Kerri Nuku
Lynlee Aitcheson-Johnson
Trish Giddens
Ana Apatu
Hine Flood
Dr Fiona Cram
Beverly Te Huia

Apologies:
Kerri Nuku
Sharon Mason (Executive Director, Providers Services HBDHB)

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

Our vision

HEALTHY HAWKE'S BAY

TE HAUORA O TE MATAU-Ā-MĀUI

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

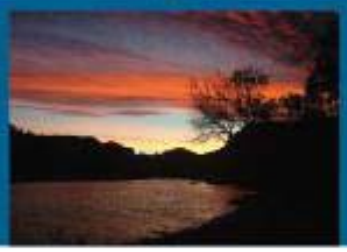
Our values

Tauwhiro – delivering high quality care to patients and consumers

Rāranga te tira – working together in partnership across the community

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

Ākina – continuously improving everything we do



PUBLIC MEETING

Item	Section 1 : Routine	Time
1.	Karakia	**9.00am**
2.	Whakawhanaungatanga	
3.	Apologies	
4.	Interests Register	
5.	Minutes of the Previous Meeting and Notes of Workshop held 12 December 17	
6.	Matters Arising - Review of Actions	
7.	MRB Workplan 2018	
8.	MRB Chair's Report	
9.	General Manager Māori Health Report	
10.	Clinical Council Verbal Update – Ana Apatu	
	Section 2: For Information/Discussion	**9.30am**
11.	Ngātahi Vulnerable Children's Workforce Development Progress – Bernice Gabrielle	15 mins
12.	Clinical Services Plan Update – Ken Foote	15-mins
13.	Suicide Prevention Update – Penny Thompson	15-mins
	Section 3: Monitoring - for Information Only	**10.30am**
14.	Te Ara Whakawaiora - Access 0-4 / 45-65 yrs (local indicator) – Jill Garrett	5-mins
15.	HBDHB Performance Framework Expectations Report Q2 (Dec 2017 to Feb 18) – Patrick LeGeyt	5-mins
	Section 4: General Business	**11.00am**
16.	**Section 5: Recommendation to Exclude the Public**	**11.30am**

PUBLIC EXCLUDED

Item	Section 6: Routine	Time
17.	Minutes of Previous Meeting	5-mins
18.	Matters Arising - Review of Actions	5-mins
	Karakia Whakamutunga (Closing Prayer)	
	Light Lunch	**12.00pm**

Māori Relationship Board Interest Register - 1 November 2017

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict (if any)	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Declared
Ngahiwi Tomoana (Chair)	Active	Chair, Ngati Kahungunu Iwi Incorporated (NKII)	Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The HBDHB Chair	01.05.08
	Active	Brother of Waiariki Davis	Perceived Conflict of Interest. Non-Pecuniary interest. Waiariki Davis is employed by HBDHB and is the Health Records Manager.	Will not take part in any decisions in relation to Health Records management. All employment matters in relation to Waiariki Davis are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Uncle of Tiwai Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Tiwai Tomoana is employed by HBDHB and is a Kitchen Assistant in the Food and Nutrition Department at Hawke's Bay Hospital.	All employment matters in relation to Tiwai Tomoana are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Uncle of Iralee Tomoana	Iralee Tomoana is employed by HBDHB and works in the Radiology Department as a clerical assistant.	All employment matters in relation to Iralee Tomoana are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Brother of Numia Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital.	Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital.	The HBDHB Chair	01.05.08
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
Kerri Nuku	Active	Kaiwhakahaere of New Zealand Nurses Organisation	Nursing Professional / Industrial Advocate	Will not take part in any discussions relating to industrial issues	The Chair	19.03.14
	Active	Trustee of Maunga HaruruTangitu Trust	Nursing Services - Clinical and non-Clinical issues	Will not take part in any discussions relating to the Trust	The Chair	19.03.14
George Mackey	Active	Wife, Annette Mackey is an employee of Te Timatanga Ararau Trust (a Trust aligned to Iron Maori Limited)	The Trust Holds several contracts with the HBDHB	Will not take part in any discussions relating to the Trust	The Chair	19.03.14
	Active	Wife Annette is a Director and Shareholder of Iron Maori Limited (since 2009)	The company is aligned to a Trust holding contracts with HBDHB	Will not take part in any discussions relating to Iron Maori Limited	The Chair	04.08.16
	Active	Trustee of Te Timatanga Ararau Trust (a Trust aligned to Iron Maori Limited)	The Trust Holds several contracts with the HBDHB	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.06.14
	Active	Director and Shareholder of Iron Maori Limited (since 2009)	The company is aligned to a Trust holding contracts with HBDHB	Will not take part in any discussions or decisions relating to the Contract aligned to Iron Maori Limited).	The Chair	04.08.16
	Active	Employee of Te Puni Kokiri (TPK)	Working with DHB staff and other forums	No conflict	The Chair	19.03.14
Lynlee Aitcheson-Johnson	Active	Chair, Maori Party Heretaunga Branch	Political role	Will not engage in political discussions or debate	The Chair	19.03.14
	Active	Trustee, Kahuranaki Marae		No conflict	The Chair	14.07.16
	Active	Treasurer for Ikaroa Rawhiti Maori Party Electorate		No conflict	The Chair	04.07.17
Na Raihania	Active	Wife employed by Te Taiwhenua o Heretaunga	Manager of administration support services.	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.03.14
	Active	Member of Tairawhiti DHB Maori Relationship Board		Will not take part in any matters that may to any perceived contracts with Tarawhiti	The Chair	19.03.14
	Active	Employeed as a Corrections Officer		No conflict	The Chair	19.03.14
	Active	Board member of Hauora Tairawhiti	Relationship with Tairawhiti may have contractural issues.	Will not take part in any matters that may to any perceived contracts with Tarawhiti	The Chair	27.03.17
Ana Apatu	Active	CEO of U-Turn Trust (U Turn is a member of Takitimu Ora Whanau Collective) The U-Turn Trust renamed /rebranded "Whararíki Trust" advised 30-8-17	Relationship and and may be contractural from time to time	No conflict	The Chair	12.08.15
	Active	Chair of Directions	Relationship and contractual	Potential Conflict as this group has a DHB Contract	The Chair	12.08.15
	Active	Chair, Health Promotion Forum (previously Deputy Chair from 12.08.15)	Relationship	No conflict	The Chair	12.08.15 04.08.16
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	23.02.17
	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	23.02.17
Dr Fiona Cram	Active	Board Member, Ahuriri District Health Trust	Contribution to the health and wellbeing of Māori in Napier, as per the settlement under WAI692.	Declare and interest and withdraw from any discussions with respect to any contract arrangements between ADHT and HBDHB	The Chair	14.06.17

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict (if any)	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Declared
	Active	Adjunct Research Fellow, Women's Health Research Centre, University of Otago, Wellington	Health research involving data and/or participant recruitment from within HB DHB rohe.	Declare a potential conflict of interest, if research ethics locality assessment requires MRB input.	The Chair	14.06.17
Trish Giddens	Active	Trustee, HB Air Ambulance Trust	Management of funds in support of HB Air Ambulance Services	Will not take part in discussions or decisions relating to contracts with HB Air Ambulance Service.	The Chair	19.03.14
	Active	Member Heatlh HB Priority Population Health	TBC		The Chair	1.01.17
	Active	Committee Member, HB Foundation	TBC		The Chair	1.01.17
	Active	Committee Member, Children' Holding Foundation	TBC		The Chair	1.01.17
	Active	Trustee, Waipukurau Community Marae	TBC		The Chair	1.01.17
Beverley TeHuia			TBC		The Chair	
			TBC		The Chair	
			TBC		The Chair	

MINUTES OF THE MĀORI RELATIONSHIP BOARD (MRB) MEETING HELD ON WEDNESDAY, 8 NOVEMBER 2017, IN TE WAIORA MEETING ROOM, DISTRICT HEALTH BOARD (DHB) ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS COMMENCING AT 9.00AM

Members:	Ngahiwi Tomoana (Chair) Heather Skipworth (Deputy Chair) Na Raihania George Mackey Trish Giddens Lynlee Aitcheson-Johnson Kerri Nuku Ana Apatu Dr Fiona Cram Hine Flood Beverly Te Huia
Apologies:	Dr Fiona Cram Ngahiwi Tomoana George Mackey Heather Skipworth (late) Kevin Atkinson (Chair Hawke's Bay District Health Board) Tracee Te Huia (Executive Director of Strategy & Health Improvement HBDHB) Matiu Eru (Pouahurea, Māori Health HBDHB)
In Attendance:	Peter Dunkerley (Board Member HBDHB) Helen Francis (Board Member HBDHB) Dr Kevin Snee (CEO HBDHB) Chris Ash (Executive Director Primary Care HBDHB) Sharon Mason (Executive Director Provider Services HBDHB) Chris McKenna (Chief Nursing and Midwifery Officer, HBDHB) Patrick Le Geyt (Acting General Manager, Māori Health HBDHB) Wayne Woolrich General Manager of Te Oranga Hawke's Bay - Health Hawke's Bay (HHB)
Minute Taker:	Lana Bartlett

SECTION 1: ROUTINE

1. KARAKIA

Patrick LeGeyt (Acting General Manager, Māori Health HBDHB) opened the meeting with karakia.

2. WHAKAWHĀNAUNGATANGA

Deputy Chair, H Skipworth was arriving late. N Raihania was asked to chair the meeting until the arrival of H Skipworth. All were in support of N Raihania chairing the meeting until the Deputy Chair arrived.

3. APOLOGIES

Apologies were received from the MRB Chair and MRB members Dr F Cram and G Mackey.

Apologies were also received from Kevin Atkinson (Chair Hawke's Bay District Health Board), Tracee Te Huia (Executive Director of Strategy & Health Improvement HBDHB) and Matiu Eru (Pouahurea, Māori Health HBDHB).

4. INTERESTS REGISTER

No MRB members declared any additional conflict of interest to the register or with any agenda items for today's meeting.

5. MINUTES OF THE PREVIOUS MEETING

The minutes of the MRB Board meeting held 11 October 2017 were taken as read and confirmed as a correct record.

Moved: A Apatu
Seconded: L Aitcheson-Johnson
CARRIED

6. MATTERS ARISING FROM THE PREVIOUS MINUTES

The following matters were raised from the October minutes:

Item 6, page 7: Review of Action Item 7

L Aitcheson-Johnson expressed her concern about the behaviour displayed by CEO at the last meeting during the discussion about the visit in 2018 by Paul Connett (Ph.D). It was acknowledged there is a lot of passion from all sides regarding this matter. The MRB Chair will have a discussion with the CEO about the etiquette for all visitors.

Item 9, page 8: Māori Nursing Workforce Strategy

To ensure the longevity of the Māori Nursing Workforce Strategy, the strategy needs to be available and easily accessible.

Item 10, page 8: Clinical Council Update

Last sentence should read "… dashboard is a positive step, however my caution needs to be a clear definition of what each of these indicators are intending to measure which is beneficial to **consumers**".

Item 12, page 9: The Big Listen

Although it might be a little late, MRBs feedback has been taken on board. It was requested to workshop with MRB in December to start again and begin from the conception design stages. To be discussed further under agenda item 13. Kōrero Mai Project.

REVIEW OF ACTIONS

The Action and Progress List as at October 2017 was taken as read. The following actions were discussed.

Item 7, Student Report: Report is due at the end of November.

Sharon Mason (Executive Director Provider Services) joined the meeting at 9.25am

7. MRB WORKPLAN 2017

The workplan as at November 2017 was taken as read.

8. MRB CHAIRS REPORT

The Chairs Report for November 2017 was taken as read and the contents noted.

9. GENERAL MANAGER (GM) MĀORI HEALTH REPORT

The GM Māori Health report for November 2017 was taken as read and the contents noted.

The following matters were discussed:

- Whānau Ora Collective – from a local perspective, it would have been good to have received an update on what's happening.
- Safe Sleep Programme – programme acknowledged. HBDHB is the only DHB that funds this programme. Programme is not restricted to only Māori and non-Māori have also shown an interest in Wahakura.
- Pregnancy and Parenting Information and Education Programme RFP - in negotiation with successful tender at the moment.

Concerns about the cost to print colour agenda packages was briefly discussed. K Nuku requested an electronic version only. MRB Admin to confirm with members their preference of a hard or electronic copy, or both.

10. CLINICAL COUNCIL UPDATE

While K Nuku did not attend the last Clinical Council meeting, the information that was presented at the meeting was also presented to MRB earlier that same day. Sharon Mason (Executive Director Provider Services) mentioned that the refresh of the functions of the Clinical Council was discussed at the last meeting.

Ken Foote (Company Secretary) joined the meeting at 10.45am

There was a discussion about the role of the MRB representative for Clinical Council and MRBs intent of the position. K Nuku felt the position lacks credibility. Ken Foote (Company Secretary) provided an overview of the role clarifying the role was established as a liaison to the Clinical Council to convey MRBs decisions, provide input and how the Council exercise their responsibilities in terms of a clinical perspective to the Board.

K Nuku is unable to attend every meeting and MRB emphasised the need to have a representative present at the meetings. And so K Nuku is to notify MRB Admin when unable to attend meetings.

Shari Tidswell (Intersectoral Development Manager) and Bill Murdoch (Hastings District Council) joined the meeting at 9.40am

SECTION 2: PRESENTATIONS

11. SURGICAL EXPANSION PROJECT

RECOMMENDATION

That the Māori Relationship Board:

1. **Note** that additional surgical capacity is required by 2020.
2. **Endorse** the expansion of in-house capacity by building and staffing an 8th operating theatre and wrap around services, and continued outsourcing (Option 5).
3. **Endorse** the investment of $12 million for capital costs associated with expanding in-house capacity and to proceed to tender for these capital works.

Moved: K Nuku
Seconded: L Aitcheson-Jonson
CARRIED

A large contingency was in attendance to speak to the paper consisting of Sharon Mason (Executive Director Provider Services), Rika Henctshel (Service Director Surgical), Phillip Manoy (Deputy Service Director Surgical), Anna Harland (Perioperative Unit Manager), Ben Duffus (Quality and Improvement Advisor), Trent Fairey (Energy & Capital Projects Manager), William van't Sant (Management Accountant) and Janet Heinz (Project Manager PMO).

The following feedback was received:

- Public and Private Partnership is a concern as research has proven these partnerships have never been successful. Additionally, patients in the public sector being referred by doctors to their private clinics needs to be monitored as this is already occurring
- Inadequate cover for surgeons on leave is an inequity. Internal sourcing for cover should be utilised.
- Investment of $12 million is for capital costs associated with expanding in-house capacity. How is it proposed for the cost for human resource be funded as this was not included?

12. MATARIKI REGIONAL ECONOMIC DEVELOPMENT AND SOCIAL INCLUSION STRATEGIES

Shari Tidswell (Intersectoral Development Manager HBDHB) and Bill Murdoch (Hastings District Council) were in attendance to provide a presentation on strategies; Matariki Regional Economic Development (REDS) and Social Inclusion.

Bill provided a brief introduction and gave an outline of the origination of the strategies, progress to date and future plans. Dr Kevin Snee (CEO) is the Sponsor and Tracee TE Huia (Executive Director SHID) is the Lead. Shari Tidswell (Intersectoral Development Manager HBDHB) acquired the role following the resignation of

Carina Burgess, former Head of Planning. Bill Murdoch, who works for the Hastings District Council (HDC) has been part of Social Inclusion since REDS. Bill was seconded to the REDS project from the outset.

Dr Kevin Snee (CEO) joined the meeting at 10.10am followed by Chris Ash (Executive Director Primary Care) at 10.15am

The following matters were discussed:

- Ensure that the voluntary sector are involved and the homeless are included in Social Inclusion
- This is an opportunity to role model the living wage. To engage small business need to ensure businesses and agencies are living wage registered. MWWL do a substantial amount of work but don't have the funding to increase wages/salaries to the living wage.

Kate Rawstron (Manager Project Management Office), Hayley Turner (Project Manager PMO) and Robyn Richardson (Health Services Planner) joined the meeting at 10.34am.

SECTION 3: FOR DISCUSSION/ INFORMATION

13. KŌRERO MAI PROJECT (VERBAL)

Kōrero Mai was initiated to ensure the Māori voice is included into The Big Listen following concern that our feedback about the questionnaire lacking the inclusive of all cultures, particularly Māori and Pacific. Furthermore, that ethnicity data was not being captured. Dr Fiona Cram was asked by MRB to develop an approach and is working with Patrick LeGeyt (Acting General Manager Māori Health) and Ngāti Kahungunu Iwi Inc. who will lead this engagement activity to feedback into the People Strategy (The Big Listen) project and also Clinical Services Plan (CSP).

An apology was received and an offer to make things right by having a workshop in December with the teams from the Project Management Office (PMO) and Quality and Patient Safety.

The results of The Big Listen have only just been published and showed a good number of Māori consumer participation. MRB requested to view The Big Listen and Māori Consumer Analysis Reports **ACTION Patrick LeGeyt**. MRB were asked to workshop in December. The 12 December 2017 was proposed and agreed by MRB.

Kate Rawstron (Manager Project Management Office), Hayley Turner (Project Manager PMO) and Robyn Richardson (Health Services Planner) were in attendance and presented the timelines of the strategic projects. Working in partnership was emphasised as key to ensure the outputs of projects are delivered in a timely fashion to influence planning and projects. The slide provided an overview of the project timelines and how key projects connect. Two key projects are The Big Listen and CSP that we need to ensure Kōrero Mai links with and ensure the outputs from Kōrero Mai integrate concurrently with these pieces of work. Also, we need to identify what the gaps are and what needs to be addressed.

The following matters were discussed:

- An Integration Team does not exist as such but a Working Group is in place. In addition, teams from Māori Health and Pacific Health have been working with Kate Rawstron (Manager, Project Management Office) and her team. The teams will be pulled together for the implementation process and co-design will occur at this point
- MRB want to ensure Kōrero Mai adds value by making certain that what we are delivering works for both Māori, Pacifica and non-Māori. Hayley Turner (Project Manager) will work closely with MRB to ensure MRBs outcomes are included and align with The Big Listen and CSP
- For the workshop, look at 'Where we are at with CSP, where we are with The Big Listen and where we are with Kōrero Mai'
- The visibility of Kōrero Mai at an Executive Management Team is impaired therefore needs to strengthened.

Johanna Wilson (Acting Smokefree Programme Manager) joined the meeting at 11.20am.

SECTION 4: FOR DISCUSSION/ DECISION

14. GOVERNANCE RESPORTS AND PRESENTATIONS – PRINCIPLES, STANDARDS AND GUIDELINES

Ken Foote (Company Secretary) was in attendance to present the Governance Reports and Presentations – Principles, Standards and Guidelines.

MRB noted and supported the reintroduction of the proposed 'Principles, Standards and Guidelines' for the development of Governance Reports tabled by the Company Secretary. The principles, standards and guideline is very clear, easy to follow and prompts the report writer to highlight key outcomes/impacts on vulnerable populations and Implications/outcomes arising from the application of a HEAT tool that impact on reducing inequities/ disparities. MRB endorse the recommendation to the Board to adopt the proposed 'Principles, Standards and Guidelines' including the proposed 'Governance Report Overview'.

Moved: K Nuku
Seconded: T Giddens
CARRIED

SECTION 5: FOR INFORMATION ONLY

15. BEST START HEALTH EATING & ACTIVITY PLAN UPDATE

Shari Tidswell (Intersectoral Development Manager) was in attendance to speak to the Best Start Healthy Eating & Activity Plan Update.

MRB noted the progress of the plan and highly praised Shari for the work she has done evident in the results. H Skipworth (Deputy Chair) added that the positive outcomes of the plan is a result of Shari's ability to listen to the feedback and advice given by MRB, then implementing the recommendations and continuously seeking affirmation to ensure she got it right. The Deputy Chair acknowledged Shari for her honesty and transparency reporting the truths including what's not working. The results of this initiative is an example of effective communication and engagement, and a collaborative partnership. The Deputy Chair thanked Shari and encouraged her to keep up the great work that is having a positive impact on better equity outcomes.

16. TE ARA WHAKAWAIORA: SMOKING (NATIONAL INDICATOR)
17. REGIONAL TOBACCO STRATEGY FOR HB - ANNUAL UPDATE

Shari introduced Johanna Wilson (Acting Smokefree Programme Manager) to MRB. Shari and Johanna spoke to both papers because the papers link together. The contents of both reports was noted in particular the increase in Smoking Mothers. EMT have asked Shari and her team to pull together a working group to reverse the trend and review what we are currently doing.

MRB provided the following feedback for consideration:

- Encourage 'Tane' to get on board to promote and support wahine to quit smoking
- Work with whānau to participate more in physical activities
- Enrol the entire whānau to get on board to quit smoking
- Need to get more disruptive – is this more a social and/ or cultural issue? Investigate how we can address the issue such as integrated health care, therapeutic programmes and cultural wellbeing programmes i.e. spiritual healing etc. It is time to consider what are the cultural responses to smoking
- Smoking is not a cultural issue but a 'type' of culture.

Peter McKenzie (Operational Performance Analyst) joined the meeting at 11.40am

18. HBDHB NON-FINANCIAL EXCEPTIONS QUARTER 1 (JULY-SEPT 2017) FULL REPORT – LATE PAPER

Peter McKenzie (Operational Performance Analyst) was in attendance to present the HBDHB Non-Financial Exceptions Quarter 1 Full Report. The following was discussed:

- Layout changed to a dashboard because it was difficult to get a flavour of the ethnicities with the old layout
- Annual Māori Health Plan is integrated into Annual Plan (AP). The AMHP has 72 actions. Currently looking at the Population Health Plan to identify inequity and identifying activities on how to address these at a service level
- Targets with high statistics will go under the Te Ara Whakawaiora programme

- Feedback form EMT was to add more areas of focus such as Mental Health and Peter will send the updated report to MRB
- Working on a method to present the inequities and quantify the inequities in real life. Although there is no statistical information at present we are still refining this data that needs more stringent definitions.
- Individual numbers and timelines are not included currently in the new format. But investigating how to include these but space is scarce. Timelines are included in full report

MRB will consider engaging Dr Russell Wills from a quantitative and qualitative perspective as the Medical Director of the Quality Manager, and the Flow Project and Faster Concern Treatment teams to possibly present at the December workshop. The Flow Project team look at the patients' journey through the hospital to primary care, same as Faster Cancer Treatment. It would also be prudent for MRB to wānanga the new dashboard and exceptions report therefore consider adding this topic to the workshop agenda.

SECTION 6: GENERAL BUSINESS

LETTER TO THE BOARD BY NZNO KAIWHAKAHAERE

K Nuku informed MRB of her intent to write a letter to the Board as the NZNO Kaiwhakahaere about the negative feedback, poor behaviour and bullying Kerri experienced following a meeting she facilitated off-site for nurses about how responsive the DHB is to staff needs. Kerri believed there was some misunderstanding by the DHB thinking the meeting was a MECA ratification meeting. There was a brief discussion about Kerri's concern around writing the letter because of the possible repercussions due to her membership on MRB. MRB did not think there is reason for concern because Kerri is writing to the Board as the NZNO Kaiwhakahaere and not as a MRB member.

19. RESOLUTION TO EXCLUDE THE PUBLIC

RESOLUTION

That MRB exclude the public from the following item:

20. Minutes of the Public Excluded Meeting held 11 October 2017.

Moved: A Apatu
Seconded: T Giddens
Carried

The public section of the MRB Meeting closed at 11.50am.

Signed: _____
Chair

Date: _____

Date of next meeting: 9.00am Wednesday, 14 February 2018
Te Waiora (Boardroom), HBDHB Corporate Administration Building

NOTES OF THE MĀORI RELATIONSHIP BOARD (MRB) WORKSHOP HELD ON TUESDAY, 12 DECEMBER 2017 IN TE WAIORA MEETING ROOM, DISTRICT HEALTH BOARD (DHB) ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS COMMENCING AT 9.00AM

Members:	Heather Skipworth (Acting Chair) Kerri Nuku Ana Apatu Dr Fiona Cram (teleconference) Trish Giddens Na Raihania Ngahiwi Tomoana Lynlee Aitcheson George Mackey
Apologies:	Ngahiwi Tomoana Lynlee Aitcheson George Mackey
In Attendance:	Patrick Le Geyt (Acting General Manager Māori Health Service HBDHB) Justin Nguma (Health & Social Policy Advisor Māori Health Service HBDHB) Laurie Te Nahu (Programme Administration Officer Māori Health Service HBDHB) Kate Coley (Executive Director People and Quality Directorate HBDHB) Jeanette Rendle (Consumer Engagement Manager HBDHB) Hayley Turner (Project Manager HBDHB) Lana Bartlett (Execitive Assistant, Executive Director SHID HBDHB)
Note Taker:	Casey Duff (Administration Coordinator Māori Relationship Board, Māori Health Service HBDHB)

SECTION 1: ROUTINE

1. KARAKIA

Patrick LeGeyt (Acting General Manager, Māori Health HBDHB) opened the workshop with a karakia.

2. WHAKAWHANAUNGATANGA

Patrick Le Geyt (Acting General Manager Māori Health Service HBDHB) welcomed everyone to the worshop. Those in attendance were asked to give a brief introduction.

3. APOLOGIES

Apologies were received from Ngahiwi Tomoana (MRB Chair), Lynlee Aitcheson (MRB member), and George Mackey (MRB member) for today's workshop.

SECTION 2. BUSINESS

4. INTRODUCTIONS

Kate Coley (Executive Director People and Quality Directorate HBDHB) and Jeanette Rendle (Consumer Engagement Manager HBDHB) provided a brief introduction.

Kate is the Responsible Owner of Consumer Engagement Strategy (CES) and Patient Experience Survey (PSE). Kate and Jeanette were asked by the MRB Chair to facilitate a workshop to identify ways in which the DHB could operate that would substantially improve engagement and health outcomes for Māori.

Transform and Sustain are engaged with CSE & PES to build a culture around the workshop focusing on staff and primary care foremost: and how they are delivering their services & are they benefitting and having positive impacts in the community.

Jeanette Rendle (Consumer Engagement Manager HBDHB), Chris Ash (Executive Director of Primary Care), Andy Phillips (Chief Allied Health Professions Officer), and Hayley Turner (Project Manager) value the voice of consumer and are all part of the CSE and CES Team.

However at the time of the workshop it was decided by all that the workshops were to become a discussion.

Kate Coley (Executive Director People and Quality Directorate HBDHB) excused herself from the meeting at 9.30am

What does the evidence tell us and what do we already know?

The following ideas were discussed:

- The challenge is how we empower the community and better understand the complexity with the health system
- CES should be developing strategies to suit each individual, not just using one set strategy because Māori whānau cases are different
- Good questionings for surveys are around "what is not working for consumers?". Priorities came through as reducing violence and suicide
- Motivation from what whanau and community know about primary care and mental health can come from them working side by side
- Dealings to be people orientated as lack of social intervention
- Māori whānau have a main healing process which comes from the spiritual realm and natural environment, surrounded by whānau. Clinical and medical healing is utilised to access all avenues available. This needs to be recognised withing the health system.
- Primary Care is widget focused, based on input and output, a way of being not doing.
- Patient and whanau centred care is the DHB response.
- Devolve services into community – CES overlaps into equity and equity overlaps into Iwi providers. Equity in DHB is about power and resources.
- Strategy is an approach based on western model of health care. What is the better service? What matters to the people? Start from scratch.
- System needs to transform the way equity is gauged.
- Improvement evaluates to patient experiencing positive relationships with primary care and hospital care
- Look into finding a way to move forward and what to do differently?
- How do we work with the community and the whānau? Look for precise data.
- How can a system be put in place to tailor and interpret? We don't want it lost in translation
- Simplify the language we use to empower whānau and the community to take control of their own care.
- When it comes to operationalising the CES and PES, the system can be represented with both operational and philosophical reporting systems.

What outcomes do we want?

The following discussions occured:

- Co-designing CES allows everyone to work together for a positive outcome.
- Strategies should look at like relationships. Relationships make people well not titles.
- Clinicians delivering care and best practise.
- Have whānau and patient at the centre to reduce harm and best possible outcome.
- MRB are wanting to incorporate Board, Clinical and Consumer advisory roles.
- CSE & PES investing to NUKA systems. Where do we fit the findings and experience that are acceptable to Māori and how do we incorporate the models of practise with the focus more on consumer?
- Large scale stages are focused on fixing legislation. This method of making changes takes hundreds of years. Start with whānau for the system to make changes.

What does that look like?

The following matters were discussed:

- Community led CES. The understanding is the same as the NUKA philosophy.
- Using an empowering and informing approach.
- Co-design or co-owned giving the community power and control to determine what the best health care is for them.
- Whānau and community engagement needs to be from the start based on philosophy.
- Trust needs to be built then barriers will be broken.
- An approach from Health Hawke's Bay should be a part of managing system.
- Hush puppy story: It is not what it is that you are doing, it is about who to be, who you are, finding a tipping point, being the change or transforming.
- NUKA has in place a Social Justice Tribal Union based on indigenous views and values. It is not determined by who the FTE is.
- Co-designed strategy. What would make an Indigenous owned primary care or hospital. Transformative models.
- Customer owner. A system used to empower.

What do we do to achieve it?

The following discussions occured:

- Iwi providers contracted to manage project to engage to get the communities' point of view. Not legislative.
- Need for CES within HB in regards to "how do we develop a service?"
- Core concepts are not just for work/legislative environment it is for lifestyle.
- Values of being Māori, there is no separation.
- MRB sees a need for CES to be engaged with community and whanau.
- Changing mind-sets of primary care.
- Define changes to health care and equity, as community and whānau have self-determined health care values relative to their beliefs.
- Building design should start from the need of the people. Being treated fair.
- Owning and living the strategy.
- Whānau stories need to be heard and told in order to find the loop holes.
- Have actions, reflections and improvements.
- Identify why the strategy is not working and change the approach.
- Be truthful in order to get strategies right.
- CES and PES utilising NUKA process. IPad with patient delivery survey model being implemented within the primary care sector, this process will show results.
- Have equity lenses across the community.
- Enthusiasm and affirmation from NUKA about their policy written strategies being utilised daily and not on the shelf.
- Steps 1. Matter, 2. Acted and 3. Delivered
- We need to find the equation. Government and private run systems are legislation. Look at it as a philosophy. No need for legislation, willingness to utilise this way of thinking provides outcomes.

How do we measure success?

The following ideas were discussed:

- Co-design CES to achieve truthful outcomes.
- As simple as engaging and actioning.
- Capture data and provide regular reports and updates on progress. Then develop an action plan or improvement plan. Show an evolving strategy not one set process. Adapt strategies to whānau and community needs.
- Joint Governance with Project Managers and look at MRB in place of clinicians.
- Patient's safety is paramount.
- Reduced, minimised and no harm to patients.
- Refer to Kōrero Mai process as follows:

- (Survey 90% KPI) How did we do?
- (Action Plan/Report) What will we do?
- (Measure) Performance-What did we do?
- (Outcome) Who is better off?

H Skipworth (Deputy Chair) excused herself from the meeting at 12.00pm

The workshop was closed at 12.40pm with a Karakia by Laurie Te Nahu (Programme Administration Coordinator, Māori Health HBDHB).

MĀORI RELATIONSHIP BOARD
Matters Arising – Review of Actions

Action No.	Date issue first entered	Action to be taken	By whom	Month	Status
1.	8 Nov 2017	The Big Listen and Māori Consumer Analysis Reports MRB requested to view the documents.	Patrick LeGeyt	Nov 2017	**COMPLETE** Circulated via MRB Administrator 16/11/17 on behalf of P LeGeyt.
2.	7 Sept 2017	**Nuka Model Wānanga** Wānanga at a later date to put forward input into the Nuka Model process.	MRB	TBA	**IN PROGRESS**
3.	9 Aug 2017	**Te Ara Whakawaiora - Mental Health (National And Local Indicators)** Mental Health Services to develop proposal, including whānau and community groups, to have greater input into whole of sector approaches, i.e. the Intersectoral Forum.	Allison Stevenson / Simon Shaw	TBA	**IN PROGRESS** 09/10/17 - Alison on leave. Nothing to report from the Medical Director perspective.
4.	9 Aug 2017	**Te Ara Whakapiri Hawke's Bay (Last Days of Life)** 4.1 Support Leigh to make amendments to the care plan with reflection of Māori, including spiritual aspects to support whānau beliefs and empowering staff around spiritual values.		Nov 2017	**IN PROGRESS** 14/02/18 - Patrick will speak to this today. Refer to Leigh's update on page 2. 31/10/17 - Meeting in November. 28/08/17 - Leigh White (Portfolio Manager, Long Term Conditions advised the development team met and discussed the issues raised at MRB. Please refer to the September Review of Actions, item 2.1.2.
		4.2 Align Dr James Graham (Senior Advisor Cultural Competency) and Laurie Te Nahu (Programme Administrator) to work with Leigh White to ensure this plan is appropriate.	Patrick LeGeyt	Nov 2017	**COMPLETE** 14/02/18 - Refer to Leigh's update below. 29/01/18 - Laurie and a small team of developers are continuing to work with Leigh. 31/10/17 – Meeting confirmed

					for 07/11/17 with James and Laurie.
		4.3 Coordinate with Leigh to present the updated plan to Kaumatua in Wairoa for feedback.	Hine Flood	Nov 2017	**IN PROGRESS** Meeting being coordinated with Hine Flood in November.
5.	12 July 2017	**Student Report** Circulate research paper to MRB.	Kerri Nuku	TBA	**IN PROGRESS** 08/11/17 Report due November 2017. 14/02/18 Awaiting report Kerri will circulate once the paper is available for public distribution.
6.	12 May 16	**Review form and function of MRB and Youth Representative** NKII and MRB are reviewing MRB including the composition and consideration of a Youth Representative.	CEO NKII	Sept 2017	**NKII REVIEW ON HOLD** 09/08/17 – Chrissie Hape and Ngahiwi Tomoana will bring a paper to MRB in September for the Toiora Board.

Item 4: Te Ara Whakapiri Hawke's Bay (Last Days of Life)

- Small team of developers (Leigh White, Sarah Nicol, Laurie TeNahu, Jo Loney, Sue-Mary Davis, Karen Franklin, Anne Gray, and Anita Rarere) met in November. Next meeting planned for 15 February 2018
- The work of the group is to "Focus the last days of life into a 1-2 pager to complement/symbolise tikanga best practice." This information will be used as a guidance document that will align to the Last Days of Life care plan template
- Draft 1 has been completed and this will be discussed at meeting on 15 February 2018
- Then further consultation will occur – Laurie leading this
- The intent is to present to MRB in April 2018.

MĀORI RELATIONSHIP BOARD
WORKPLAN FEBRUARY - JUNE 2018

NOTE: The workplan is a working document and is subject to change.

Date/ Month 2018	Performance Monitoring and for Information and Discussion	EMT Lead	Strategic / Decision Papers	EMT Lead
14 Feb	Te Ara Whakawaiora - Access 0-4 / 45-65 yrs. (local indicator) HBDHB Performance Framework Expectations Q2 Ngātahi Vulnerable Children's Workforce Development	Mark Peterson Tim Evans Sharon Mason	Clinical Services Plan February Update Suicide Prevention Update	Chris Ash Sharon Mason
7 Mar	HB Health Sector Leadership Forum - NAPIER SAILING CLUB			
14 Mar	Establishing Health and Social Care Localities in HB Te Ara Whakawaiora - Breastfeeding (National Indicator) Building a Diverse Workforce and Engaging Effectively with Maori Te Ara Whakawaiora - Culturally Competent Workforce (local indicator) July to Oct to Nov	Chris Ash Chris McKenna Kate coley Kate Coley	Annual Plan 2018-19 First Draft Building Culture Oncology Model of Care	Chris Ash Kate Coley Sharon Mason
11 Apr	Te Ara Whakawaiora - Did not Attend (local Indicator)	Sharon Mason	Mobility Action Plan Update Presentation Building Culture Implementing the Consumer Engagement Strategy (tbc) Policy on Consumer Stories (tbc) People Strategy Draft	Andy Phillips Kate Coley Kate Coley Kate Coley Kate Coley
9 May	HBDHB Performance Framework Exceptions Q3 Smokefree Update	Tim Evans Sharon Mason	Annual Plan 2018/19 Second Draft Building Culture Best Start Healthy Eating & Activity Plan Update - For Information	Chris Ash Kate Coley Sharon Mason
13 June	Youth Health Strategy	Kate Coley	People Strategy FINAL	Kate Coley

Māori Relationship Board Chair's Report

Author:	**Heather Skipworth**
Designation:	**Deputy Chair of MRB**
Date:	**14 February 2018**

PURPOSE

The purpose of this report is to update the Māori Relationship Board (MRB) on relevant discussions at the Board meeting held in December 2017 pertaining to Māori health.

INTRODUCTION

This month's report provides a brief overview of the CEOs Report regarding the performance of the Hawke's Bay health system with the financial pressure identified as the major concern in November 2017, modifications to the Pasifika Health Leadership Group (PHLG) Terms of Reference plus an increase in membership numbers, and a short update on The People Strategy, timelines and the expectation of a draft by March is also provided.

HAWKE'S BAY HEALTH SYSTEM PERFORMANCE

In November, the Hawke's Bay health system was under less pressure then previous months but the flow through the hospital remained substandard. Financial pressure was the biggest concern for November with the year-to-date result to the end of November $653 thousand unfavourable to plan, with November $525 thousand unfavourable.

- Shorter stays in Emergency Department (ED6) performance improved but remained below target
- Elective activity remained below the desired target for the month but the CO anticipates the DHB to deliver to our plan by year end. A locum ophthalmologist was appointed to help resolve the problems with access to this service.
- Better help for smokers to quit in primary care continues above target. There is still no new data on helping smokers to quit in pregnancy, and the work to review the validity of this data continues
- Faster Cancer Treatment is above target at 90.8 percent for the six months to October. But the number of people identified remains significantly below where it should be
- Immunisation at eight months has seen a slight drop to 94 percent for the quarter ending in November
- There is no new data for raising healthy kids.

PASIFIKA HEALTH LEADERSHIP GROUP

The HBDHB Board accepted the minor modifications to the terms of reference for the Pasifika Health Leadership Group (PHLG) with the inclusion of 'enhancing Pacific health staff resources" under the aims of the PHLG. In addition, the HBDHB Board endorsed the four new appointments to the group; Iami Tukalau, Anna Marie Faavae, Ina i-te-roe Graham and Traci Tuimaseve, increasing the PHLG to the maximum membership number of eight.

THE PEOPLE STRATEGY

Feedback following the publication of the final results of the Big Listen in December 2017 was utilised to inform the development of a People Strategy. The strategy will outline the programme of work to support the building of our culture and investment in our workforce. The People Strategy will be a key foundation and enabler to ensure we deliver the Transform and Sustain programme and the Clinical Services Plan. The strategy will be developed through engagement and collaboration with our staff, leaders and unions over the next few months, and will be shared in draft with all governance groups at the Hawke's Bay Health Sector Leadership Forum in March. The quick wins that have been identified with the Board in relation to a number of the identified priorities from the Big Listen will be shared, and implementation will begin in early 2018, along with an overarching framework for the People Strategy.

Bullying and behavioural issues amongst staff was discussed and the Board was advised about a big piece of work underway around behaviours and attitudes. Some behavioural issues have been addressed through training that has raised staffs awareness and insight to their own behaviour, and how this behaviour had been perceived by those affected. In addition, the workshops have given staff the courage to speak out. Furthermore, people are being trained to understand and identify what is bullying behaviour, and what is not. Other areas of work include the Induction Process, and the Exit Feedback Interview as an opportunity to establish if bullying was the reason for leaving and ensure there is understanding of bullying.

Timelines advised for The Big Listen/People Strategy:

- Jan, Feb & March 2018 – run further co-design workshops with staff and leaders
- February –run co-design workshops with Bipartite Group and all Union Delegates
- March – share draft strategy and run co-design workshop with all leaders
- March – share draft People Strategy – co-design at Health Sector Leadership forum
- March/April – incorporate feedback and information
- April – share final draft People Strategy with all governance groups, staff and unions for feedback (Normal consultation process)
- May/June 2018 – endorsement of People Strategy.

HUMAN RESOURCES KEY PERFORMANCE INDICATORS (HRKPI) QUARTER ONE REPORT

The Māori representation target as at 30 September 2017 was 14.52 percent of employees identifying as Māori (target of 15.68 percent for 2017/18). Therefore, the gap sits at 37 positions compared to 44 at the end of June 2017. Staff turnover was 10.12 percent in the last 12-months, very close to the 10.0 percent annual target. Reasons for leaving will be monitored closely and a full review of exit interviews will be completed to ensure the identification of the issues and reasons for staff leaving is carried out more effectively to identify areas for improvement.

This year Pasifika staff representation will be reported. As some staff identify with both Māori and Pasifika this poses a challenge in the system because we count only the first field.

The layout of the HR KPIs report will change by June 2018. Board members suggested a traffic light one page summary at the beginning of the report as an interim measure.

RECOMMENDATION:

It is recommended that the Māori Relationship Board:

1. **Note** the contents of the MRB Chairs Report dated 14 February 2018.

General Manager Māori Health Report

Author:	**Patrick Le Geyt, Acting General Manager Māori Health**
Designation:	**Māori Relationship Board**
Date:	**14 February 2018**

PURPOSE

The purpose of the report is to update the Māori Relationship Board on implementation progress of the Māori Annual Plan objectives for the month of January 2018.

INTRODUCTION

Despite a number of 'changes of the guard' within the Māori Health Service over the past couple of months the team have demonstrated great resilience and continued to focus on the kaupapa. This month's report provides a summary of updates on key pieces of work such as the Cultural Competence Framework that is near completion, a review of the Annual Māori Health Plan Implementation revealing performance concerns and the Tūruki Annual Report 2016-17 identifying key highlights, in particular an increase in Māori participation in the HBDHB workforce since this target became a priority in 2012. Māori and Pacific Workforce targets as at January 2018 are included in this month's report showing the Māori workforce has fallen short of the 2017/18 target, and while the number of Pacific positions have increased it is not keeping up with the overall growth in DHB.

This month's report also provides progress updates on key activities underway for the Ambulatory Sensitive Hospitalisation (ASH) 0–4 Respiratory Care Pathways, a review of the Oral Health ASH 0–4 Dental Pathways with a full report of the findings and recommendations for the next monthly report, and the Pregnancy and Parenting Information and Education Programme RFP with Te Taiwhenua o Heretaunga identified as the preferred supplier to deliver this programme.

I have provided a detailed report on the HBDHB National Bowel Screening Programme, and Te Ara Whakapiri: Principles and Guidance for the "Last Days of Life Committees for this month's report.

RETIREMENT OF MATIU ERU

An intimate farewell was held by the Māori Health Service team in honour of Matiu Eru that was attended by a select few including Matiu's wife Whare and son Matiu Jnr, the HBDHB CEO and Kevin Atkinson, Board Chair. Matiu has enjoyed his time and experiences during his employment with the HBDHB for the past five years. He has provided the HBDHB with a great amount of knowledge and support over the years going above and beyond his role to also support and engage with the community. Matiu has offered his continued support to the Māori Health Services on his departure. Matiu played a significant role in the implementation of Te Reo Māori throughout the organisation and the policy solidifying the partnership of biligual signage. Matiu's final day was 26 January 2018 and he will be sadly missed, particularly by Māori Health.

SENIOR ADVISOR CULTURAL COMPETENCY RESIGNATION

Dr James Graham has resigned from the role in late December 2017, accepting a new position at the Hastings District Council. James final date is 16 February 2018. James has enjoyed his time with the DHB having gained valued experiences and learnings from his peers and leadership within the Māori Health Service, in particular within the Māori Health Leadership Team. The recruitment process to fill the role has commenced.

'TE MATAU' - CULTURAL COMPETENCE FRAMEWORK

The contextualising and development of the HB Cultural Competence Framework – 'Te Matau' has progressed to its completion and almost ready to be trialled and/or piloted. 'Te Matau' encompasses Kahungunu knowledge, values and cultural traditions. This framework, grounded in 'Kahungunutanga', is cognisant of whānau aspirations, but relative too to the DHB's Core Values and to multi-layered professional contexts that comprise the HBDHB workforce. The framework will include assessment components across three specific levels:

1. Organisational
2. Directorate / Service
3. Individual

The self-assessment process, that will also be monitored by the Senior Advisor Cultural Competency will enable the workforce to facilitate their own professional learning and development with the guidance and direction of their respective services and leaders. These checkpoints or levels will also provide layers of accountability and credibility i.e. are we, a DHB, a Directorate, a Service, and or individuals, walking the talk? If not, then the respective levels should and can be held accountable for actions or lack of action.

ENGAGING EFFECTIVELY WITH MĀORI (EEM)

Across the months of December and January there have been four mandatory training workshops received great feedback, and participation and involvement by those participants. The Prescription of Engaging Effectively with Māori has been updated and the Education Centre have booked in the 2018 workshop dates with venues also booked where the majority will be at Mihiroa Whare. There are 32 workshops booked in for 2018 from January through December.

HBDHB KAHUNGUNUTANGA / TIKANGA MĀORI / TĀ TE KAWA

The role of the Senior Cultural Competency Advisor has seen a continuation of supporting the Māori Health Service to lead and uphold the mana of Ngāti Kahungunu through facilitating appropriate cultural responses to 'blessings' and or relative kaupapa both here at the DHB and in the wider community including the final opening and karakia at the Ātea-a-rangi (star compass) at Awatoto, the DHB Christmas service at the Chapel, pōwhiri for new staff, mihi whakatau for manuhiri, and karakia, kawa and blessings here across the organisation.

DNA FSA REDUCTION

The DNA Kaitakawaenga returned an impressive Monthly FSA DNA (ESPI Specialities) rate of **7.6%**. The following is a breakdown of support provided for the month:

Pre-emptive Calls – **425**
Confirmed Appointments – **171**
Re-scheduled Appointments – **12**
Home Visits – **43**
Messages Left – **42**
Not Contacted – **23**

SAFE SLEEP PROGRAMME

For the month of January, 29 Wahakura were issued. There were no Pēpi pods or training session required for this period.

2-YEAR REVIEW OF THE ANNUAL MĀORI HEALTH PLAN IMPLEMENTATION

Māori Health completed a review paper on the implementation of the Annual Māori Health Plans (AMHPs) for the past two years, 2015-16 and 2016-17. The objectives of the review included:

i) To determine the level of activity implementation and accomplishment under each indicator in the AMHP *(Were the activities in the plans effectively implemented/achieved?)*

ii) To determine the impact of activity implementation and accomplishments in reducing health inequalities between Māori and non-Māori *(What are the statistical trends telling us about the health inequalities between Māori and non-Māori?)*

iii) To identify challenges in the planning and implementation of the AMHPs and make recommendations for improvement.

Overall, the implementation reports revealed quite some unsatisfactory performances as follows:

- Out of the 13 indicators with 127 activities, and 15 indicators with 137 activities in the 2015-16 and 2016-17 plans respectively, less than 55% of these activities were fully implemented according to the review criteria
- Only 4 indicators (e.g. immunisation; access to care; smoke free and cardiovascular disease) appear to have successfully registered some progress towards their annual targets on different quarters of the 2015-2016 implementation compared to 3 (e.g. immunisation, Māori workforce development and alcohol and other drugs) in 2016-2017
- Furthermore, health inequalities between the Māori and non-Māori population has not significantly improved for some indicators over the two years
- Key challenges in the annual planning, implementation, and reporting were identified and recommendations made.

NGAIRA HARKER, NURSING DIRECTOR MĀORI HEALTH

In January, Ngaira joined the Māori Health Service on a fulltime basis. Ngaira comes from an extensive nursing background bringing with her a wealth of knowledge in this field. She has previous working relationships within the HBDHB and the community and looks forward to gain further relationships and experiences.

TŪRUKI ANNUAL REPORT 2016-17

The Tūruki Annual Report has been drafted and will be available in a calendar format by the end of February. Key highlights from the report include:

- An increase in Māori participation in HBDHB workforce since this target became a priority in 2012. For 2016/17, the target was 13.75% with 14.25% achieved
- The introduction of an online database that provides accurate and real-time data on Māori student progression within the programme
- The reconfiguration of the Tūruki Advisory Group with membership including Health Hawke's Bay, Chief Nursing & Midwifery, Chief Allied Health, Acting General Manager Māori Health and Executive Director People & Quality
- The launch of a Māori Health Career's Video prepared in partnership with Te Aute College and Kia ora Hauora.

HEALTH WORKFORCE NEW ZEALAND FUNDING ROUND OPEN

Applications are being received for Health Workforce New Zealand (HWNZ) funding for 1st Semester enrolment within entry-level certificate and diploma course related to health. The scholarships are targeted at Māori wanting to work within the non-regulated workforce i.e. administration and support workers roles. Qualifications eligible for funding include; Certificate in Health & Wellbeing, Certificate or Diploma in Mental Health & Addictions, and Certificate or Diploma in Business.

SENIOR CLINICAL WORKFORCE COORDINATOR SABBATICAL

Dr Dianne Wepa will be taking a six month sabbatical from mid-February to mid-August to pursue her interests in Indigenous Health Research. Dianne will be undertaking a lecturing position teaching First Peoples' health at the University of South Australia in Adelaide.

Donna Foxall, NETP Educator has been seconded into the role during this period. Donna who has family connections to Tainui and Taranaki, is a Registered Nurse with a clinical and tertiary education

background and is looking forward to taking on responsibilities as the Senior Clinical Workforce Coordinator and working alongside the Māori Health team.

CHRISSY KEMP, NEW TŪRUKI ADMINISTRATOR

Chrissy has commenced in the role as Administrator for the Tūruki programme. She whakapapa to Omahu and was an administrator for Big Save in Napier in her previous role.

HASTINGS INTERMEDIATE SCIENCE AND LEADERSHIP ACADEMY PROGRAMME REVIEW

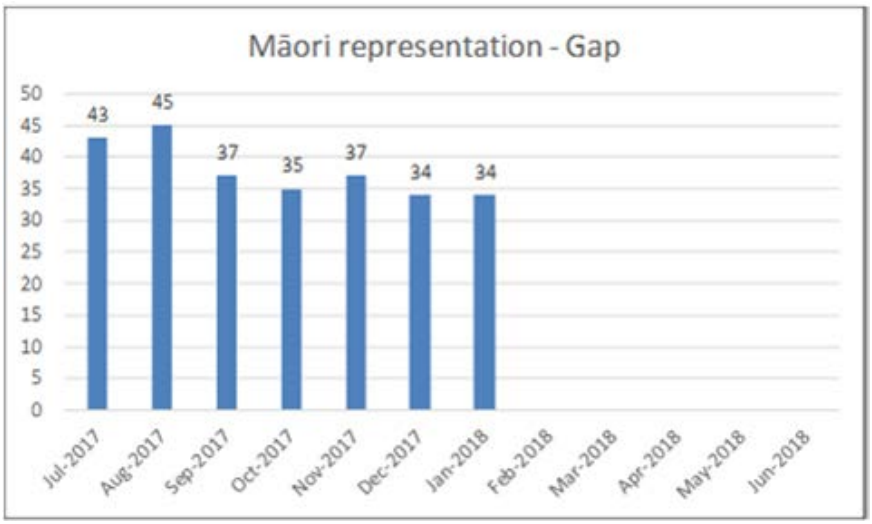
The Science and Leadership Academy programme currently based at Hastings Intermediate will be reviewed in 2018. The programme has successfully engaged Māori student to participate in science-related programmes which includes the yearly Otago University Science Wānanga and noho marae. The Academy has recently rolled out to Heretaunga Intermediate with Hastings providing a Hub for student experiential learning. The intention is for Flaxmere Intermediate-aged students to also participate in the Hub. Napier Intermediate has signalled an intention to engage also. An external review will provide an evaluation on student outcomes to date and possible pathways forward to support the next phase of the provision of science to Māori students during these formative years.

UPDATE OF TŪRUKI WEBSITE

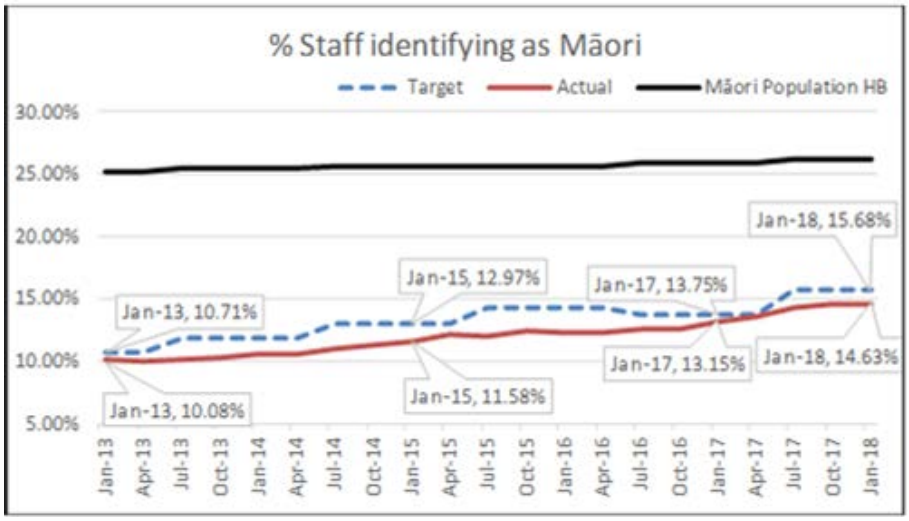
An update of the Tūruki website www.Tūruki.org.nz is almost complete. The new website will allow for scholarship applicants to engage more easily when applying for funding. Better integration with Facebook and the increasing use of cell phones and tablets will provide a more seamless process for users. The new website will become live by the end of February.

MĀORI STAFF GAP TO 31 JANUARY 2018

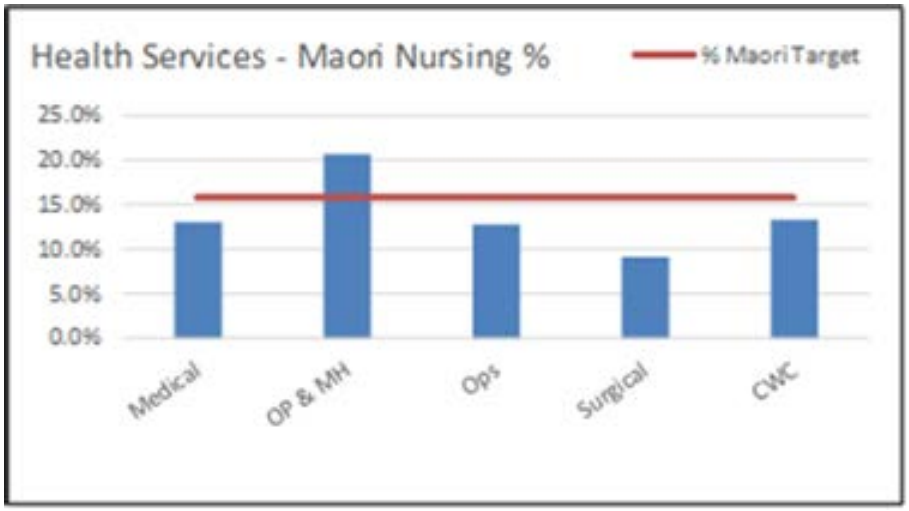
The target for 2017/18 is 15.68% while the actual to 31 January 2018 is 14.63% meaning we have a gap to the target of 34 positions.



The occupational group is made up of 35 Medical Staff, 42 Nursing staff, 6 Allied Health staff, 39 Support staff, and 10 Management and Administration staff.

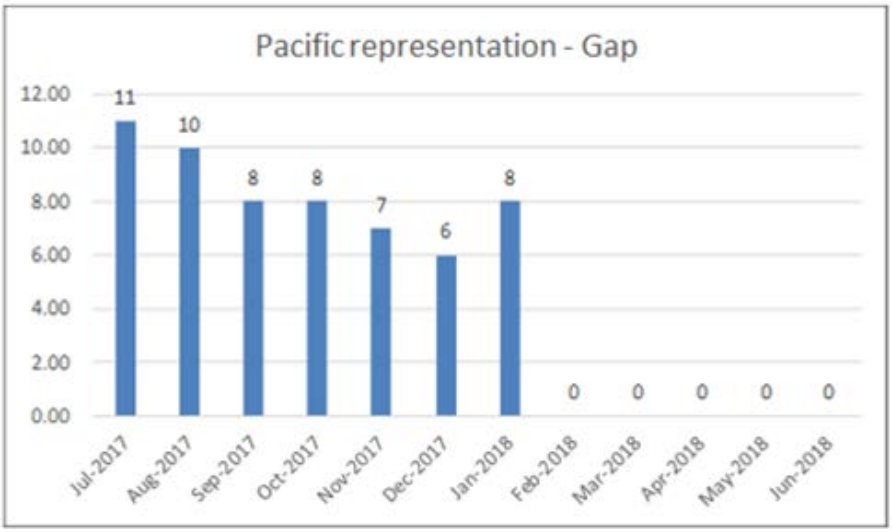


Māori Staff Percentages in Health Services Nursing and the Gap to the DHB Target

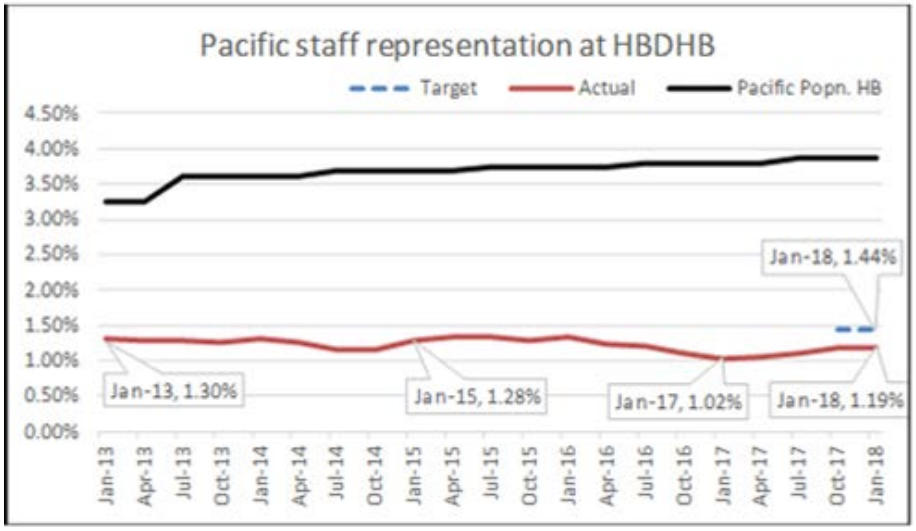


PACIFIC WORKFORCE GAP TO 31 JANUARY 2018

The 2017/18 target for Pacific representation in the HBDHB workforce has been set at 1.44% compared to the actual at 31 January 2018 of 1.19% leaving a gap of 8 positions to our target.



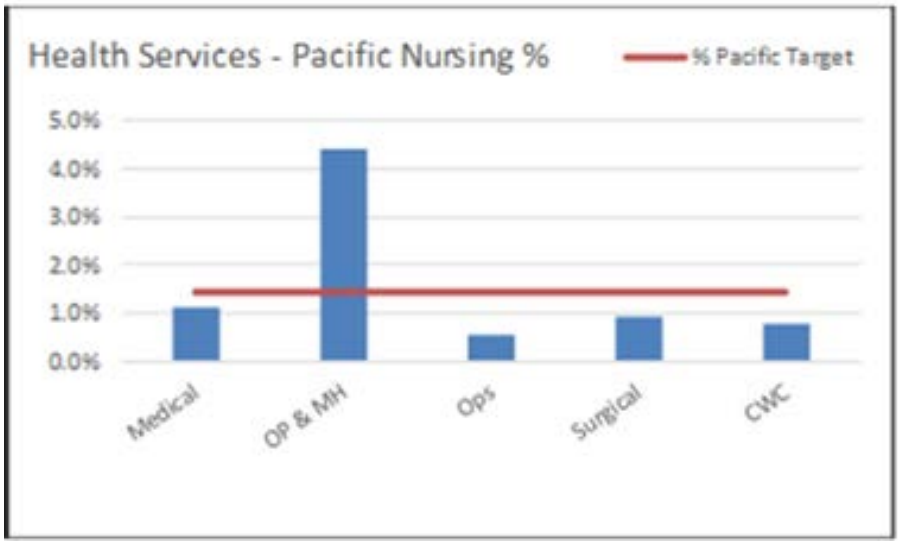
The occupational group is made up of 3 Medical staff 4 Nursing staff, 3 Allied Health staff, 1 Support staff and 3 Management and Administration staff.



So while the number of Pacific positions have increased it's not keeping up with the overall growth in DHB numbers meaning a drop in the percentage.

Pacific Staff Percentages in HS Nursing January 2018

The following graph illustrates the Pacific staff percentages in Health Services Nursing and the gap to the DHB target for 2017/18.



AMBULATORY SENSITIVE HOSPITALISATION 0–4 YEARS RESPIRATORY CARE PATHWAYS

The Respiratory Working Group is making some good progress on the actions identified in the ASH 0-4 years Respiratory Care Pathways report (August, 2017). Key activities at present include:

- The Group requested a plan from Breathe HB about opportunities to improve respiratory responsiveness to tamariki Māori, Pacific, and their whānau. The Group has reviewed the plan and has sought further clarification from Breathe HB more specific approaches they propose to use to effectively engage whānau Māori and Pacific, and how partnerships with other services/providers/programmes can be strengthened. The Working Group is due to meet again on 13 February to consider the revised plan.
- The development of the respiratory pathway for tamariki 0–4 years is in progress and is due to be completed by 30 June 2018.

- Working with the HBDHB Business Intelligence Team to create specific reports that will act as a mechanism for quality improvement. Health Hawke's Bay is engaged in this work with us as we determine what reports will be most useful to inform primary care efforts to improve access to respiratory support for tamariki 0–4 years and their whānau.

ORAL HEALTH

ASH 0–4 years dental pathways

A review of the ASH dental pathway for tamariki 0–4 years has been completed, and the draft report submitted to the 'Oral Health Equity for Tamariki 0–4 years' project team. The review examined the interactions and experiences of whānau prior to, during, and after their tamaiti (childs) dental surgery. Findings indicate quality improvements needed in early engagement, improved wait-times, better follow up care and support in the community, and approprite and responsive information and support for tamariki Māori, Pacific, and children living in deprived areas. A fuller presentation of the findings and recommendations will be presented in the next monthly report.

TE ROOPU MATUA HUI - MĀORI ORAL HEALTH ADVISORY GROUP

Te Roopu Matua met last year in December. The Roopu were able to provide valuable advice and feedback on current activities happening as part of the Oral Health Equity for 0–4 years project. The Roopu will likely to meet again in March 2018 to consider the findings of the ASH dental pathway report and implications for whānau Māori.

PREGNANCY AND PARENTING INFORMATION AND EDUCATION PROGRAMME RFP

Te Taiwhenua o Heretaunga (TToH) is the preferred Provider for the Pregnancy and Parenting Information and Education Programme. TToH is currently developing the programme, and plan to start delivering classes from 1 March 2018. HBDHB is very excited about this new programme, and the potential to improve the responsiveness and uptake of pregnancy and parenting education for whānau Māori. There are plans to formally launch the new programme, and these details are yet to be confirmed.

COMMITTEE FOR HBDHB NATIONAL BOWEL SCREENING PROGRAMME

New Zealand has one of the highest rates of Bowel Cancer in the developed world and the fifth highest rate of colorectal cancer mortality. Bowel Cancer is the second most commonly registered cancer, and is the second most common cause of cancer death in New Zealand. New Zealanders with Bowel Cancer are likely to be diagnosed with advanced stages than people in Australia, the United States and the United Kingdom. This translates directly to death rates which are 35 percent higher in New Zealand than Australia for women, and 24 percent for men. Bowel cancer is one of the few cancers for which Māori show lower registration and death rates than non-Māori. However, whilst bowel cancer occurs less frequently in Māori, once diagnosed, Māori are more likely to die of bowel cancer than non-Māori.

An evaluation of the New Zealand Bowel Screening Pilot has concluded that Bowel Screening will save lives with data from international studies indicating that a screening programme may reduce mortality in the population offered screening by at least 16–22 percent, and potentially up to 30 percent, after 8–10 years. The evaluation also concluded that a National Bowel Screening Programme will result in significant cost savings from reduced treatment which outweighs the cost of screening.

As experienced internationally, screening programmes often increase ethnic inequalities in health. The findings of the December (2015) paper, University of Otago suggest, that although a National Bowel Screening Programme would offer health gains for both Māori and non-Māori, it will almost certainly increase inequalities between the two. Māori tend to have lower incidence of colorectal cancer, a higher background mortality, and are likely to have lower screening coverage compared to non-Māori. This would almost certainly result in an increased disparity in cancer outcomes. A national Bowel Screening Programme would improve total population health and result in health gains for both Māori and non-Māori, however, non-Māori gains are likely to be larger. The net effect is that the disparity between Māori and non-Māori cancer outcomes would increase.

Māori are also often diagnosed with Bowel Cancer at a more advanced stage than non-Māori and treatment options are more frequently complicated by a greater co-morbidity burden. Therefore, Māori have more potential to benefit from early prevention, earlier detection, more treatment options and better survival outcomes for early stage disease that result from a Screening Programme.

Since 2013/2014, the Government has invested over $19 million in additional colonoscopy capacity to reduce the number of people waiting for a procedure. This is a key factor in enabling a roll-out of a Bowel Screening Programme. In June 2016, the Ministry of Health received signed confirmation from all DHB CEO's that they agree in principle, with the support of their Board Chair, that delivery of the Bowel Screening Services according to the National Bowel Screening pathway and standards is achievable for their DHB, subject to receiving funding to cover the cost of the Programme.

COMMITTEE FOR HBDHB, "TE ARA WHAKAPIRI" PRINCIPLES AND GUIDANCE FOR THE "LAST DAYS OF LIFE"

The term 'Last Days of Life' defines the period of time in which a person is dying. It is the period in which death is imminent, and may be measured in hours or days. Te Ara Whakapiri addresses the care of adults who are in their last days of life. It is recognised that the trajectory of dying is significantly different for children. In 2014, the Paediatric Society of New Zealand and Starship Foundation developed Te Wā Aroha ('time of love'), an advanced care planning model of care for paediatric palliative care.

The 'Seven Principles of Te Ara Whakapiri' are underpinned by Te Whare Tapa Whā, a model of care that is concerned with the total wellbeing of the person and their whānau:

1. Care is patient-centred and holistic.
2. The health care workforce is appropriately educated and is supported by clinical champions.
3. Communication is clear and respectful.
4. Services are integrated.
5. Services are sustainable.
6. Services are nationally driven and supported to reduce variation and enhance flexibility.
7. Resources and equipment are consistently accessible.

Te Whare Tapa Whā model of care supports these seven principles relevant to last days of life. It is a holistic Māori model of health that compares health to the four walls or cornerstones of a house: all four cornerstones are required to maintain positive wellbeing. When one of the cornerstones become damaged or is missing, the person or a collective may become unbalanced and therefore unwell. The Te Whare Tapa Whā model is consistent with other frameworks and legislation underpinning quality care, including the Code of Health and Disability Services Consumers Rights, the Health Practitioners Competence Assurance Act 2003 and competency requirements set out by the Nursing Council and the Medical Council of New Zealand.

The Te Ara Whakapiri Committee, working in conjunction with members of Cranford Hospice have also added a local touch in the formulation of a model of care for last days of life. The model acts as a platform to symbolise tikanga best practice and is about the application of tikanga in last days of life as follows;

Assessment:

For Māori, there is sentiment attached to the voice and face-to-face communication; hence the emphasis is on conversation. Whānaungatanga (relationships) develops as a result of sharing whakapapa (kinship ties) commonalities and shared experiences, which provides people with a sense of connection, belonging and comfort, but most importantly, it opens the door to open communications.

Māori whānau advise that discussing future healthcare needs and, in particular end of life care can be a tapu (sacred) subject. Therefore consideration is needed whether patients feel comfortable

talking about this subject in the presence of kai (food). Caution should be taken not to make assumptions about whether Māori speak te reo (language), know their whakapapa (heritage, ancestors) or practice tikanga and kawa (cultural practices).

Care Planning:
The platform which follows is intended to illustrate that no care plan can be considered from a single dimension of health or wellbeing. Physical well-being is intertwined with spiritual, emotional and family well-being. During a patient's assessment and care planning process, an understanding and consideration of Māori world views, and the ways in which tikanga can be incorporated can enhance the relationship developed with the person and their whānau and the efficacy of the care plan interventions. The platform provides a foundation for consideration:

Collective Principles of "Te Ara Whakapiri – End of Life"

Tikanga (custom lore)
Custom lore provides the basis of all important decisions for tribal groups as well as individuals. It remains valuable as a guiding principle and a source of wisdom.

Mana (authority, status, prestige)
A person gains authority through displaying the qualities of integrity, generosity, bravery, humility, respect, commitment to the community, using history, stories and legends to explain things, facilitating rather than commanding.

Whakapapa (genealogy)
A common ancestry provides a platform for identity, common histories, and similar understandings of the material world.

Wairuatanga (spirituality)
The spiritual world is an important part of reality which is integral to day to day activities and necessary for successful endeavours.

Kaumatuatanga (respect for elders)
Elders play a crucial role in keeping families and the community together and offer both guidance and advice.

Utu (reciprocity and restoring balance)
Maintaining balance and harmony through "give and take", reciprocal obligations, honesty in all things, the punishment of wrong doing and the exchange of gifts are still essential practices which increase the welfare of the community

Kaitakitanga (the duty of care, for people and the environment)
People should acknowledge their spiritual responsibility to the resources they work with, ensuring health and safety in any endeavour, and pursuing quality and excellence.

Whakawhānaungatanga (family responsibilities)
Family bonds should take priority over all other considerations in deciding what action to take.

Manakitanga (generosity and hospitality)
Organisations should support the social objectives of the Māori community through contribution of money, people and facilities, treating visitors, partners or competitors fairly and generously.

Whakarite Mana (Agreements – contracts)
A contract is a statement if intention to form a lasting relationship and the elements of the contract should be open to review as circumstances change. The objective is to provide long-term satisfaction for both parties rather than relying on "the letter of the law".

Hui (tribal/whānau meetings)
Full and active participation in decision-making is important

RECOMMENDATION:

It is recommended that the Māori Relationship Board:

1. **Note** the contents of the General Manager Māori Health report dated 14 February 2018.

HB CLINICAL COUNCIL

Verbal Update

Governance Report Overview

HAWKE'S BAY District Health Board Whakawāteatia	**Ngātahi Project – progress report, end of year one**
	For the attention of: **Māori Relationship Board, Pasifika Health Leadership Group, HB Clinical Council, HB Health Consumer Council and the HBDHB Board**
Document Owner	Dr Russell Wills
Document Author	Dr Russell Wills, Paediatrician, Medical Director, Quality Improvement and Patient Safety, Project Sponsor
Reviewed by	Bernice Gabriel, Project Manager; Viv Kerr, Education & Development Manager; Executive Management Team
Month/Year	February 2018
Purpose	For Information only
Previous Consideration Discussions	Previously discussed at EMT, MRB, Clinical Council, Consumer Council and the Board, who supported the project.
Summary	The Ngātahi Project has met all milestones for year one: • Agreement across 24 Hawke's Bay government and non-government health, social service and education agencies on the competencies required for practitioners working with vulnerable children (see Appendix 1 for participating agencies) • 441 practitioners completed assessments against the competencies, noting in particular those additional competencies they needed but did not yet have, or partially had • Leaders from the 24 agencies have agreed the three most important domains of practice to focus workforce development on in 2018 and 2019: Working Effectively with Māori, Mental Health and Addictions, and Trauma-Informed Care (including burnout and vicarious trauma for practitioners) • Training successfully delivered for 140 staff working in child and adolescent mental health, led by CAFS, has already shown early impacts on practice and outcomes • Three workstreams of local leaders are meeting currently to agree curriculum, who would teach, how to integrate cultural and clinical competencies, how to embed the new competencies into daily practice and evaluate the impact of these • Research report for year one received from Prof Kay Morris-Matthews (EIT) notes high engagement of workforce, exemplary leadership from Project Manager (Bernice Gabriel, CAFS psychologist), support for the competency framework and process to date, early impacts of training in CAFS and lessons learnt • Funding discussed with Deputy Chief Executive for the Ministry for Vulnerable Children for FTE for Y2-3. Project sponsor

	currently working to secure funding for evaluation and training costs for Y2-3. • RFP drafted for evaluation for Y2-3, focusing on process and lessons learnt (Y2) and measurable outcomes (Y3)
Contribution to Goals and Strategic Implications	Contributes to HBDHB Statement of Intent 2015-19 (p8, Fig 3): Working with Others; People better protected from harm; Health issues and risks detected early; Longer, healthier and independent lives; High quality, timely and accessible services; Sustainability. Contributes to NZ Health Strategy 2016 goals: Closer to Home; Value and High Performance; One Team; Smart System.
Impact on Reducing Inequities/Disparities	70% of vulnerable children are Māori so this project has been created with tamariki and whānau Māori at the fore: early and regular consultation with Māori providers and leaders, specific domain on Working Effectively with Māori (WEWM), co-constructed with Māori service leaders; cultural *and* clinical competency in teaching and learning; WEWM workstream to have oversight of other workstreams.
Consumer Engagement	Early consultation with caregivers of children and young people in care and with care-experienced young people, facilitated by MVCOT. Strong support for the competencies and process, no additional competencies identified. Evaluation RFP requires direct assessment of outcomes for children, young people and whānau.
Other Consultation /Involvement	MRB, Māori providers, facilitated by HBDHB Māori Health Unit. Support for project, helpful advice regarding tikanga, added several additional competencies to the WEWM domain, WEWM workstream has oversight of other domains to ensure cultural competency.
Financial/Budget Impact	Y1 $250,000 Y2 $232,500 Y3 $212,500
Timing Issues	Secure funding: February-March RFP for evaluation advertised: April Training begins mid-year Evaluation reports mid-2018, early 2019, early 2020
Announcements/ Communications	Outcomes from evaluation will be shared: Internally — Project Sponsor Dr Wills Key Stakeholders — Meetings, conferences Community — Through HBDHB communications team

RECOMMENDATION:

It is recommended that MRB, Pasifika Health Leadership Group, HB Clinical Council, HB Health Consumer Council and the HBDHB Board:

1. Note the progress of the Ngātahi Project in the first year
2. **Note** the approach endorsed for Years 2 and 3 of the Ngātahi Project and the forecast budget of $232,500 for 2018 and $212,500 for 2019
3. **Note** that theTransform and Sustain Steering Group will be asked to contribute funding of $80,000 in FY2017/2018 and FY2018/2019 for the evaluation component of the project.
4. **Note** that the remaining funding has been sought from the Ministry for Children Oranga Tamariki and a philanthropic funder.

Ngātahi Project
Progress report - end of year one

Author:	**Dr Russell Wills**
Designation:	**Paediatrician, Medical Director, Quality Improvement and Patient Safety, Project Sponsor**
Date:	**1 February 2018**

SUMMARY
The Ngātahi Project is about Hawke's Bay health, education and social services (the "vulnerable children's workforce") working together as one to deliver excellent care and interventions to vulnerable children and their families. In this first year of the project we have been successful in meeting all our milestones. We have:

- mapped the skills and learning needs of 441 professionals from the vulnerable children's workforce
- agreed on the three priority training areas for 2018 and 2019
- established three work streams to develop, implement and monitor training and development programmes in these three priority areas to improve the confidence and competence of the vulnerable children's workforce, and improve collaboration
- completed an independent research programme of interviews with a representative group of managers and practitioners, which provides assurance on the current direction, lessons learnt and important pointers for the following two years of the programme.

We are a step nearer to our vision of better collaboration between disciplines and sectors, sharing of effective practices, development of a common language and improved workforce capacity.

This briefing paper describes the context and progress to date. A business case for funding for 2018 and 2019 has been written and will be pitched to potential philanthropic funders.

BACKGROUND
In 2015 an expert panel reviewed Child, Youth and Family. There were a number of reasons that the care and protection system failed vulnerable children and their families[1] and recommendations were made to address these issues.

Children 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 and the Government accepted all of the Panel's recommendations.

A new programme was created to reform the way these families are supported, including:

- changes to legislation and accountabilities of Ministry Chief Executives
- dissolution of Child, Youth and Family and creation of the Ministry for Vulnerable Children 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. See Appendix Two for a roadmap of these changes.

In addition to these structural changes, the expert Panel acknowledged, *"the need for a shift from rules, compliance and timeframe-driven practice to professional judgement based on an evidence-based understanding of the impact of trauma on children and young people, the science of child development and attachment, and best practice approaches"* (p65).

There are now many reports[2],[3],[4],[5] that recommend a focus on additional knowledge and skills ("competencies") for practitioners working with vulnerable families. These competencies include the ability to identify vulnerable whānau and families, assess both strengths and risks, formulate an assessment, design and implement a plan with families, and work collaboratively with the agencies involved.

The Ministry of Social Development Children's Action Plan Directorate therefore 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. Hawkes Bay is piloting the Ngātahi Project, leveraging the draft Vulnerable Children's Core Competency Framework.

PURPOSE

The Ngātahi Project aims to assess the skills and development needs of health, education and social service professionals in Hawke's Bay who are working predominantly or exclusively with vulnerable children and families. Over a three year period Ngātahi and its partners will design, implement and evaluate a workforce development plan to support practitioners. By improving practitioners' competencies, including their ability to practice collaboratively and share information, in conjunction with the structural changes above, outcomes for vulnerable children and their families should improve.

PROGRESS TO DATE

Funding was obtained in 2016 from the Hawke's Bay District Health Board (HBDHB), Ministry of Social Development and Lloyd Morrison Foundation to progress the project. Bernice Gabriel, a senior psychologist at the HBDHB Child, Adolescent and Family Service (CAFS) was appointed as project manager in March 2017.

<u>HBDHB CAFS</u>

HBDHB CAFS is a multidisciplinary team of 30 staff working with children and young people (C&YP) with moderate to severe mental illness and their families. Many of these C&YP have experience of abuse, neglect, witnessing parental violence, and developmental issues such as foetal alcohol spectrum disorder. CAFS' staff work with the most complex of these children and families and accept referrals from all the other 24 agencies or services involved in the Ngātahi project.

CAFS' staff completed their competency assessment against the Ngātahi framework and the Real Skills Plus CAMHS competency framework early in 2017[6]. Priorities for staff development were identified and experienced clinician-trainers recruited to deliver training for CAFS. Trainers were asked to give particular thought to integrating clinical and cultural competence, prioritise examples of practice with Māori tamariki and whānau and advise on subsequent activities to support CAFS' staff to integrate the new competencies into everyday practice.

Peer review groups meet regularly to review cases and are the primary mechanism to integrate the new competencies into everyday practice. Four training sessions have been completed to date:

- Attachment & Trauma
- Emotional Regulation/Dialectical Behaviour Therapy*

* Designed as a treatment for people experiencing chronic suicidal thoughts as a symptom of borderline personality, DBT is used to treat people who experience a range of chronic or severe mental health issues, including self-harm, eating and food issues, addiction, and posttraumatic stress, and borderline personality.

- Acceptance & Commitment Therapy[†]
- Family Therapy supervision.

Wider workforce

In May 2017 a hui of 72 leaders from health, education and social services, kaupapa Māori, mainstream, Government and NGO services was held at HBDHB (Appendix One).

The hui agreed on the competencies and tiers of competency that each sector required of its staff. Some competencies were added to the original framework and some were moved between tiers. The revised competency framework included 289 competencies in three tiers: Foundation, Practitioner and Leader of Practice. The original six domains and 12 sub-domains from the Vulnerable Children's Workforce Competency Framework were retained. See Appendix Three for a one-page summary of the framework. The full framework is available if required.

A Survey Monkey tool was created from the framework for practitioners to identify the competencies they did not need (N/A), already had (Y), needed and partially had (P) or needed and did not yet have (N). Staff completed the tool online or on paper in September and early October. Paper copies were entered into the Survey Monkey tool by a data administrator. Results were copied into SPSS and analysed, with a focus on the number (%) of staff in each service and across all services recording P and N responses (Table 1 below). Most practitioners also entered demographic data including discipline and years since graduation.

RESEARCH AND EVALUATION

Professors Kay Morris-Matthews and David Tipene-Leach (Eastern Institute of Technology) were contracted to provide the evaluation. Interviews were completed with staff from CAFS and the wider workforce to understand the process to date, assess manager and staff engagement, what had worked well and could be improved in this first phase of the project, and any additional themes that would inform the next steps for the project. The project manager and project sponsor have also kept logs of lessons learnt, which are reported below.

[†] ACT is an evidence-based approach for young people experiencing anxiety, depression and/or addiction.

RESULTS

Qualitative research

Key themes from staff interviews have included:

- High levels of engagement of managers and staff: Both groups agreed that the competency framework worked well to identify the competencies staff needed. While the 289 competencies initially looked onerous to assess, most staff took only an hour to do so and found the process helpful.
- Value of clinical leadership: There was high agreement that the project manager, due to her clinical credibility and general approach, made the process accessible and understandable, generated high trust in the process, and that these factors were likely to generate more accurate and reliable responses, that would in turn lead to training that would be of value.
- High levels of practitioner stress: High levels of stress, burnout and fatigue were noted in many interviews. Self-care competencies were identified as a high need by many staff, which was a gap in the competency framework.

Lessons learnt

Bicultural approach

- Tamariki Māori are 70% of the target population for this project so it was agreed that tikanga Māori and Māori voices would be privileged in the project. Initial face to face meetings with Māori leaders to agree tikanga and values provided wise advice and guided the development of the project.

Engagement, values, language

- Initial face to face engagement with managers and practitioners is crucial and needs to be led by people with high degree of trust and fidelity in the region.
- Presenting to all staff in a service before mapping the competencies was crucial to get consistent messaging out and to stress values and philosophies
- Neutral, non-judgmental language was more successful in engaging staff. E.g., "mapping/needs analysis" of competencies rather than "performance appraisal"; "additional" needs, rather than "deficits".
- Stressing trust and confidentiality with practitioners.
- Honest and open acknowledgment of NGOs' difficulty with sharing resource/ intellectual property in an environment of competing for funds from the same funding pool.

Reliability of competency mapping

- Competency mapping was more reliable when done with a senior staff member who is trusted and knew staff well.
- With the Leaders of Practice tier, it would have been helpful to remind (in person and in Survey Monkey before that section) them to say N/A if not applicable to their role.
- Self-assessment on mapping is not enough, most people tend to underestimate their competencies and a very few overestimate them.

Pioneering

- Many of the lessons above were learnt from early adopter services/agencies, which changed our subsequent messaging and prevented lessons from being repeated.
- Dedicated admin and event co-ordination time/resource is crucial.

The detailed research report will be completed by 31 January 2018.

Survey Monkey: priorities for competency development

In the final analysis, 441 practitioners from 24 services mapped their competencies against all 289 competencies. The number and proportion (out of 441) of practitioners identifying that they needed but did not have (N) or partially had (P) each competency was ranked. Only those competencies with >25% of respondents N or P were further analysed. Competencies scoring

highly were then grouped into themes that are naturally practised and taught together (Table below).

Table1: Highest-ranked competencies by theme (range, number responding N or P and %)

Competencies (theme)	No.	%
1. Mental health and addictions	113-258	26-59%
2. Working effectively with Maori	110-220	25-50%
3. Trauma-informed practice	112-196	26-45%
4. Professional practice, self-care, UN Convention on the Rights of the Child	109-178	25-41%
5. Child health and development, engaging effectively with children and young people,	110-164	25-37%
6. Assessment, formulation, treatment planning	114-163	26-37%
7. Networking, liaison, legislation, policy, information sharing	110-148	25-34%
8. Child protection, family violence	115-142	26-32%
9. Engaging families, whanau and caregivers	111-127	25-29%

The competency with the greatest number of practitioners identifying themselves as N or P was "Has an awareness of the legislation relating to addiction issues" (258, 59%). Addiction and mental health competencies generally were the highest-ranked by the sector overall.

DISCUSSION AND NEXT STEPS

Stakeholder interviews, surveys and our own observations suggest a high level of engagement has been achieved across sectors for the Ngātahi Project. Four hundred and forty one staff across 24 agencies or services in Hawke's Bay have identified the competencies they believe they need but do not yet have to work effectively with vulnerable children. There is high consistency in the rankings of competency needs between services. The mapping results are also consistent with the competency gaps observed in everyday practice.

On 6th November sector leaders met again to agree the training and development priorities for the Ngātahi Project in 2018 and 2019. Given that staff release time is limited and that there is a large workforce to put through the training, three areas were prioritised: Working Effectively with Māori, Mental Health and Addictions, and Trauma-Informed Practice. Self-care was agreed as needing to be the first priority of the Trauma-Informed Practice work stream.

Sector leaders joined or nominated staff to join one or more of the three work streams. Work streams are currently in the process of agreeing a chair(s), membership and terms of reference, and will commit to attending and contributing to the work stream. Work streams will be empowered to recommend what will be taught, how and by whom, follow-up activities to embed the new competencies into practice and how each competency should be assessed.

OPTIONS ANALYSIS FOR 2018 AND 2019

Three options have been identified to address the additional competencies/ development needs indicated by the mapping process:

Option one is to buy in external trainers. This is not the preferred option because:

- There is agreement among sector leaders that there is considerable expertise in the identified training areas within the participating agencies and services.
- Buying in training would be expensive.
- Buying in training would not allow for building local trainer capacity, and would not allow for the sustainability of training on an ongoing basis.

Option two is to only use local training resource. This is not the preferred option because:

- While there is considerable skill and expertise in the identified training areas, there are some training areas that are specialised and have been well-developed by experts in the field.
- Buying in some external training will reduce the work load on local trainers.

Option three (recommended) is to use a hybrid approach to training, i.e. a mixture of using external trainers where local expertise needs to be augmented (in a train-the-trainer approach to develop local capacity) and using local training resource.

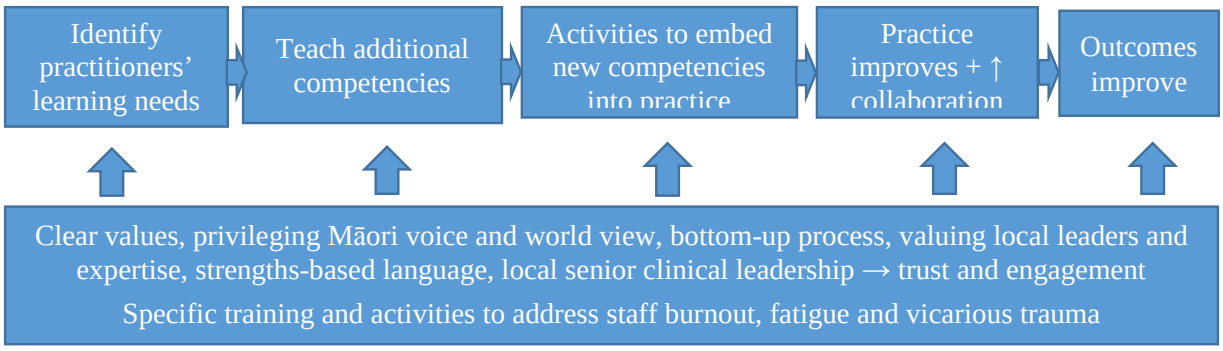
The intended approach for the roll out of training is as follows:

- Leaders chose three training areas to progress in 2018 at the hui on 6th November, i.e. Working Effectively with Māori, Mental Health and Addictions, and Trauma-Informed Practice.
- Three work streams were formed to determine the content and process of the training, how it will be embedded into practice, and how it will be evaluated. These work streams will make decisions on the internal and external resources needed.
- Working Effectively with Māori work stream members will support the other two work streams to advise on the cultural competency aspects of the training.
- Table 1 above and the detailed analysis suggests that for each programme of learning, up to 250 practitioners may wish to attend training and enter a programme to embed the new competencies into practice. Our experience in teaching assessment of child protection and family violence is that this is best achieved in small groups of no more than 20, particularly when role play is involved, so we may expect registrations for up to 12-15 courses for each theme. In 2018, the estimated number of registrants for the Working Effectively with Māori and Mental Health and Addictions training programmes are 250 each. The competency survey did not allow the estimation of the likely number of registrants for the self-care training, but the research interviews indicate that this will be high-demand training and we estimate approximately 300 registrants for 2018. This could mean approximately 250+250+300=800 registrations and 40 training programmes for groups of 20 people in 2018.

EXPECTED OUTCOMES AND BENEFITS

Hawke's Bay is 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 for Children Oranga Tamariki 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 MCOT, MSD, HBDHB, Special Education and NGO social services in HB working with vulnerable children, who have a well-established history of collaborative working. We believe that this project could become a template for development of the vulnerable children's workforce nationally.

Our theory of change is essentially:



Measures and indicators

Outcome sought	Demonstrated by
Engagement	Research interviews year one with practitioners and managers
Practitioners' learning needs identified	Survey Monkey results Research interviews year one with practitioners and managers
Competencies taught	Number of attendees at training, number of trainings provided Evidence of programme delivery with fidelity Pre-post self-report of competence and confidence
New competencies embedded into practice	Description of activities and attendance at these Manager report of initial practice change with examples
Practice improved	Manager report of practice change with examples Practitioner self-report of competence and confidence New evidence-based programmes delivered, description, attendance Direct observation by evaluators
Collaboration improved	Manager report of improved collaboration with examples Practitioner self-report of improved collaboration with examples Direct observation by evaluators Reports from collaborative bodies (e.g., FVIARS, Strengthening Families, High and Complex Needs Interagency Management Group, Maternal Wellbeing Programme, Intensive Wraparound Service)
Reduced staff burnout, fatigue & vicarious trauma	Practitioner self-report HR indicators, e.g. recruitment, retention, turnover Direct observation by and feedback to evaluators
Improved outcomes for children and families	Client direct feedback within services Direct observation by and client feedback to evaluators Substantiated abuse (MCOT) Police family violence (POL 1310) callouts Number of children usually resent at POL 1310 callouts Intimate partner violence convictions (Courts) Referrals for severe behaviour to MOE and HBDHB

All outcomes to be assessed by independent researchers contracted to Ngātahi Programme.
All outcomes dis-aggregated by ethnicity.

ASSUMPTIONS

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

RISKS and MITIGATIONS

Risk	Mitigation
If agency leaders do not contribute their agency's time and skills to work streams this risks losing the mandate for that training.	At the hui on 6th November a clear message was given that it is important to engage or will not be able to influence the training. It was also made clear that all contributions are welcome
If work stream members do not agree on the content and implementation approach by the deadline this will impact negatively on the project timeline.	The work stream chairs will be supported to facilitate work stream well, value all contributions and look at best practice evidence. If no agreement in work stream this will be escalated to the governance group.

BUDGET HBDHB Ngātahi Project Financials				
Activity	**FTE**	**Amount 2018**	**Amount 2019**	**Why this is important**
Senior clinical leadership	0.5 FTE	$55,000	$55,000	Clinical leadership is required to engage managers and staff in the learning programme, identify, recruit and brief the trainer, support managers and staff to arrange peer review groups, and support the evaluation.
Event management	0.5 FTE	$27,500 ($55k pro rata)	$27,500 ($55k pro rata)	Experience this year suggests that we need event management capacity for the following: website design; online registration, tracking and reporting attendance and feedback; venue hire, IT, catering and certificates. The HBDHB EDC team is a multidisciplinary team with considerable experience in the above tasks.
External trainers		$50,000	$50,000	We would take a train-the-trainers approach with external trainers but a small budget will be required to bring in external trainers initially and for follow-up peer review.
Evaluation To be sought from HBDHB Transform and Sustain Fund		$80,000	$80,000	Ngātahi is a pilot project that, if successful, is likely to be taken up nationally. There is therefore a strong obligation to ensure the programme is evaluated independently and thoroughly, so clear documentation of lessons learnt and areas to improve are essential. Measures and indicators for 2018 and 2019 are noted above. The budget for 2017 was $80,000. We estimate that a credible evaluation could be expected for $80,000/year in 2018 and 2019.
Training costs		$20,000	$0	See table below re training costs
TOTAL COST		**$232,500**	**$212,500**	

Costs to participating services				
Activity	**FTE**	**Amount 2018**	**Amount 2019**	**Why this is important**
Training costs		$0	Contribution per agency to be determined	There will be costs for venue hire, IT, photocopying, catering and certificates. We will ask services, whenever possible, to donate venues for training and staff to bring their own lunch. Work streams will be asked, wherever possible, to identify local leaders to deliver training and support ongoing activities such as peer review. While this a cost to services (time spent training is time not spent in practice), reciprocity occurs because these services also gain from their staff attending training provided by others, and improving their practice. While we are asking for funding for the training costs in 2018, we will ask agencies/services to contribute to these costs in the 2019. The first year will give us an indication of how much we will likely need in 2019, and the contribution from each agency will then be determined.

RECOMMENDATION

That the MRB, Pasifika Health Leadership Group, HB Clinical Council, HB Health Consumer Council and the HBDHB Board:

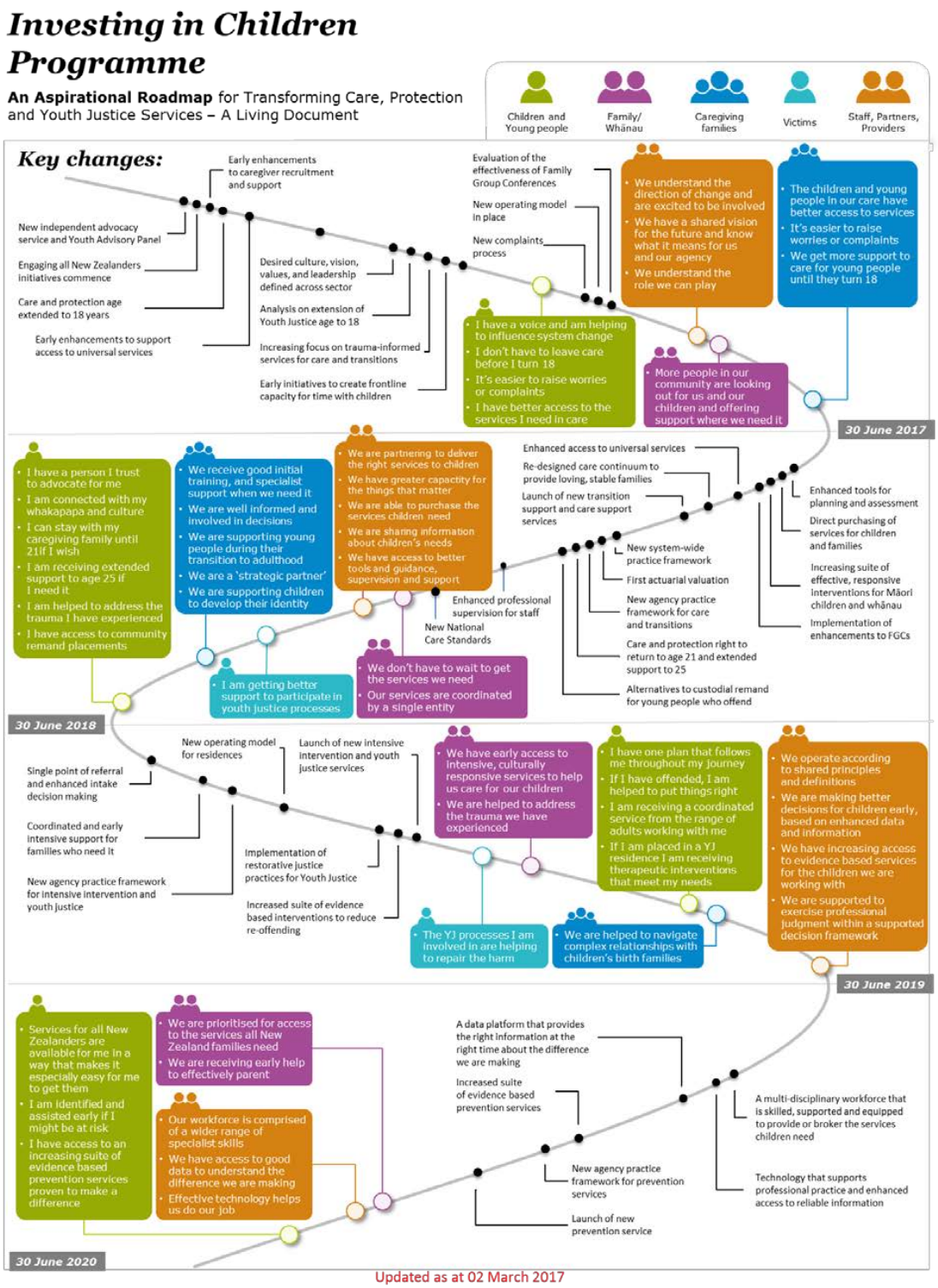
- **Note** the progress of the Ngātahi Project in the first year
- **Note** the approach endorsed for Years 2 and 3 of the Ngātahi Project and the forecast budget of $232,500 for 2018 and $212,500 for 2019
- **Note** that theTransform and Sustain Steering Group will be asked to contribute funding of $80,000 in FY2017/2018 and FY2018/2019 for the evaluation component of the project.
- **Note** that the remaining funding has been sought from the Ministry for Children Oranga Tamariki and a philanthropic funder.

Appendix 1: Agencies/Services Participating in the Ngātahi Project

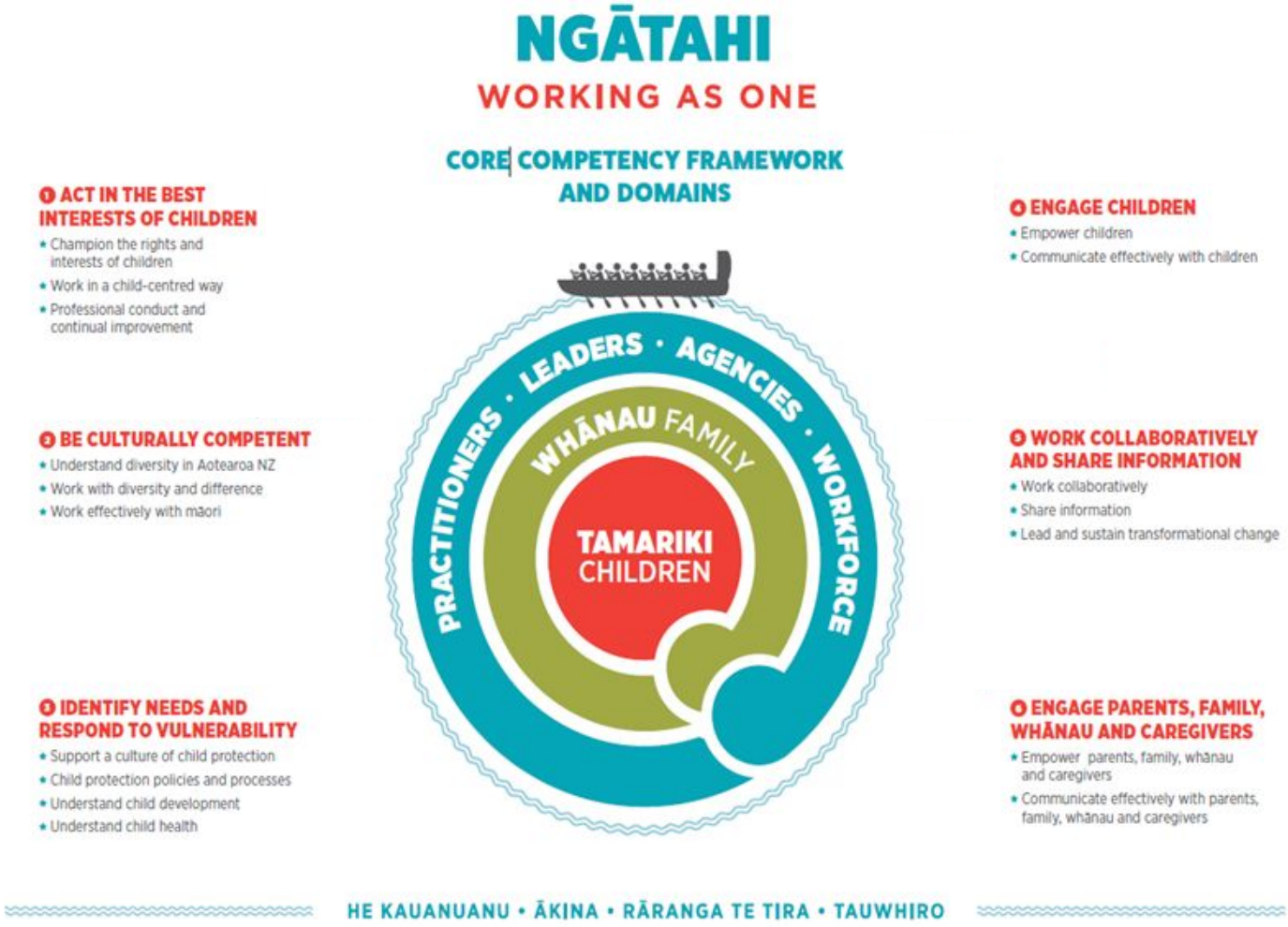
1 HBDHB – Child Development Service (CDS)
2 HBDHB - Child, Adolescent & Family Service (CAFS)
3 HBDHB – Family Violence & Child Protection Programme
4 HBDHB – NASC
5 HBDHB - Public Health Nurses
6 HBDHB – Te Ara Manapou (Parenting & Pregnancy Service)
7 Te Kupenga Hauora
8 Roopu a Iwi
9 NZ Police
10 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

Appendix 2: Investing in Children Aspirational Roadmap

http://www.msd.govt.nz/about-msd-and-our-work/



Appendix 3: Core Competency Framework Summary



[1] https://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/investing-in-children/investing-in-children-report.pdf
[2] Office of the Children's Commissioner. Final report on the investigation into the death of Riri-o-te-Rangi (James) Whakaruru. Wellington, Office of the Children's Commissioner, 2000
[3] Office of the Children's Commissioner. Report of the Investigation Into the Deaths of Saliel Jalessa Aplin and Olympia Maria Aplin. Wellington, Office of the Children's Commissioner, 2003
[4] Laming Lord. The Victoria Climbie Enquiry. London, HMSO, 2003. http://vcf-uk.org/wp-content/uploads/2010/07/laming-report.pdf
[5] Smith Mel. Report to the Hon. Paula Bennett Minister for Social Development and Employment. Following an Enquiry Into the Serious Abuse of a Nine Year Old Girl and Other Matters Relating to Welfare, Safety and Protection of Children in New Zealand. Wellington, Ministry of Social Development, 2011.
http://www.beehive.govt.nz/sites/all/files/Smith_report.pdf
[6] http://www.werryworkforce.org/real-skills-plus-camhs

CLINICAL SERVICES PLAN

Verbal Update

12

HAWKE'S BAY District Health Board Whakawāteatia	**Suicide Prevention Update**
	For the attention of: **Maori Relationship Board, Clinical Council, Consumer Council and HBDHB Board**
Document Owner:	Allison Stevenson – Acting Executive Director Provider Services
Document Author(s):	Penny Thompson – Suicide Prevention Coordinator
Reviewed by:	Allison Stevenson, Jenny Cawston and Executive Management Team
Month:	February, 2018
Purpose	• Provide Suicide Prevention update to the HBDHB Board
Previous Consideration	N/A
Summary	• Suicide Prevention Activities • Barriers and Limitations • Future Activities
Contribution to Goals and Strategic Implications	• Improving quality, safety and experience of care • Improving Health and Equity for all populations • Improving Value from public health system resources
Impact on Reducing Inequities/Disparities	• Working with Flaxmere Planning Committee • AEIOU voice over via social media
Consumer Engagement	• Community led initiative • Resource revised according to feedback
Other Consultation /Involvement	• Flaxmere Planning Committee • Clinical Advisory Services Aotearoa
Financial/Budget Impact	• Raising Awareness Campaign for December 2017 – March 2018 • Communications System
Timing Issues	N/A
Announcements/ Communications	• Clinical Advisory Services Aotearoa support initiated in late November
RECOMMENDATION **That MRB, Clinical Council, Consumer Council and HBDHB Board** • Provide feedback • Approve this report be submitted to the February HBDHB Board meeting	

HAWKE'S BAY
District Health Board
Whakawāteatia

Suicide Prevention Update

Author:	Penny Thompson
Designation:	Suicide Prevention Coordinator
Date:	18 January 2018

OVERVIEW

Every year one in five New Zealanders experience some form of psychological distress or develops a diagnosable mental disorder (Ministry of Health, 2006). These numbers are increasing and will continue to do so under the current system and the way services are delivered. According to Stone et al (2017) an effective suicide prevention strategy is strengthening accessibility and improving delivery of suicide care. It is believed that improved delivery for suicide care should occur on a continuum that starts with whanau and ends with acute inpatient services. Our future initiatives will need to add significant value to existing primary and community care services with potential to reduce the economic cost of a range of Government services, as well as improving population health status across both mental and physical health.

BACKGROUND

New Zealand has one of the highest youth suicide rates in the Organisation for Economic Cooperation and Development (Ministry of Health, 2017). Māori have higher suicide rates of 21.1 per 100,000 compared to that of non-Māori recorded at 14.6 per 100,000 in 2013. (Ministry of Health, 2013). According to Gluckman (2017) of particular concern is young Māori males aged 15 to 29. The rates of suicide for 15 to 19 years of age in 2010 was recorded at 15.6 per 100,000 adolescents (Gluckman, 2017).

In Hawkes Bay, twenty nine people took their lives in 2013 (Ministry of Health, 2013). According to Coronial Services New Zealand (2017) the rates of suicide for Māori are disproportionate to that of non-Māori with a decline in non-Māori suicide rates since 1996 and although trends are hard to determine with population fluctuations, there appears to be no decline for Māori nationally.

Suicide is a complex issue and will require multi-faceted interventions to reduce or eliminate suicides such as; building resilient people and communities, creating protective environments and eliminating inequities caused by poverty or hardship (Stone et al, 2017). The social reasons behind suicide is emphasised by adverse childhood experiences suggesting that increased exposures to adverse childhood trauma such as child abuse, neglect, poverty, family violence or parent in prison can significantly increase the occurrence of depression and suicide attempts compared to those people who do not experience adverse childhood trauma (Felitti et al, 1998).

SUICIDE PREVENTION INITIATIVES - CURRENT

The HBDHB has shown a great deal of commitment to suicide prevention since the four youth suicides in December 2013. Such commitment can be seen in the management and operational leadership to drive suicide prevention activities across public sectors, allocating permanent funding, building and creating strong relationships with non-government organisations, schools and communities such as Flaxmere, Central Hawke's Bay and Havelock North. The network of

agencies participating in suicide prevention/postvention continue to improve what they do whilst looking for opportunities to do things differently. There are currently three large initiatives in progress, one working with the Flaxmere Planning committee to implement their community plan and the other being the Local Response Team (LRT), who is responsible for ensuring support is in place for those who have been impacted by suspected suicide. The LRT has extended its scope to include the youth suicide prevention space.

1. Flaxmere Planning Committee
   On the 9th October, the same week of Mental Health Awareness week, the Flaxmere Planning Committee launched a Flaxmere Wellbeing Challenge that finished on the 24th December promoting group, individual activities and events that focus on the Five Ways to Wellbeing. The challenge asked people to register and share their journeys on their Facebook page. The challenge has been driven and created by the Flaxmere Planning Committee with involvement from Flaxmere based services.

2. Youth Suicide Prevention
   The LRT youth suicide prevention work is intended to take a comprehensive cross sector approach for youth up to the age of 17, who have a child protection and suicide attempt event in the Police system. The LRT designate a lead agency, create and/or share plans. This process has taken some time to initiate and the network of agencies working in the multi-disciplinary space is continuously attempting to improve the process and outcomes. This work increasingly requires mental health clinical expertise to guide best practice.

3. Postvention (the time after a suicide occurs)
   Postvention management continues as a component of suicide prevention care. The need to coordinate support increases significantly when a suspected self-inflicted death notification for a youth is received. This is due to the impact of friend's networks, social media and the effect on schools. This year the LRT has actively been working together to support various high schools in the region with timely risk assessments, communications support, promoting services available and parent evenings.

   The suicide prevention network have been working closely with the Clinical Advisory Services Aotearoa Community Postvention Response Services (CPRS) to manage recent suspected self-inflicted death notifications for two people who knew each other. A cross sector response was initiated immediately with the timely review and development of resources, creation of a two month communications plan from December to March, ongoing guidance from CPRS and clear actions for the suicide prevention network. CPRS has commended the Hawke's Bay Suicide Prevention network for the decisive response and will continue to support the network as needed.

BARRIERS AND LIMITATIONS

There are two main barriers and limitations that could significantly improve the capacity of the suicide prevention network.

1. One communication system – patient/client management systems accessible across sectors, especially Ministry of Vulnerable Children, Police and HBDHB.

   Currently, under the guidance of the Privacy Rights and Vulnerable Children's Act, the Suicide Prevention Coordinator provides intensive administration support collating information, assigning clear actions and managing accountability for stated actions. One communication system would make the information more accessible, current for all major sectors and reduce the administrative process overall. The States Services Commission et al (2014) Working Better Together and Getting to Great reports suggest core business effectiveness and efficiencies need to be as strong as an organisations ability to react to events. However, there is no escaping the economic impact of creating one communication system, unless the costs and rewards are shared across sectors.

2. Mental Health – increased demand on services (internal and external to the DHB) could be an acknowledgement of the increased awareness of services in the community. However, the demand compared to the full time equivalents available makes timeliness to access support difficult. In conjunction, there is an increased need for mental health and addictions services available in the community.

   In contrast, there has also been some mental health specific initiatives implemented in the last 18 months that address some of the contributing factors connected to suicides

   - Te Ara Manapo – a maternal and parental mental health and addictions service that works through the parents to give the child the best start in life.
   - Mental Health Credentialing of Primary Care/Practice nurses to increase the confidence of primary care staff to manage mental health in the community
   - Day Programme at Te Harakeke involving group interventions
   - Home-based Services – managing clients care in their home
   - Resilience coaching for youth – through Health Hawke's Bay, the DHB is funding Youth Resilience programmes being delivered in schools. The programme began in Term 2 of 2017 and the feedback from schools has been very favourable.

   However to increase the level of wellbeing, resiliency and equity requires a shift in focus. We need to ensure the services have the flexibility to respond to the social complexity of people's lives. Felitti et al (1998) supports this approach understanding that adverse childhood experiences can have a significant effect on individuals and impact their overall health outcomes.

THE FUTURE OF SUICIDE PREVENTION

- Researching Zero Suicides Quality Improvement Framework
  Zero Suicides Quality Improvement Framework is growing interest in New Zealand with Canterbury and Waitemata choosing to implement. The Zero Suicides workshop for Health Professionals held in October 2017 had international presenters sharing their results such as, improved organisational performance and culture post training, improved patient/client outcomes and service specific results including reductions in restraint care, assaults on staff and disciplinary cases. Joe Rafferty of Mersey Care described the zero framework, as having revolutionised their organisation approaches and that it is not a sprint to the end but rather a journey. It is expected more research into this area is required to determine the resources needed to implement such a framework.

- Community
  A "By Community for Community" approach has been a focus for the suicide prevention network. We have continued to work with Flaxmere Planning Committee to guide and support them to promote wellbeing in partnership with their local community centre, waterworld, GP Practice, church groups, park features (such as disk golf), local businesses and local events. There have been some early learnings which will be discussed in more detail later in the 2018 year. The suicide prevention network in partnership with the Flaxmere Planning Committee intends to utilise a Results Based Accountability (RBA) to gauge effectiveness of a "By Community for Community" approach. In addition, alongside the Hastings District Council the next community we are working with is Havelock North, with the potential to include Omahu and Raureka.

- Resources and Education
  Recently the suicide prevention network have approved back of bus marketing over the summer holidays to further promote "it's ok to ask for help" and the 1737 telehealth service. Furthermore the "it's ok to ask for help" wallet card resource has also been reviewed. This was done as a direct response from feedback acquired from parent evenings and

presentations. The overwhelming need from community is to know what they can do. An acronym AEIOU has been added to the resource and will be included to suicide prevention education/training sessions. In addition, a video clip of AEIOU with Maori voice over has been created to be shared via social media during the summer holidays. Early stages of planning have been initiated with sessions to be held for church groups and schools (including primary and intermediates). Furthermore, we expect to have Le Va – Lifekeepers training available in 2018.

- Post/Prevention
  Lastly, postvention response is a necessary process to ensure those bereaved by suicide have support. Postvention along with the youth suicide prevention work will continue with the overwhelming consensus from LRT agencies to work better together, utilise our resources efficiently and improve outcomes for youth. This work will continue to develop and expand as required and if feasible.

- Strategy Development
  The suicide prevention network expect to focus on the development of a suicide prevention strategy, to submit to the Ministry of Health by 30th June 2018.

In summary the suicide postvention/prevention space requires flexibility to adapt or respond to the needs on any given day. The work across sectors continues to grow with the ongoing commitment of those agencies and services participating in the network. It is clear that ongoing clinical mental health expertise is required to support best practice. We look forward to completing a RBA framework to evaluate the effectiveness of working community by community.

RECOMMENDATION

That MRB, Clinical Council, Consumer Council and HBDHB Board

- Provide feedback
- Approve this report be submitted to the February HBDHB Board meeting

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ATTACHMENTS:

- **"**It's Ok to Ask for Help" Bus Backs
- "It's Ok to Ask for Help" Wallet Card

NEED TO TALK?

1737 Free call or text any time

Aunty Dee

Aunty Dee is a free online tool you can use on your mobile phone, tablet, laptop or personal computer

www.auntydee.co.nz

www.commonground.org.nz
www.thelowdown.co.nz
www.sparx.org.nz

SAMARITANS 0800 726 666

WHATS UP 0800 942 8787 (1-11pm)

YOUTHLINE 0800 376 633 (11-11 7 days)

DEPRESSION 0800 111 757 (24 hrs)
www.depression.org.nz

DIRECTIONS YOUTH HEALTH CENTRE
06 871 5307

Child, Adolescent & Family Mental Health Services 06 878 8109 ext 5848

COMMUNITY MENTAL HEALTH

Napier	06 878 8109	ext 4220
Hastings	06 878 8109	ext 5700
Wairoa	06 838 7099	ext 4875
CHB	06 858 9090	ext 5551

EMERGENCY MENTAL HEALTH
0800 112 334

ARE YOU CONCERNED ABOUT SOMEONE?

This is one thing you can do:

A Ask if someone is feeling suicidal. Be direct and matter-of-fact.

E Ensure immediate safety (take away means to suicide like ropes, guns, pills and knives). Don't leave them alone.

I Identify the problems that a person is trying to escape from by taking their life.

O Offer hope that there are other ways out, another way to solve the problem, that there is Hope.

U Use professional / Services / Community / Kaumatua and Kuia to help. Don't be sworn to secrecy. Don't carry this alone.

We would like to acknowledge the original designers of AEIOU Roger Shave and Te Runanga o Ngāti Pikiao

13.1

WINNING WAYS TO WELLBEING

CONNECT
TALK & LISTEN,
BE THERE,
FEEL CONNECTED

Give
Your time,
your words,
your presence

TAKE NOTICE
REMEMBER
THE SIMPLE
THINGS THAT
GIVE YOU JOY

KEEP LEARNING
EMBRACE NEW
EXPERIENCES,
SEE OPPORTUNITIES,
SURPRISE YOURSELF

BE ACTIVE
DO WHAT YOU CAN,
ENJOY WHAT YOU DO,
MOVE YOUR MOOD

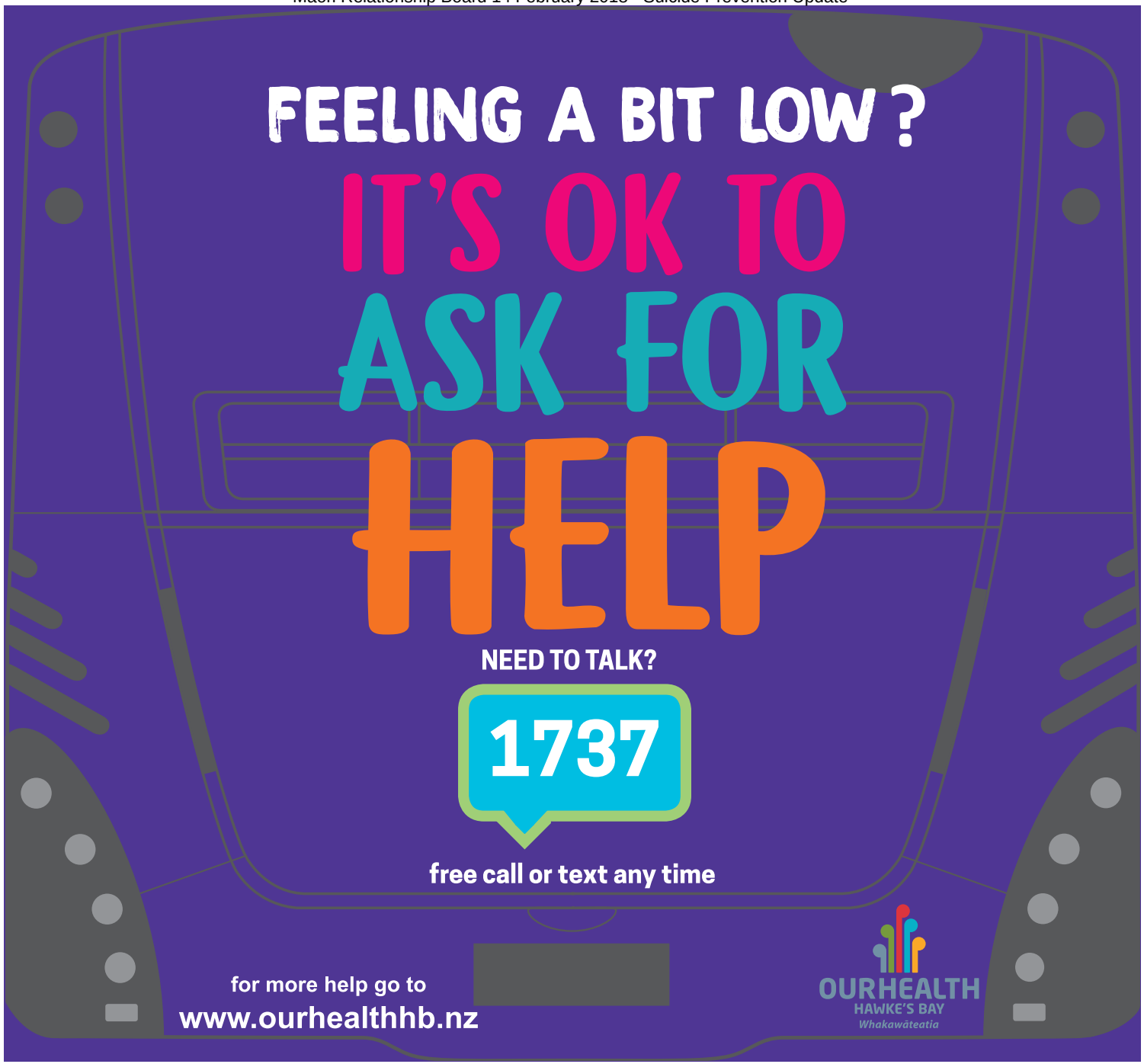
INTRODUCE THESE FIVE SIMPLE STRATEGIES INTO YOUR LIFE AND YOU WILL FEEL THE BENEFITS.

Mental Health Foundation of New Zealand
www.mentalhealth.org.nz

IT'S OK TO ASK FOR HELP

E hika mā, kei te pai noaiho, ki te pātai mō tētahi āwhina

OURHEALTH HAWKE'S BAY


FEELING A BIT LOW?
IT'S OK TO
ASK FOR
HELP
NEED TO TALK?
1737
free call or text any time
for more help go to
www.ourhealthhb.nz
OURHEALTH
HAWKE'S BAY
Whakawāteatia

13.1

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OURHEALTH
HAWKE'S BAY
Whakawāteatia

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Access (ASH Rates 0-4 & 45-64 years)**
	For the attention of: **Māori Relationship Board, Pasifika Health Leadership Group, HB Clinical Council, HB Health Consumer Council, HBDHB Board**
Document Owner	Dr Mark Peterson, Chief Medical Officer - Primary
Document Author(s)	Charrissa Keenan, Health Gains Advisor – Māori Health Patrick LeGeyt, GM Māori (Acting), Māori Health Jill Garrett, Strategic Services Manager – Primary Care
Reviewed by	Executive Management Team
Month/Year	February, 2018
Purpose	Provide an update on the Te Ara Whakawaiora priority areas relating to Access (ASH rates 0-4 and 45-64) Māori
Previous Consideration Discussions	Six-monthly update. No previous consideration.
Summary	ASH rates 0-4 (On track) • *Respiratory* - Review of the respiratory care pathways found that care pathways for this age band require development to address service and system barriers to access. • *Immunisation* - Achieving equitable outcomes for Māori. Work however needed to provide information that leads to appropriate time frames for presentation for immunisation by whanau. • *Oral health* – Showing excellent results of improved outcomes. • *Child healthy homes program* – Achieving significant increases in referrals. • *Skin Program* – The program in its initial phase of raising awareness of skin problems, identifying key stakeholders including ECE providers. ASH 45-64 (Not on track) • *System level improvement plan* – All activities are now in place. Utilisation of CPO programs by Māori is low and will need to be addressed in Q3-4. Appointments into rolls for cardiac services are now in place. • *Collaborative Pathways* – 75 pathways developed. Utilisation increasing by full complement of health professionals. New IT platform for the pathways is being sort in partnership with Central and Midland DHBs. Still more work needed to get pathways imbedded in BAU and funded accordingly • *Continuation of the Nurse led respiratory program* – Contract hold ups has meant recommencement of the program has been delayed. Working group in place to identify target groups and attach three-monthly kick start performance indicators to address current COPD rates.

	• *Implementation of the HBDHB Long Term Conditions Framework* Focus areas for the implementation team will be work force development, care coordination and transfer of care processes. The work is multi-disciplinary and spans multiple co morbidities including; respiratory, cardiac, renal and diabetes. Pharmacy is part of the multi-disciplinary team.
Contribution to Goals and Strategic Implications	Focus is on Improving Health and Equity for Māori
Impact on Reducing Inequities/Disparities	Directly aligned to addressing inequity between Māori and Other
Consumer Engagement	(Forms part of each work stream)
Other Consultation /Involvement	Not applicable for this report
Financial/Budget Impact	Not applicable for this report
Timing Issues	Not applicable
Announcements/ Communications	None

RECOMMENDATION:

It is recommended that the Māori Relationship Board and/or Pasifika Health Leadership Group; HB Clinical Council, HB Health Consumer Council; HBDHB Board:

1. **Note** the content of the report
2. **Endorse** the recommendations.

Te Ara Whakawaiora: Access (ASH Rates 0-4 & 45-64 years)

Author(s):	Charrissa Keenan, Health Gains Advisor – Māori Health Patrick LeGeyt, GM Māori (Acting), Māori Health Jill Garrett, Strategic Services Manager – Primary Care
Designations:	As above
Date:	**February, 2018**

OVERVIEW

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

UPCOMING REPORTS

The following are the indicators of concern, allocated EMT champion and reporting month for each.

Priority	Indicator	Champion	Reporting Month
Access *Local Indicator*	Reducing acute admissions of Ambulatory Sensitive Hospitalisations (ASH): 1. 0-4 year olds - dental decay, skin conditions, respiratory and ear, nose and throat infections 2. 45-64 year olds - heart disease, skin infections respiratory infections and diabetes	Mark Peterson	February 2018

MĀORI HEALTH PLAN INDICATOR

This report provides an update on programmes related to Ambulatory Sensitive Hospitalisations (ASH) for 0-4 and 45-64 years of age in Hawke's Bay.

Ambulatory Sensitive Hospitalisations (ASH) reflect hospital admissions for conditions which could potentially be prevented by early access to treatment in care. In many countries ASH is used as a means to assess the performance of primary care and to identify potential barriers to access.

However, while ensuring early access to effective primary care is still likely to be of considerable value in reducing ASH, in countries such as New Zealand, where large socioeconomic and ethnic disparities in child health exist, a greater emphasis is needed to address those factors, often outside of the health sector, which drive the underlying burden of disease (e.g. household income, housing, nutrition, exposure to second hand cigarette smoke). But what this also emphasises is the necessity for the health system to be working efficiency, effectively, and equitably in every way to ensure that health does not add to the socio-economic burden of ill-health. The HBDHB is committed to non-differential targets and significant inequality is seen in this indicator. Our work programmes focus on targeting vulnerable populations to reduce hospitalisation, improving the home environment and improving consistency of practice and early access to primary care programmes and reducing inequities.

WHY IS THIS INDICATOR IMPORTANT?

System Level Measures

The Introduction of the System Level Measures; targeted performance measures, came into effect beginning 2016-17. The measures include some previous health targets included in the Integrated Performance Incentive Framework and a set of newly introduced, nationally agreed performance measures. Ambulatory Sensitive Hospitalisation (ASH) rates are included in two System Level Measures.

- ASH 00-04yrs is reported against under the SLM-Ambulatory Sensitive Hospitalisation (ASH)
- ASH 45-64yrs is reported under the SLM-Acute Hospital Bed Days.

Each ASH band for total population is divided into; Māori, Pacific, Other[1]. Targets are derived from the DHB ASH rates for the Māori population. The base line rates for the DHB will be compared with national total population rates and targets set accordingly. These are expressed in rates per 100,000. All Māori and Pasifika data reported against for ASH will analysed by Māori vs Other to adequately examine the equity gap.

Targets have been set to work towards eliminating the gap within a 2-5 year period. Using the base line as a measure, reducing the equity gap by half each year. If below 10% the aim is to eliminate the gap. Rates within 5% would be considered equitable (e.g. HBDHB Māori ASH rates to be at or below national total population rates) [2]

0 – 4 years

For the 2017 year the contributory measures regarding the System Level Measure of Reduced ASH rates for 0-4 years as agreed by Health Hawkes Bay and the Hawkes Bay DHB are:

- Paediatric respiratory training
- Increased Immunisation Health Target
- Oral Health Initiative

The 2016 top three ASH conditions for tamariki Māori 0 – 4 years were: dental conditions, asthma and respiratory infections – Upper ENT.

45-64 years

As of September 2016 the Top Three conditions contributing to the ASH rate for 45-64yrs were; cardiac conditions, respiratory (including COPD and Pneumonias) and Cellulitis. This is unchanged.

For the 2017-18 year the target areas as identified in the SLM-Improvement Plan are;

Using Health Resources Effectively: Reduce standardised acute hospital Bed Days per 1000 population for Māori to ≤461 (by June 2018)

Contributory Measures

- ASH rates 45-64yrs (Māori)

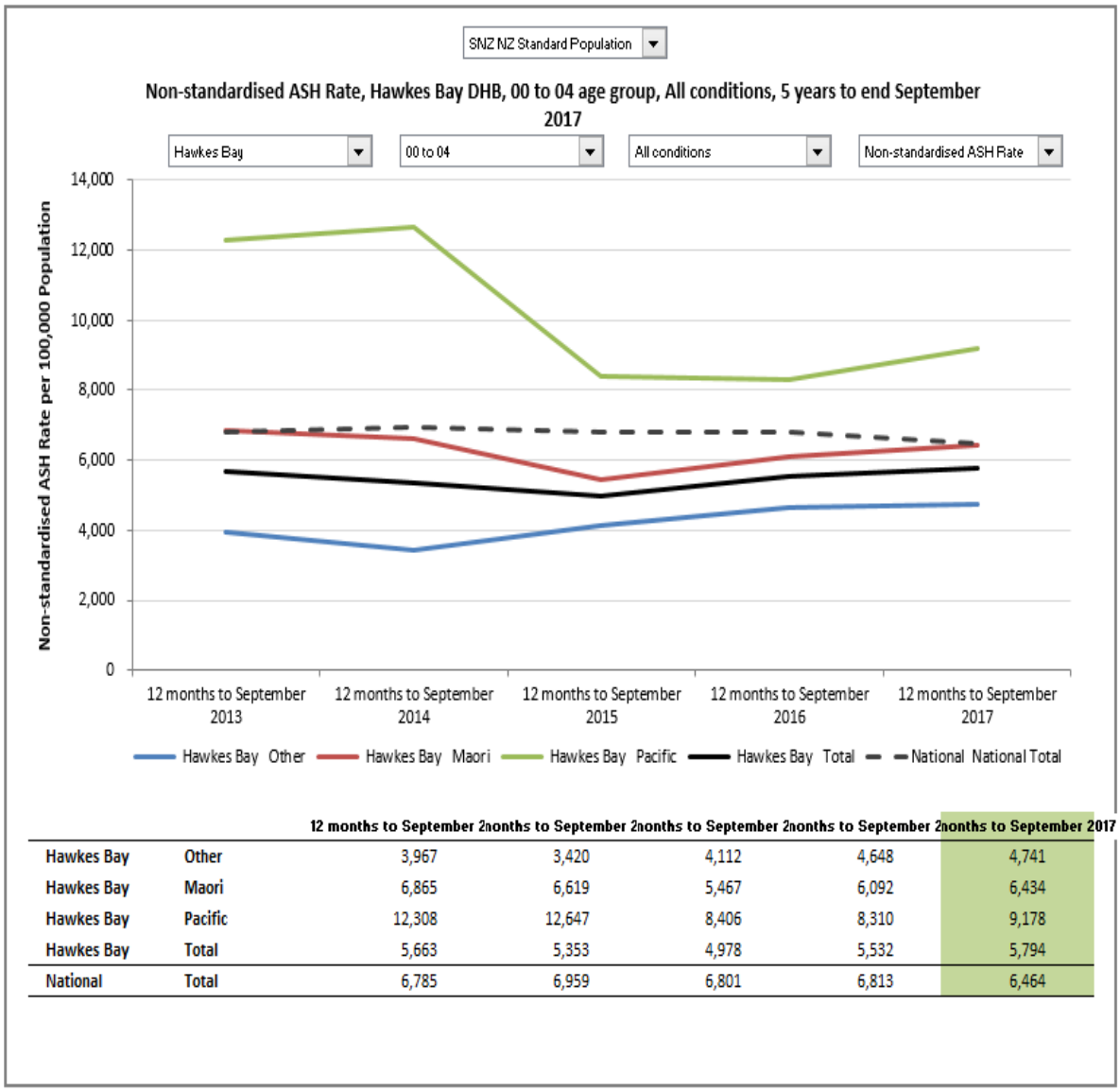
[1] MoH-System Integration SI1: Ambulatory sensitive hospitalisations.
[2] MoH-System Integration SI1: Ambulatory sensitive hospitalisations.

- Increase the number of Māori and Pasifika and Quintile 5 referred into the high needs enrolment program (PHO)
- Increase the number of referrals into the Coordinated Primary Options (CPO) program – Hospital Discharge pathway for Māori – Pasifika and Q4 and Q5.

HAWKE'S BAY DISTRIBUTION AND TRENDS

0-4 YEAR AGE GROUP

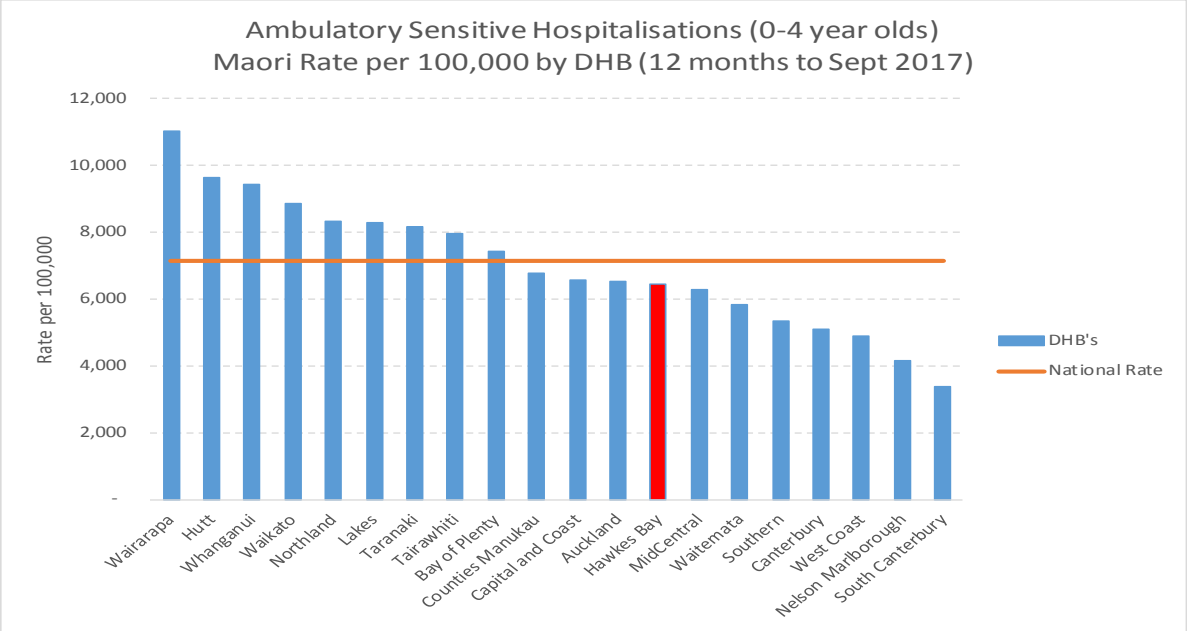
Hawke's Bay ASH rates by ethnicity 0-4 year age group – 12 months to end September 2017



		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	3,967	3,420	4,112	4,648	4,741
Hawkes Bay	Maori	6,865	6,619	5,467	6,092	6,434
Hawkes Bay	Pacific	12,308	12,647	8,406	8,310	9,178
Hawkes Bay	Total	5,663	5,353	4,978	5,532	5,794
National	Total	6,785	6,959	6,801	6,813	6,464

As at September 2017 Hawke's Bay tāmariki have lower rates of ASH compared to national rates with the total ASH Rate for HB at 5,794 compared to the national rate of 6,464. Although this is positive HB has seen its overall ASH rate increase in the latest 12 month period by 4.7% decreasing the gap between HB and the National rate by 47.7%

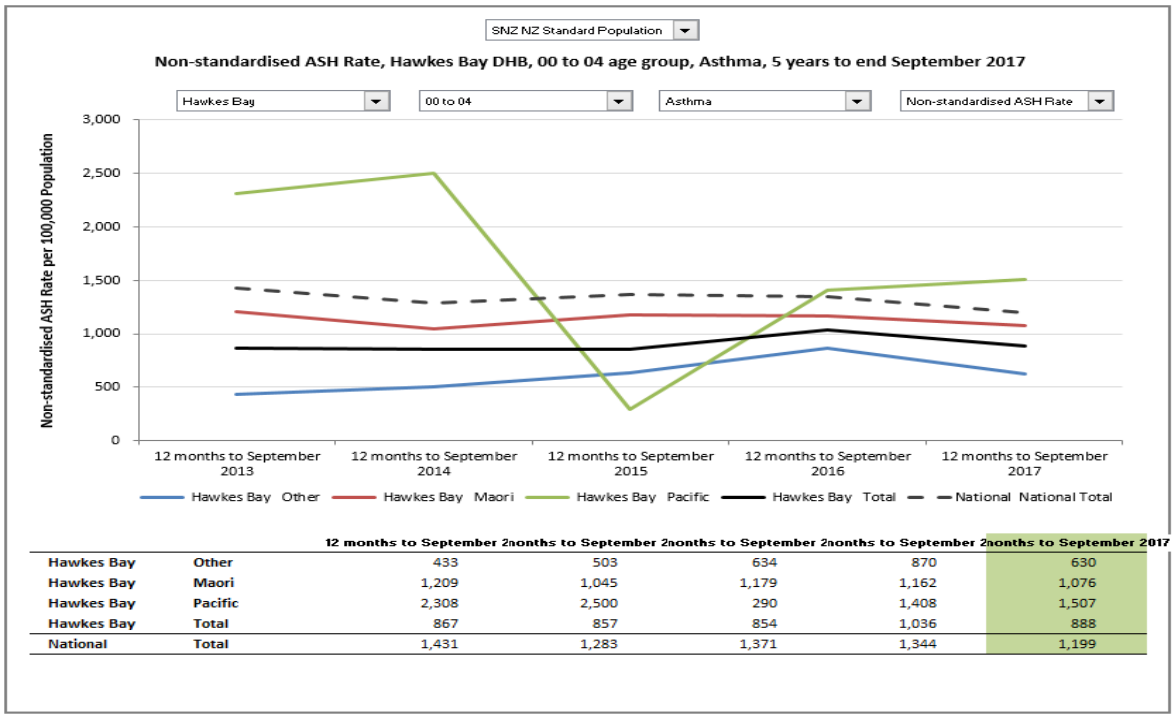
Hawke's Bay Māori ASH rates 0-4 age group 12 months to Sept 2017 – Benchmark against DHBs



In the 12 months to September 2017 the Hawke's Bay Māori rate was 99.9% of the national rate and 8th best performer of all DHB's with Māori rates, in the prior 12 month period we were the 6th best Māori performer in this age group.

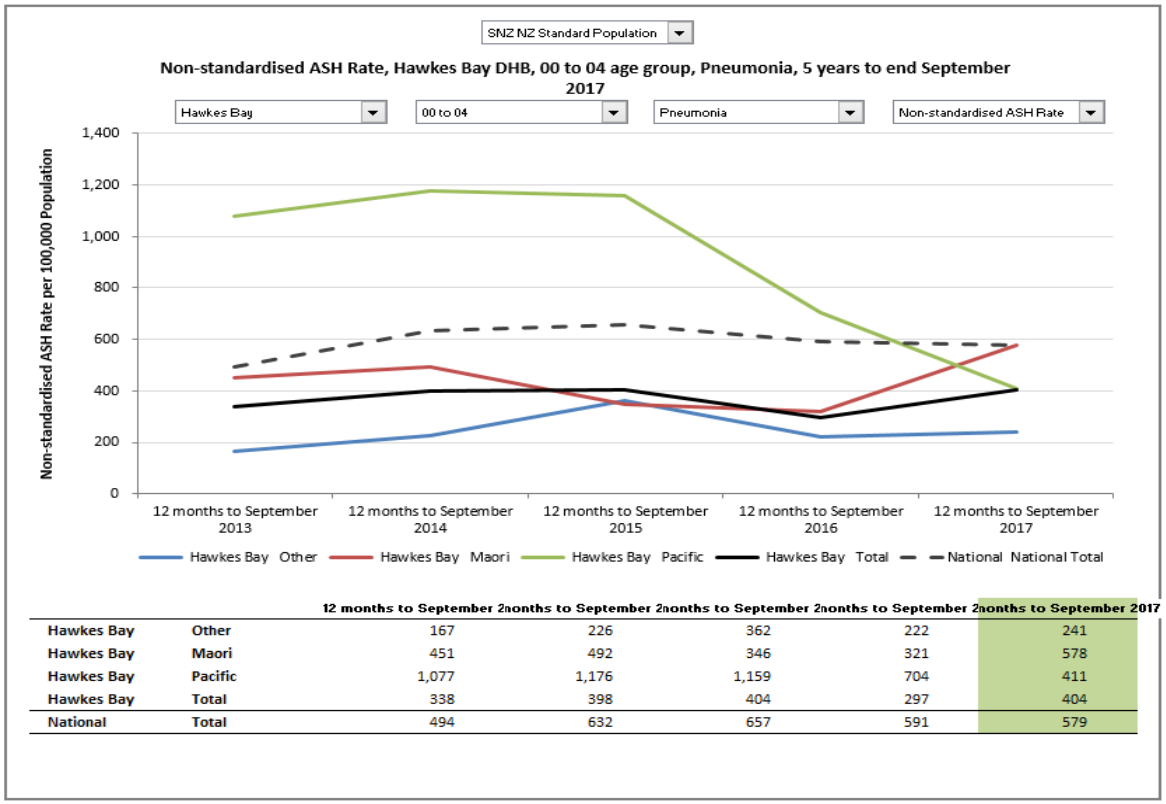
In 2017 one of the largest differences between Hawke's Bay Māori rates and national rates in the 0-4 year age group is Cellulitus, which is 29% above the nation rate.

Asthma



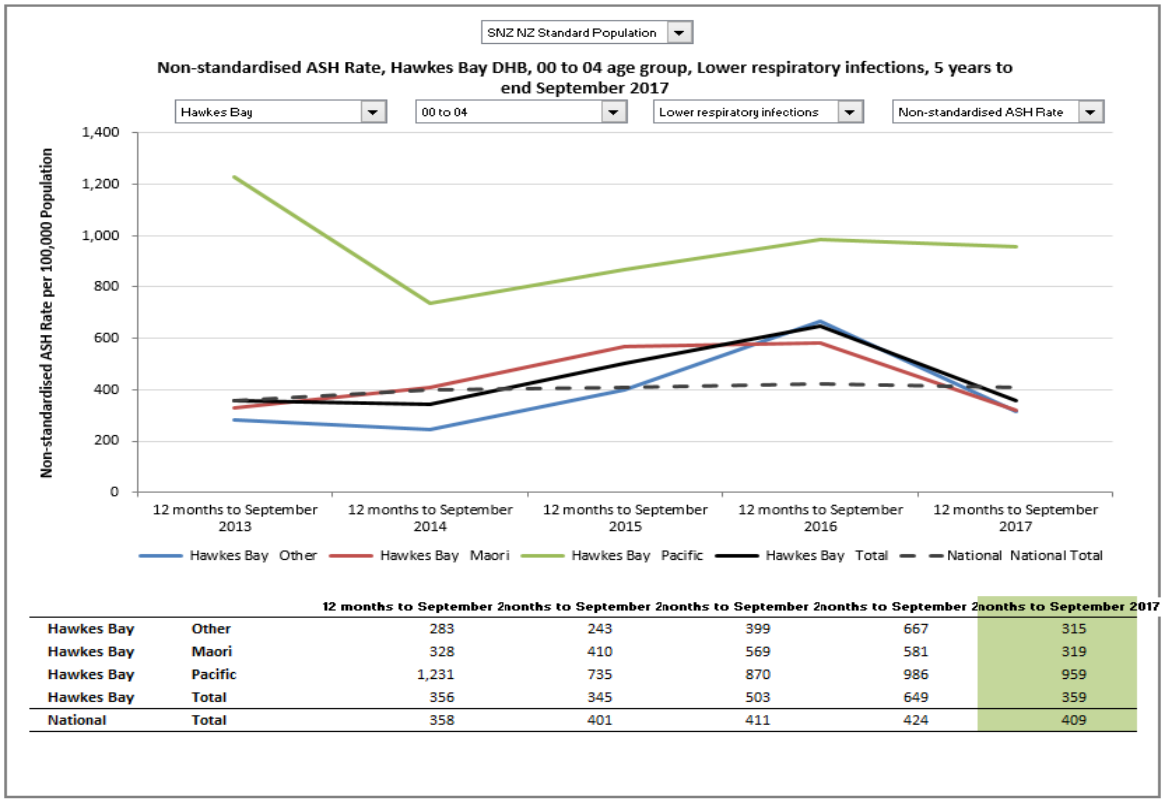
		12 months to September 2	nths to September 2	nths to September 2	nths to September 2	nths to September 2017
Hawkes Bay	Other	433	503	634	870	630
Hawkes Bay	Maori	1,209	1,045	1,179	1,162	1,076
Hawkes Bay	Pacific	2,308	2,500	290	1,408	1,507
Hawkes Bay	Total	867	857	854	1,036	888
National	Total	1,431	1,283	1,371	1,344	1,199

Pneumonia



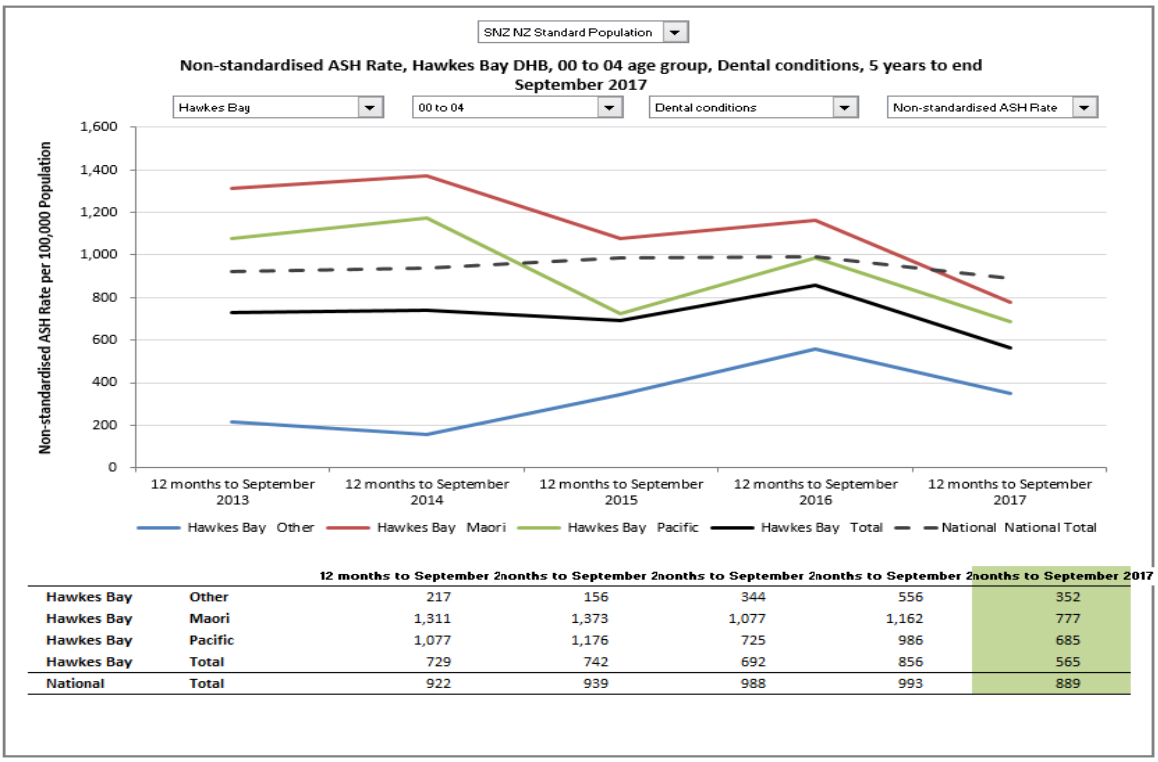
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	167	226	362	222	241
Hawkes Bay	Maori	451	492	346	321	578
Hawkes Bay	Pacific	1,077	1,176	1,159	704	411
Hawkes Bay	Total	338	398	404	297	404
National	Total	494	632	657	591	579

Lower Respiratory Infections



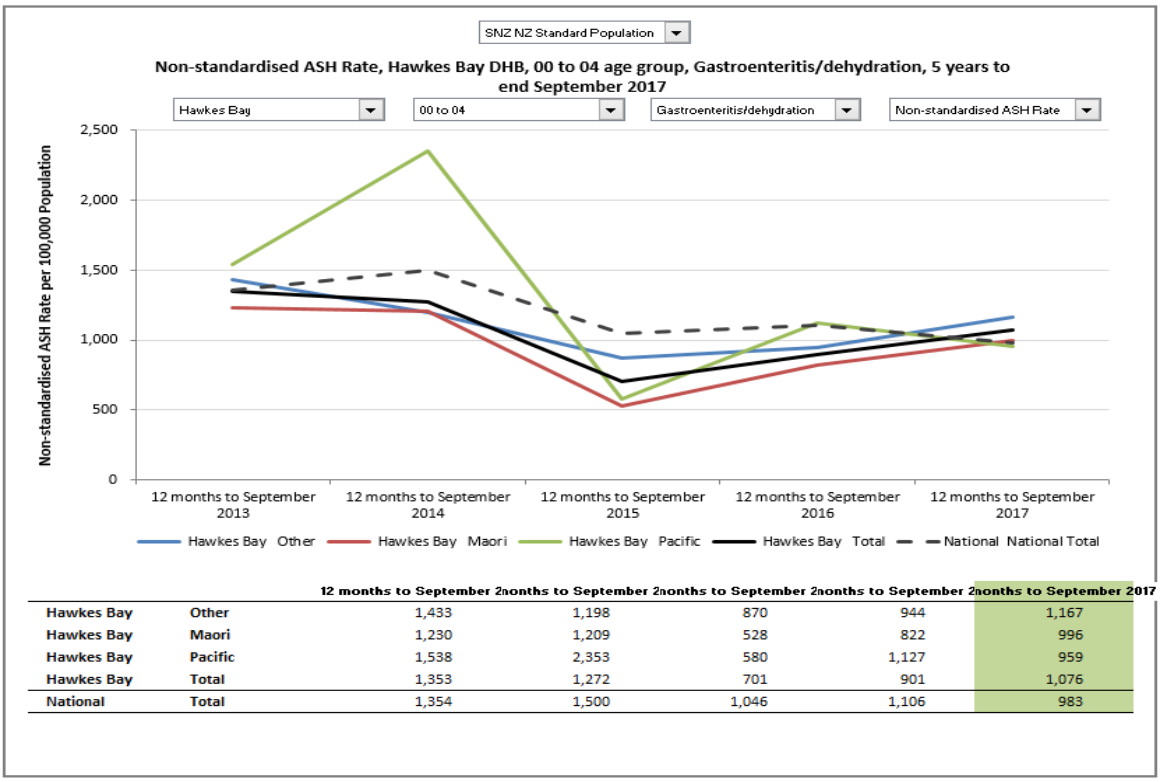
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	283	243	399	667	315
Hawkes Bay	Maori	328	410	569	581	319
Hawkes Bay	Pacific	1,231	735	870	986	959
Hawkes Bay	Total	356	345	503	649	359
National	Total	358	401	411	424	409

Dental



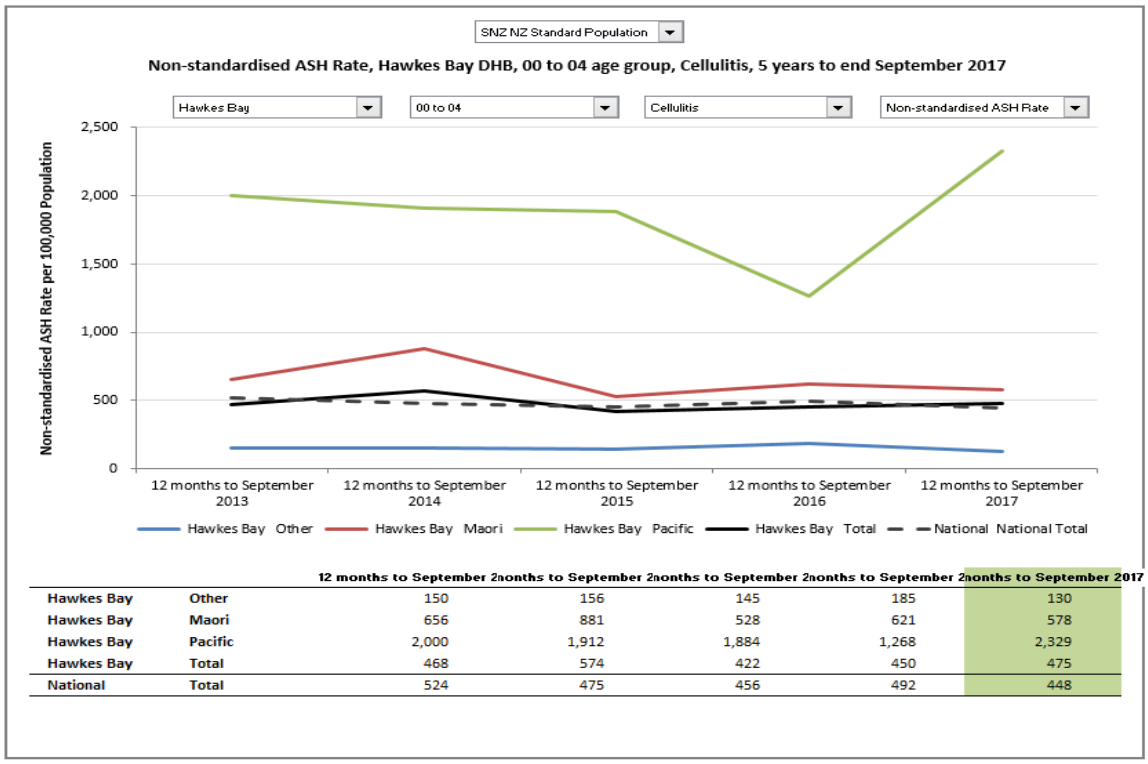
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	217	156	344	556	352
Hawkes Bay	Maori	1,311	1,373	1,077	1,162	777
Hawkes Bay	Pacific	1,077	1,176	725	986	685
Hawkes Bay	Total	729	742	692	856	565
National	Total	922	939	988	993	889

Gastroenteritis/Dehydration



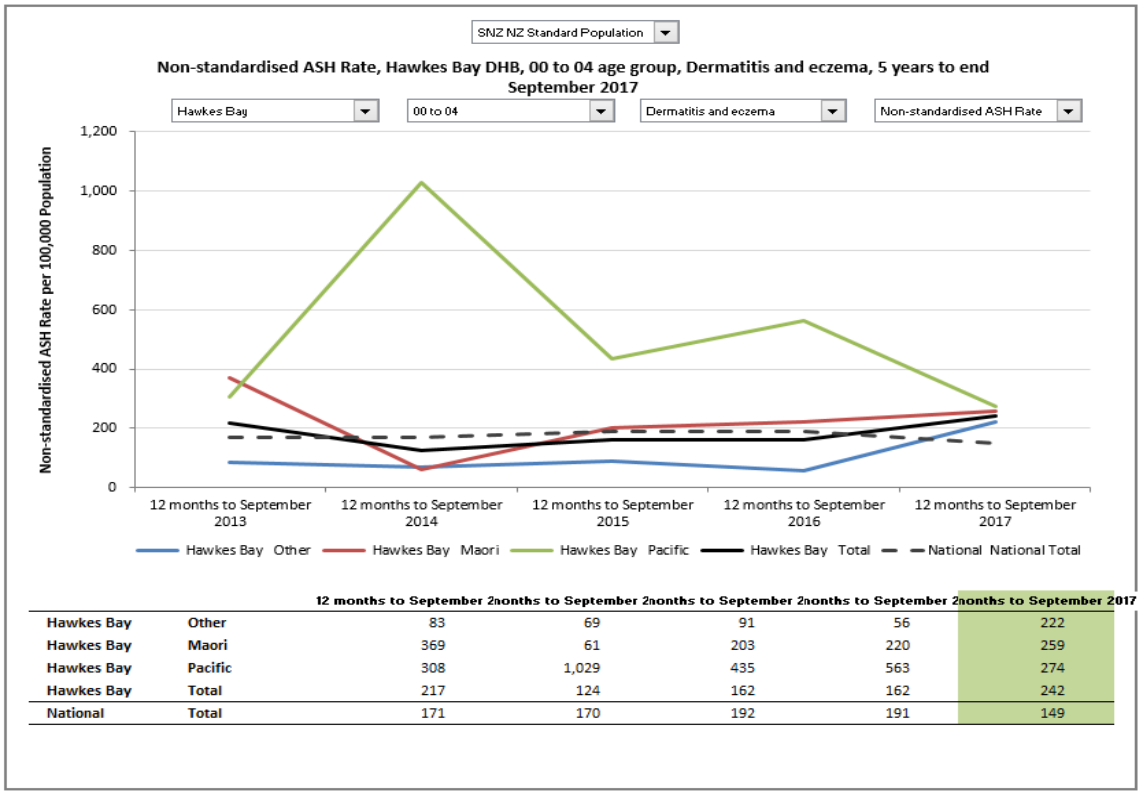
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	1,433	1,198	870	944	1,167
Hawkes Bay	Maori	1,230	1,209	528	822	996
Hawkes Bay	Pacific	1,538	2,353	580	1,127	959
Hawkes Bay	Total	1,353	1,272	701	901	1,076
National	Total	1,354	1,500	1,046	1,106	983

Cellulitis



		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	150	156	145	185	130
Hawkes Bay	Maori	656	881	528	621	578
Hawkes Bay	Pacific	2,000	1,912	1,884	1,268	2,329
Hawkes Bay	Total	468	574	422	450	475
National	Total	524	475	456	492	448

Dermatitis and Eczema



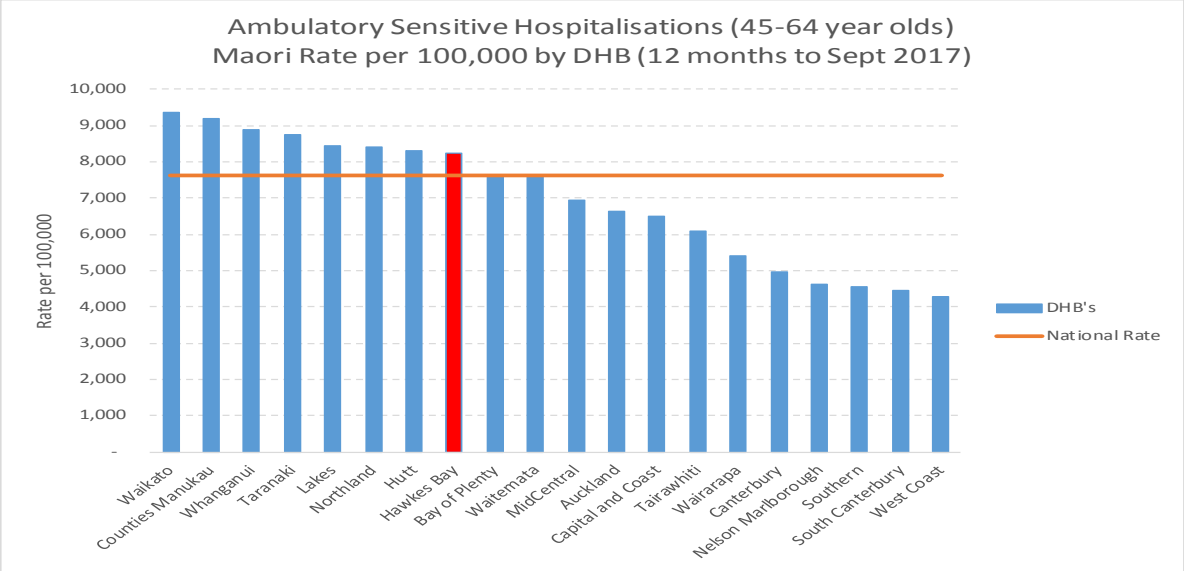
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	83	69	91	56	222
Hawkes Bay	Maori	369	61	203	220	259
Hawkes Bay	Pacific	308	1,029	435	563	274
Hawkes Bay	Total	217	124	162	162	242
National	Total	171	170	192	191	149

ASH RATES 45-64 AGE GROUP

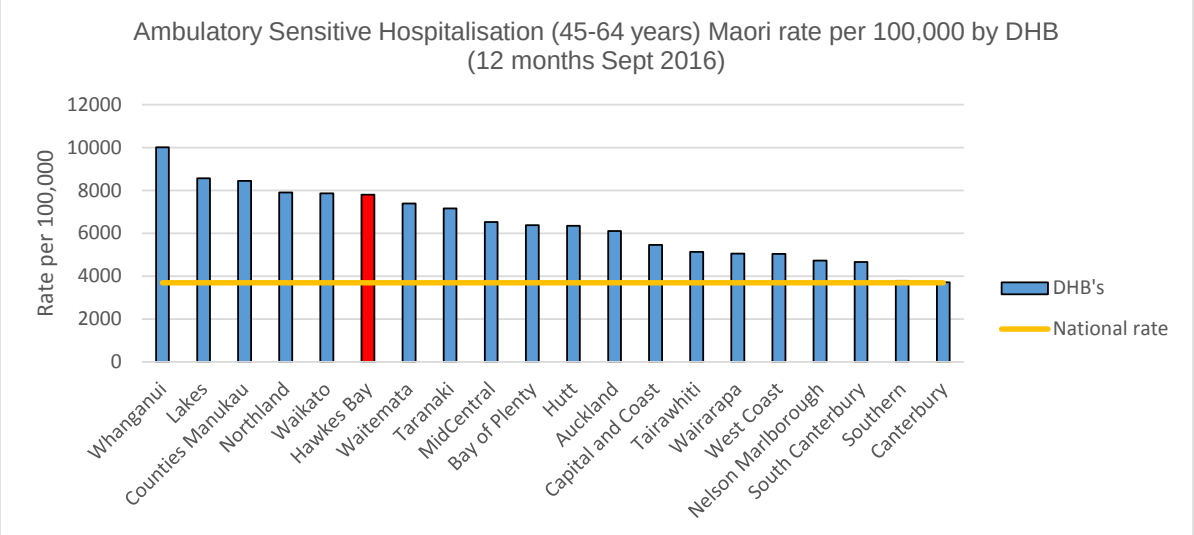
The expectation for ASH 45-64 is that there will be a minimum reduction by half of the equity gap between Māori and national total population base line data over a period of 2.5 years. Within 5% would be considered equity.[3]

Hawke's Bay Distribution and Trends

Hawke's Bay Māori ASH rates 45-64 age group 12 months to Sept 2017 – Benchmark against DHBs



Hawke's Bay Māori ASH rates 45-64 age group 12 months to Sept 2016 – Benchmark against DHBs



There are four notable points illustrated by these two graphs.

1. The National ASH rate has increased from just under 4000 in the 12 months to Sept 2016 to just under 8000 in the 12months to Sept 2017. This is statistically significant.

[3] As indicated by the MoH specifications for ASH rates.

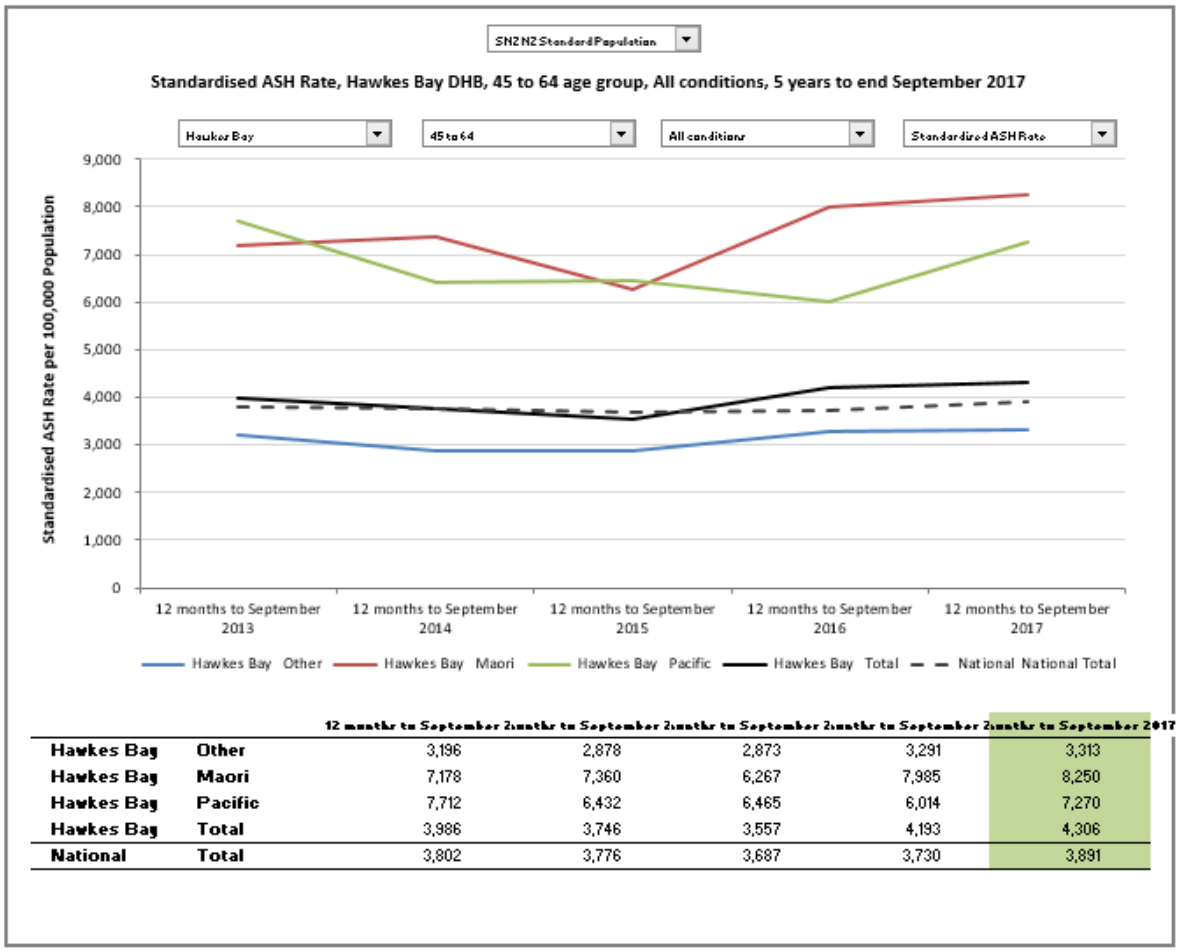
2. HBDHB rates have remained relatively static in the 24 months to Sept 17, at close to 8000.

3. The position of HBDHB has moved from 15thth to 13th position in the national benchmark.

4. All of the above demonstrate that the actions we have taken in the last 24 months have had little impact on our ASH rates. What is also of significance is that the increase in national rates demonstrate that this not peculiar to HB.

The following paragraphs detail what contributes to the ASH rate and findings for each of the top 10 conditions named as follows in order of highest contributor to lowest contributor; angina and chest pain, myocardial infarction, cellulitis, COPD, pneumonia, gastroenteritis-dehydration, kidney-urinary infection, congestive heart failure, stroke, epilepsy.

Hawke's Bay Māori ASH rates 45-64 age group 12 months to Sept 2017 – All conditions (5 Years)



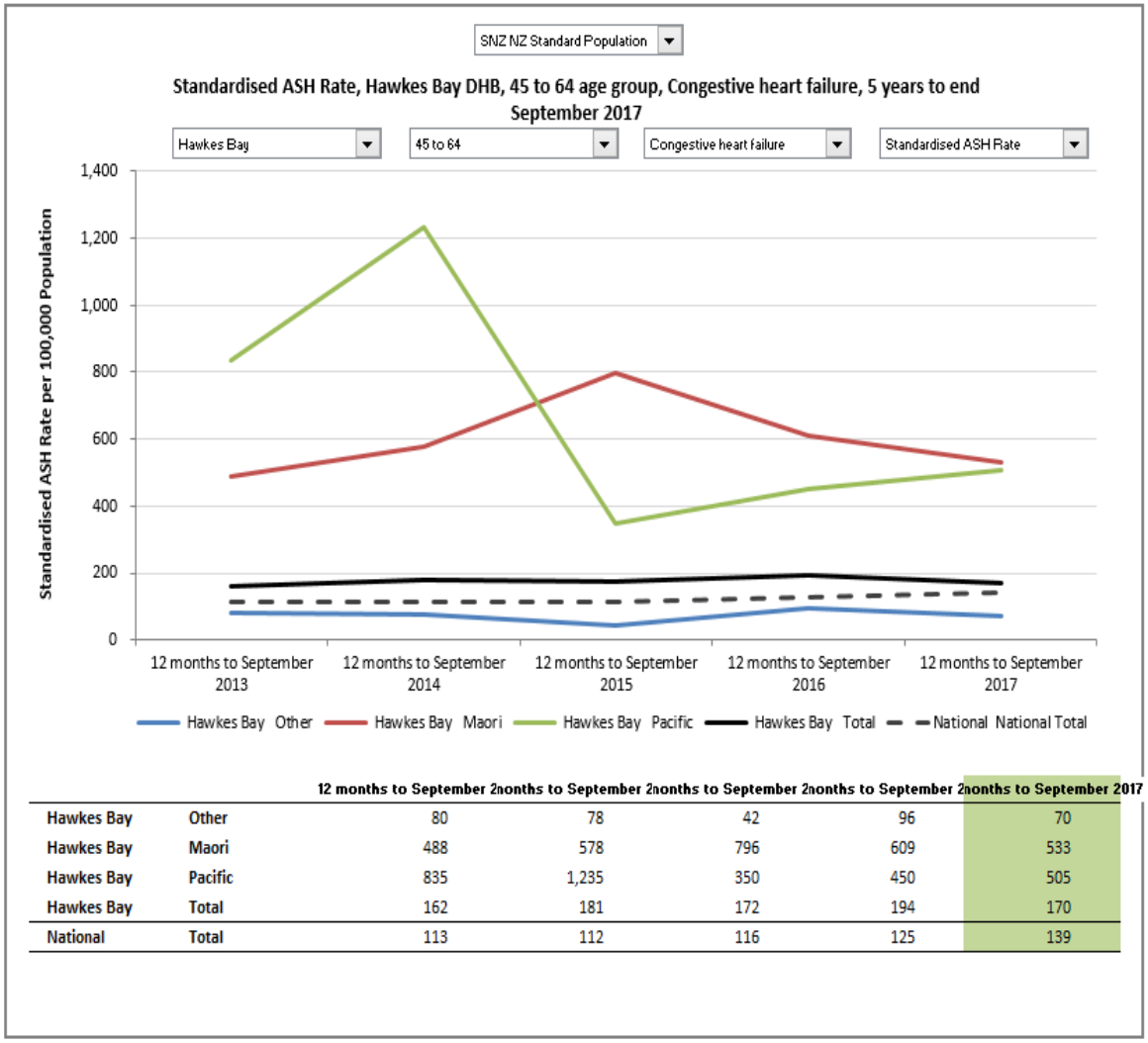
		12 months to September 2013	12 months to September 2014	12 months to September 2015	12 months to September 2016	12 months to September 2017
Hawkes Bay	**Other**	3,196	2,878	2,873	3,291	3,313
Hawkes Bay	**Maori**	7,178	7,360	6,267	7,985	8,250
Hawkes Bay	**Pacific**	7,712	6,432	6,465	6,014	7,270
Hawkes Bay	**Total**	3,986	3,746	3,557	4,193	4,306
National	**Total**	3,802	3,776	3,687	3,730	3,891

In all Top 10 conditions Māori are at least double the rate of other. In some instances e.g. COPD and Congestive Heart Failure, Māori rates are respectively 5 -7 times those of other. This is significant when Māori constitute only 22% of the population of HB. The gap in equity between Māori and Other in HB for ASH rates has increased from 4,694 per 100,000 to 4,937 per 100,000, an increase of 5.1%

Hawke's Bay DHB 45-64 ASH Rates 12 months to Sept 2017

ASH 45-64 Conditions – Contributing to Top 10 Conditions

Congestive Heart Failure



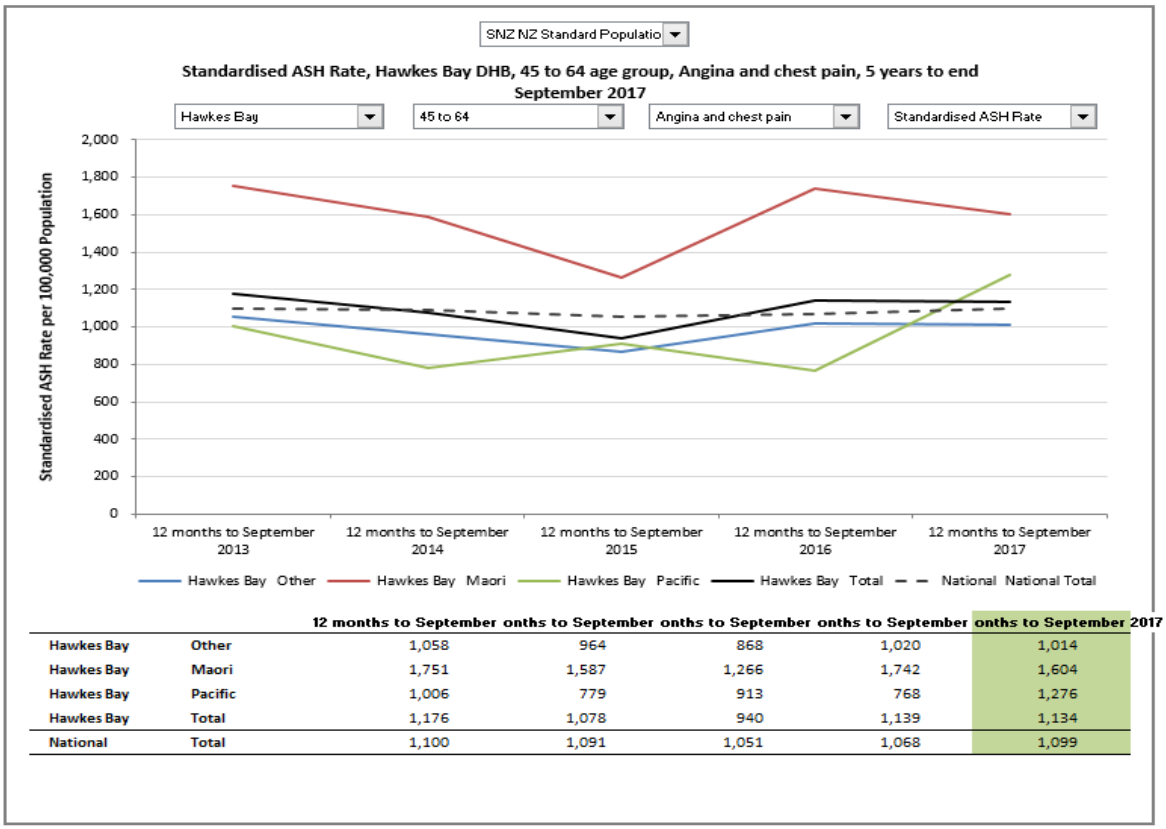
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	80	78	42	96	70
Hawkes Bay	Maori	488	578	796	609	533
Hawkes Bay	Pacific	835	1,235	350	450	505
Hawkes Bay	Total	162	181	172	194	170
National	Total	113	112	116	125	139

In the previous report CHF was ranked 5th out of all conditions contributing to ASH rates for this age group. It is now 8th in the top 10.

Table 1.0 – ASH events 45-64 Congestive Heart Failure

		12 months to September	onths to September	onths to September	onths to September	onths to September 2017
Hawkes Bay	Other	29	28	15	36	26
Hawkes Bay	Maori	35	42	59	48	43
Hawkes Bay	Pacific	7	10	3	4	6
Hawkes Bay	Total	71	80	77	88	75
National	Total	-	-	-	-	-

Angina and Chest Pain



		12 months to September	onths to September	onths to September	onths to September	onths to September 2017
Hawkes Bay	Other	1,058	964	868	1,020	1,014
Hawkes Bay	Maori	1,751	1,587	1,266	1,742	1,604
Hawkes Bay	Pacific	1,006	779	913	768	1,276
Hawkes Bay	Total	1,176	1,078	940	1,139	1,134
National	Total	1,100	1,091	1,051	1,068	1,099

The overall rate for Māori is showing a decline in the 12 month period reported.

Table 1.1 – ASH events 45-64 Angina and Chest Pain

		12 months to September	onths to September	onths to September	onths to September	onths to September 2017
Hawkes Bay	Other	366	335	299	355	351
Hawkes Bay	Maori	129	122	98	136	130
Hawkes Bay	Pacific	9	7	9	9	15
Hawkes Bay	Total	504	464	406	500	496
National	Total	-	-	-	-	-

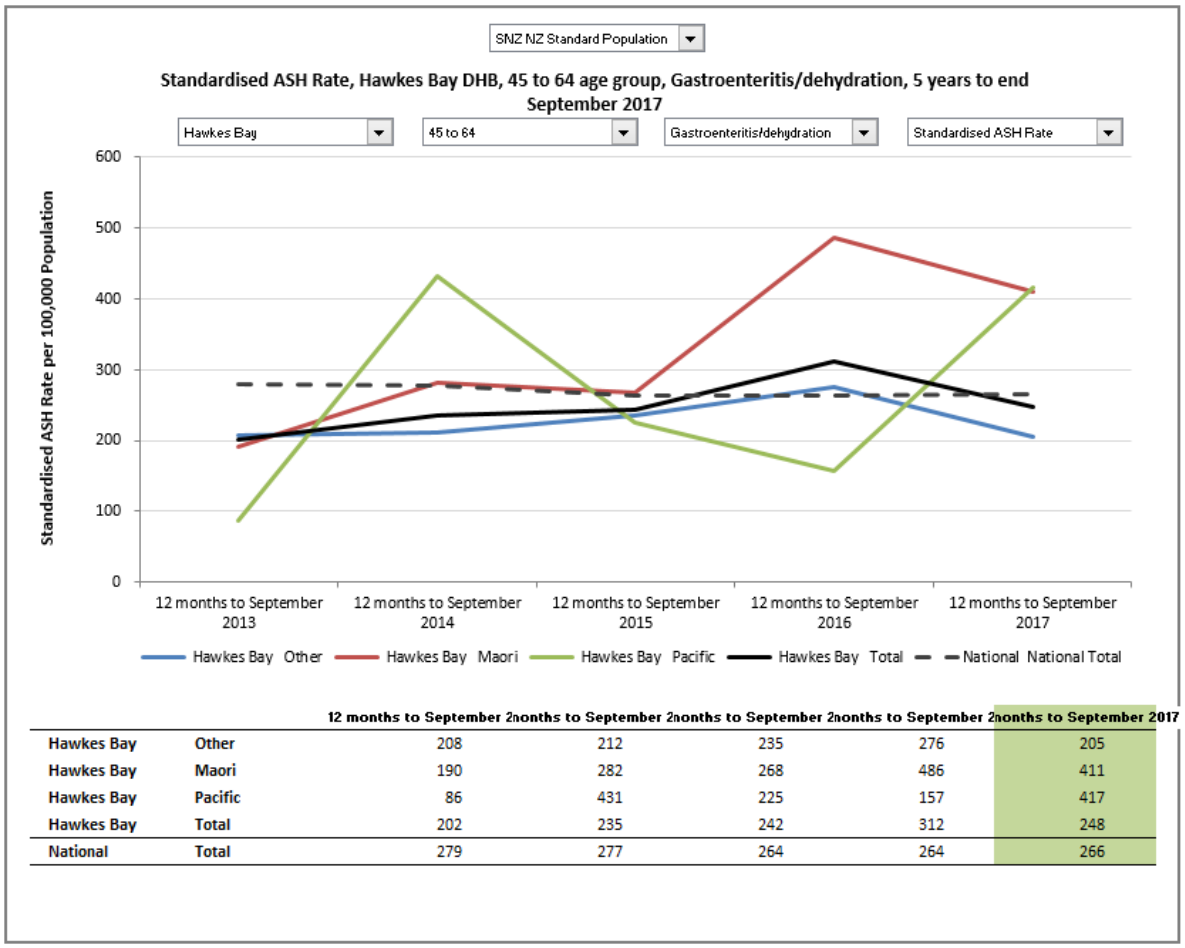
Rheumatic Fever and heart disease

The rate of Rheumatic fever and heart disease is for Māori has also shown a significant drop in the 12 months from Sept 16 to Sept 17 as depicted in table 1.2 below

Table 1.2 – ASH rates 45-64 - Rheumatic Fever

		12 months to September	onths to September	onths to September	onths to September	onths to September 2017
Hawkes Bay	Other	6	3	6	6	
Hawkes Bay	Maori	13	38	37	61	37
Hawkes Bay	Pacific					
Hawkes Bay	Total	7	10	12	17	7
National	Total	7	7	8	7	9

Gastro enteritis/Dehydration



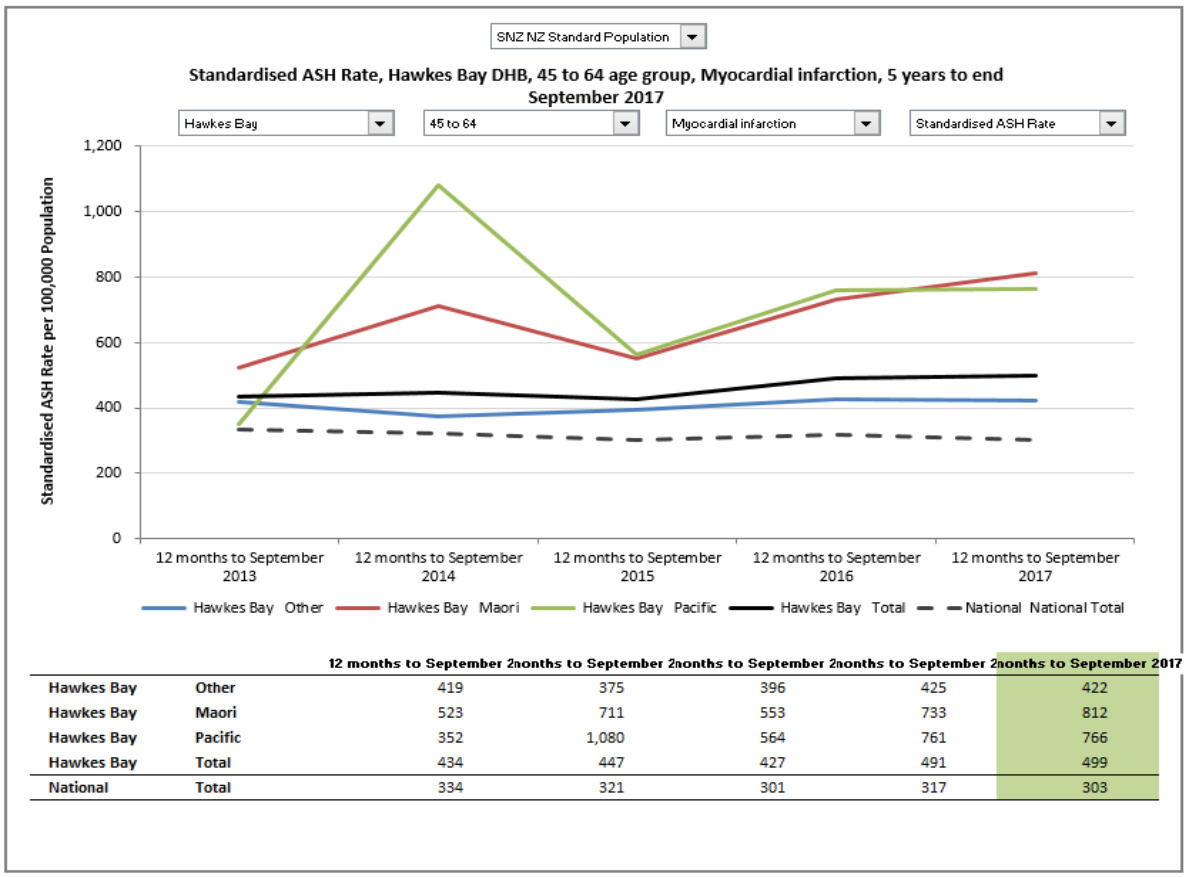
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	208	212	235	276	205
Hawkes Bay	Maori	190	282	268	486	411
Hawkes Bay	Pacific	86	431	225	157	417
Hawkes Bay	Total	202	235	242	312	248
National	Total	279	277	264	264	266

The overall rate has remained reasonably static over time. The rate for Māori is decreasing and the rate for Pasifika showing sharp increase. The pasifika spike can be attributed to the relatively small numbers. The actual events contributing to this statistic - see table 1.0 below.

Table 1.3 – ASH Events 45-64 Gastroentritis/Dehydration

		12 months to September 2	onths to September 2	onths to September 2	onths to September 2	onths to September 2017
Hawkes Bay	Other	72	73	83	96	75
Hawkes Bay	Maori	14	22	21	38	33
Hawkes Bay	Pacific	1	5	2	2	5
Hawkes Bay	Total	87	100	106	136	113
National	Total	-	-	-	-	-

Myocardial Infarction



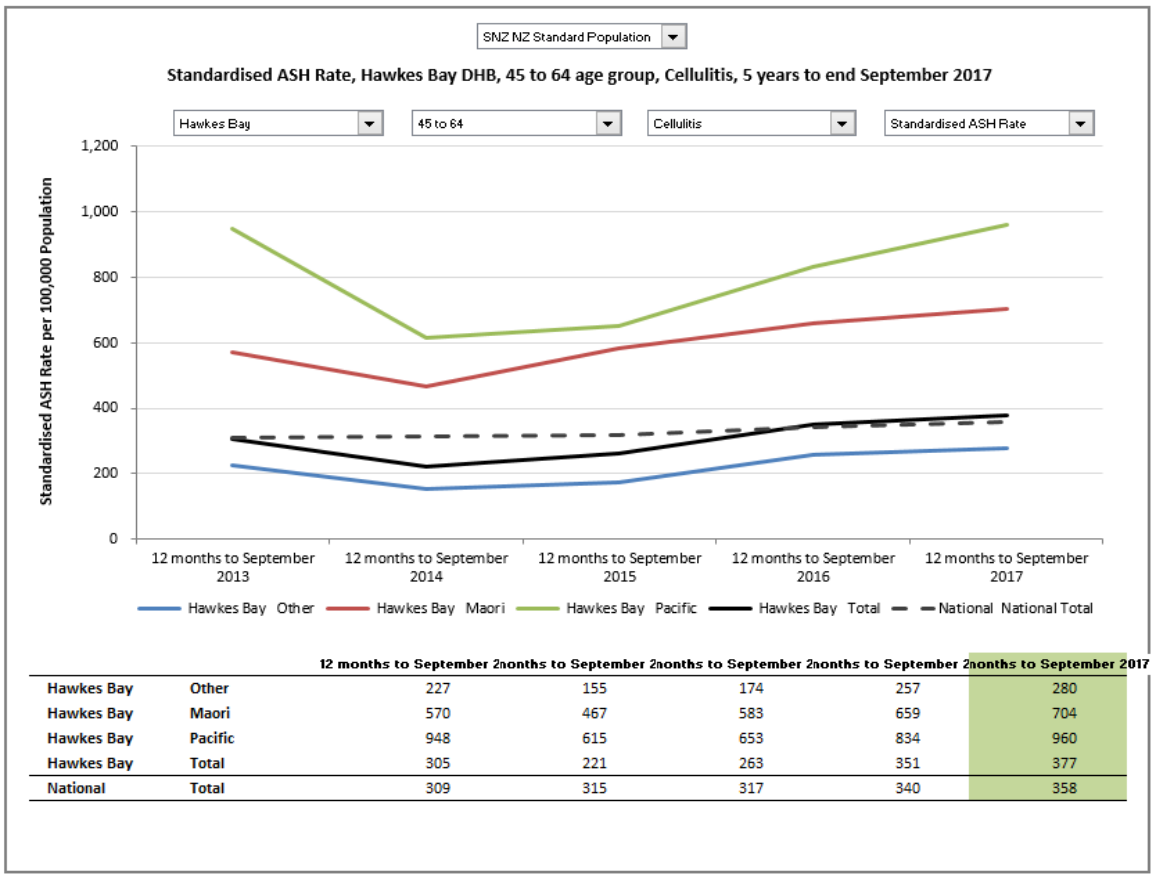
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	419	375	396	425	422
Hawkes Bay	Maori	523	711	553	733	812
Hawkes Bay	Pacific	352	1,080	564	761	766
Hawkes Bay	Total	434	447	427	491	499
National	Total	334	321	301	317	303

The rate for Māori is twice that of Other. The rate for Māori per 100,000 is currently 812 compared with 422 for Other. The equity gap has increased by 26.6%.

Table 1.4 – ASH events 45-64 Myocardial Infarction

		12 months to September	nonths to September	nonths to September	nonths to September	nonths to September 2017
Hawkes Bay	Other	150	133	141	156	151
Hawkes Bay	Maori	37	53	42	57	65
Hawkes Bay	Pacific	3	10	5	8	8
Hawkes Bay	Total	190	196	188	221	224
National	Total	-	-	-	-	-

Cellulitis



		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	227	155	174	257	280
Hawkes Bay	Maori	570	467	583	659	704
Hawkes Bay	Pacific	948	615	653	834	960
Hawkes Bay	Total	305	221	263	351	377
National	Total	309	315	317	340	358

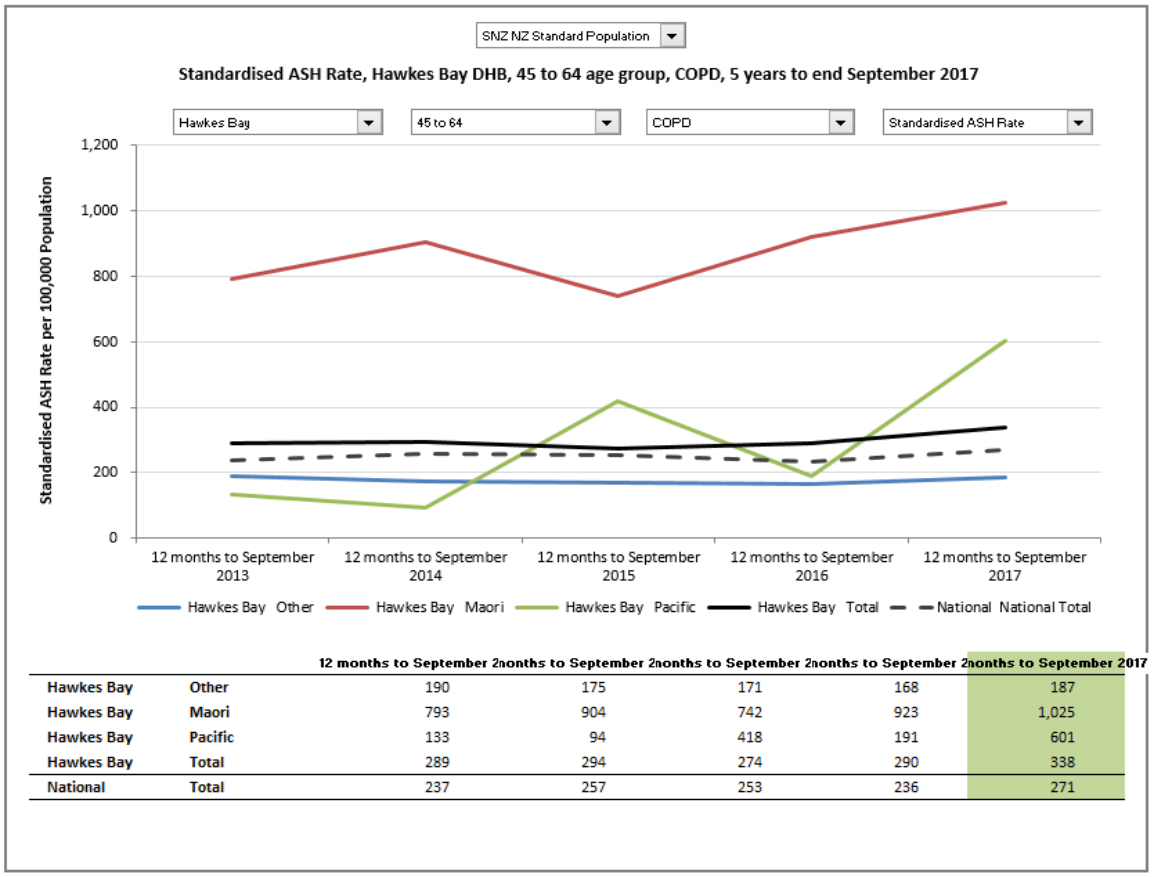
Rate for Māori have increased over the 5 year period. The utilisation rates for the cellulits pathway are showing declines and this is being addressed (see details below pg 18-19). Admissions for rural population occurs where in urban areas patients can be managed from home through the CPO program. The distance that rural patients often need to travel for follow up treatment on consecutive days, can mean that they are admitted.

There was a total of 166 admissions for the 12 month period ending September 2017 which was an increase of 10% over the previous 12 month period.

Table 1. 5 – ASH events 45-64 Cellulitis

		12 months to September 2	onths to September 2	onths to September 2	onths to September 2	onths to September 2017
Hawkes Bay	Other	77	52	61	89	98
Hawkes Bay	Maori	43	36	45	53	57
Hawkes Bay	Pacific	9	6	8	9	11
Hawkes Bay	Total	129	94	114	151	166
National	Total	-	-	-	-	-

COPD



		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	190	175	171	168	187
Hawkes Bay	Maori	793	904	742	923	1,025
Hawkes Bay	Pacific	133	94	418	191	601
Hawkes Bay	Total	289	294	274	290	338
National	Total	237	257	253	236	271

Table 1.6 – ASH events 45-64 COPD

		12 months to September 2	onths to September 2	onths to September 2	onths to September 2	onths to September 2017
Hawkes Bay	Other	68	63	62	60	66
Hawkes Bay	Maori	57	66	56	69	81
Hawkes Bay	Pacific	1	1	4	2	6
Hawkes Bay	Total	126	130	122	131	153
National	Total	-	-	-	-	-

REVIEW OF CURRENT AND PLANNED ACTIVITY RELEVANT TO SUPPORT THESE INDICATORS

0-4 YEAR OLDS

Respiratory care pathways for tamariki 0 – 4 years

In 2017, a review of the ASH 0 – 4 years respiratory care pathway was undertaken to understand more about the interactions and experiences of tamariki and their whānau prior to and after they presented to ED for a respiratory related illness. The review involved a case file audit, an analysis of ASH respiratory data, a review of care pathways and referral processes, and stakeholder and whānau interviews. Three main findings of the review are:

- There is currently no clear respiratory care pathway for tamariki 0 – 4 years.
- There are no specific respiratory care programmes for children currently being delivered in the community
- The majority of tamariki and their whānau received no follow-up in the community post presentation to ED and admission to hospital.

The respiratory working group is undertaking a number of activities to progress actions to address system and service barriers to access to respiratory care for whānau. A child respiratory care pathway, with appropriate processes is being developed for primary and secondary care services. The pathway will better support information flow between services, follow up care in the community by Respiratory Nurse Champions. Paediatric respiratory training for RNCs and wider sector stakeholders took place in December. Future training is planned in 2018, and will include, the findings of the ASH respiratory review, equitable respiratory health outcomes, and health literacy considerations for both practitioners and whānau.

The Working Group is also exploring ways to improve service responsiveness to Pacific and whānau Māori, with a view to undertake a future budget bid process. Breathe HB, who are currently contracted to provide adult respiratory support across Hawkes Bay have been invited to submit a plan about how services can reach tamariki Māori and Pacific at risk of, or with, a chronic respiratory illness. The Working Group will consider this plan on 13 February 2018. Small improvements in processes is already reporting positive results. Changes to the way patient information is managed in secondary care has led to a considerable increase in the number of referrals to the Child Healthy Housing Programme. The Working Group will continue to progress actions from the review over 2018.

Increased immunisation Health Target

The 95% target for all 8-month-old infants is proving an ongoing challenge. Families/whānau seeking information and advice via online sources is delaying parent/caregiver decision making. Some families/whanau will go on to immunise their pēpi/child, but this is occurring outside the ideal timeframes. Despite this dilemma, the most recent quarterly report (October – December 2017) shows equitable coverage for Māori. There is an ongoing focus to ensure a targeted outreach service, provision of alternative venues, and opportunistic immunisations in secondary services. An example of these efforts is a short-term agreement with Kahungunu Executive to intensify immunisation support in rural remote areas. This service will help facilitate timely access to immunisation services through improved follow up of children referred to outreach. To do this a 0.2 FTE support worker will work with primary care practitioners, primary health care workers, family/whānau, and liaise with the outreach team.

Oral Health Initiative

The 'Oral health equity for tamariki 0 – 4 years' project is well underway. This is a five year project from 2016 – 2020. Over the last year, main activities have involved establishing the project, building relationships with key internal and external stakeholders, and identifying priority areas of focus. Good progress has been made in a number of areas including:

- The appointment of a Kaiawhina position within the Community Oral Health Service (COHS). Progress in the first six months shows that as a result of this new position 280 tamariki have been re-engaged with the COHS.
- COHS staff have participated in Relationship Centred Practice training.

- Well Child Tamariki Ora providers have been contracted to provide greater emphasis on oral health at Core Health checks. Funded by Māori Health, this service aims to provide whānau with appropriate oral health information and resources, and where appropriate, facilitate access to COHS appointments.
- A closer collaboration with the Early Childhood Education/Te Kohanga Reo sectors to provide staff and whānau with better oral health information and support
- The initiation of the 'water-for-kids' project which will see the Paediatric ward implementing a fizzy free environment for children in hospital from 1 March 2018.
- The establishment of Te Roopu Matua who provide valuable advice to the project group on Māori oral health perspectives and experiences, and appropriate ways to engage whānau Māori to better meet their oral health needs.
- Working with Health Hawkes Bay to increase the focus on oral health in the Whanau Wellness Programme.
- The completion of a review of the ASH dental care pathway for tamariki 0 – 4 years. The review examines the interactions and experiences of whānau prior to and after their tamaiti/child's GA dental procedure. The final report with recommendations is currently being finalised. Early findings are indicating quality improvements in early engagement, improved wait-times for children, better follow up care and support in the community, and appropriate and responsive information and support for tamariki Māori, Pacific, and children living in deprived areas.

Child Healthy Homes Programme

During 2017, there was a significant increase in referrals to the Child Healthy Housing programme (CCHP), with the greatest percentage of these referrals for whānau Māori and Pacific. The increase in referrals can be attributed to two main factors 1) the expanded criteria relating to Rheumatic Fever prevention and vulnerable children aged 0 – 5 years, which now includes pre-schoolers hospitalised for an indicator condition, at risk pregnant women/new mothers, and priority families with pre-schoolers (who have specified risk factors), and 2) the ASH Respiratory review (August, 2017) which has led to improvements to secondary care processes in discharge plans. As a result, there is better referral information flow from secondary care services to the CHHP, so whānau can be appropriately triaged and contacted to assess eligibility.

To date, a total of 811 referrals have been received since the inception of the CHHP. Whānau have received a total of 3025 interventions to promote warm dry homes and reduce transmissible diseases. These interventions have included, but not limited to, curtains (279 homes), beds (333), WINZ FACE (full and correct entitlement assessments), 160 homes insulted, and 59 families/whānau supported to relocate to warmer, dryer social or private housing. In addition, all families/whānau receive 'key tip' messages regarding sustaining a warm dry home.

Skin Programme

The HBDHB Skin Programme aims to raise awareness of skin problems, provide appropriate resources to families/whānau to care for skin, prevent skin infections and infestations, facilitate access to early treatment, enhance help-seeking behaviour, and reduce stigma and discrimination for tamariki with skin problems. A 2014 audit showed high rates of skin problems among tamariki Māori, and children living in high deprivation areas. Skin infections include, cellulitis, scabies, impetigo, infected dermatitis, and boils. HBDHB has responded with a number of activities to provide better support to tamariki and their whānau. Key activities include:

- Skin Standing Orders for Public Health Nurses and School Based Māori health provider nurses have been developed. However, these orders do not include the provision of medication, and while nurses will encourage whānau to seek help from their primary care practitioner, barriers to access to care may prevent whanau from doing so. Expanding these Standing Orders is being explored, but will require resource of time and workforce development.
- The team has been exploring ways to include early childhood education provider information on the first contact form. Currently the form does not capture this information consistently, and it is not coded. Coding this information would enable the team to identify ECEs and target resources and support accordingly.
- Development of appropriate information, and resources for early childhood education centre (ECE) staff and whānau. These resources include flip charts in te reo Māori, and Pacifica.

Relationships with Te Kohanga Reo have been strengthened, with nurses attending purapura hui, and regular ongoing hui.
- Professional training for ECE, Te Kohanga Reo, and Pacific Kohanga kaimahi at a health day in August 2017.

A survey in 2017 of ECE and Te Kohanga Reo found there is a demand among staff and whanau for more appropriate information and resources to be translated. Another area of focus, and reiterated in the 2017 survey, is the need for more face to face visits to staff and whānau. HBDHB does fund multiple visits during the year to Te Kohanga Reo and some ECE based in quintile 5 communities. However, to deliver appropriate education, key messages, and healthy skin promotion and prevention a more comprehensive approach is required. Funding support in both these areas would assist the team to make further health gain in this area.

ACTIVITY TO ADDRESS 45-64 ASH RATES

1. System Level Measures Improvement Plan

Incorporated into the improvement plan and aligned to the SLM-Reducing hospital Bed Days are the following contributory measures and activities and progress towards achieving them;

- *Increase number of Māori Pasifika and Quintile 5 referred to CPO high needs program.*
  The goal currently is to achieve 350 Māori referrals by year end. Currently not on track. As of Q2 only 59 Māori had been referred. CPO steering and management group meeting to discuss how to increase awareness of the program, the criteria for referral and the demonstration of benefits this program produces.

- *Increase number of referrals into the Hospital Discharge initiative.*
  The gaol of this program is 500 Māori referrals by year end. Currently not on track. As of Q2- only 171 Māori had been referred. As above the steering and management group will be meeting to discuss how to increase utilisation of this program.

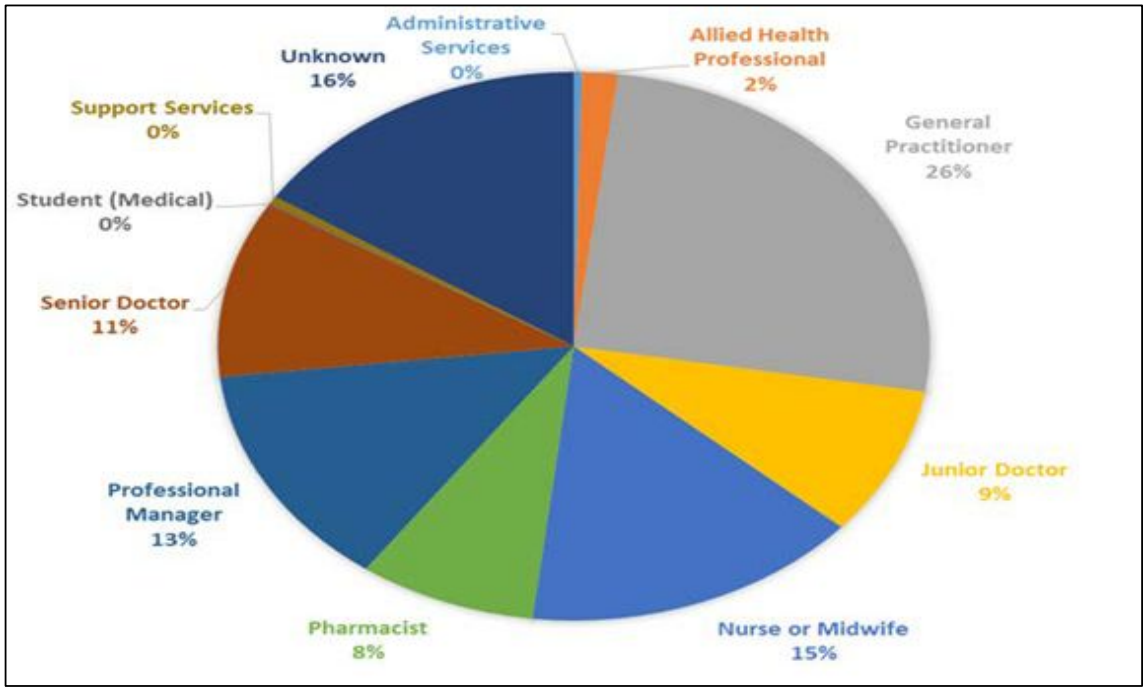
- *Recruit into the position of Nurse Practitioner for Heart Failure with a primary care focus.*
  The appointment process is now completed with preferred candidate being notified. Commencement date TBC. The candidate comes with extensive primary care experience. Recruitment to replace the retiring clinical nurse manager – cardiac has also been completed and again the preferred candidate comes with extensive primary care experience and understanding of integration of services.

- *Develop a program to implement tracer auditing to inform quality improvement (QI) initiatives.*
  The quality advisor team currently offers QI – IHI methodology training across the organisation. A more targeted approach is being implemented in Q3-4 to support the implementation of the Long Term Conditions Framework with a focus on; respiratory / cardiac, renal / diabetes service provision. This will include primary – secondary – pharmacy providers.

2. Collaborative Pathways

The Pathways Program initiated in 2014 as a pilot, with a focus on two interrelated aspects 1) development of pathways and 2) identifying the IT tool best fit for purpose. Pathways have been developed to the extent that we now have 75 pathways being used. The IT tool is under review due to the current vendor exiting the UK market. Work is underway developing a technical options paper with a partnership formed with Central and Midland DHB regions. General Practitioners are the highest users of pathways – see figure 1.0 below

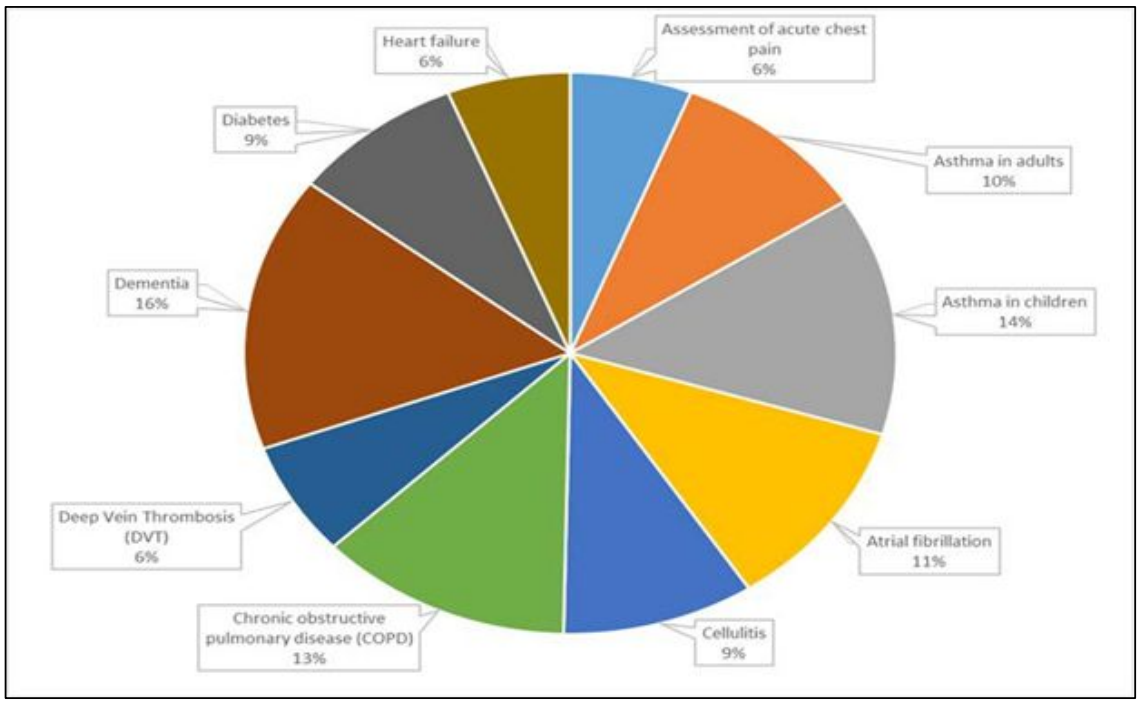
Figure 1.0 – Utilisation of pathways by service provider



Pathways utilised that address the top 5 contributing conditions to HBDHB ASH rates (Adults)

- Cardiac: Heart Failure (6%), Atrial Fibrillation (11%), Assessment of Chest Pain (6%)
- Respiratory: COPD (11%), Asthma in Adults (10%),
- Cellulitis (9%).

Figure 1.2 – Utilisation rates of current pathways



A General Practitioners' point of view (Dr Alan Wright)

Clinical management pathways designed and supported across the whole local health sector are clearly the best way forward to allow timely effective clinical care to be delivered in the best place at the best time. This is what we have been trying to achieve with the Co-ordinated Primary Options (CPO) programme for the last 14 years since its inception. Pathways offers comprehensive understanding of clinical conditions and current "best-practice".

Cardiac Pathways – These pathways are being well used. A program of CME/CNE sessions in 2017 by the Clinical Leads promoted their use and supported follow up within general practice. Visibility of pathways to provider services needs further work outside of ED.

Respiratory Pathways – Partnering with the PHO, Māori and Pacific health teams work is in progress to manage the increases we are seeing in COPD presentations and admissions. (Refer section below – Continuation of the Nurse Led Respiratory Program). Tracer auditing will also form part of this work to map patient journey and experience of care from a quality improvement perspective. This work is being supported by our Quality team.

Cellulitis Pathway – low access to this pathway and increased rates in presentations indicate the need to revisit the pathway as treatment and management changes have been introduced.

Achievements and Challenges: Promotion and socialisation of all pathways is led by a small team who are becoming well known across the health sector. There are now strong links with PHO, Medical Advisors and CMO Primary Care. The team is now proactively approached by clinicians who are seeking pathway development. The challenge now is to provide greater exposure to the use of pathways in multiple provider settings.

3. Continuation of the Nurse Led Respiratory Program

The program contract has now shifted from being outputs to outcomes focused which incurred some time in its development before the contract specifications could be finalised – end of Dec 2017. The contract and program is now ready to progress. In the interim analysis of the data, and meetings with stakeholders and providers has been underway, to determine what is the best targeted approach to address a 24% decrease in the Māori accessing respiratory services.

The team that is involved is cross sector and includes ED, specialist respiratory services and general practice teams using a targeted approach to lists of patients known to general practice and or ED with a respiratory related read code, frequent presentation to ED and or admission. The program team are in the process of identifying target groups and 3 monthly targets performance indicators.

4. Implementation Plan for HBDHB Long Term Conditions Framework

An operational working group has replaced a long term conditions advisory that was formed as it was considered more appropriate to work at this level once the framework was endorsed. The working group is made up of a collective senior group of clinicians (Nursing, Allied Health, PHO and Pharmacist).

The focus of the implementation plan is AKA two of the Long Term Conditions Service Review Matrix - the dimensions of care coordination and transition of care. Areas of focus will be nursing models; Diabetes; 45-65 years COPD patients for Māori; opportunities for improved care coordination for inpatients within secondary services e.g. diabetics-podiatry-vascular; 45-65 years CHF-COPD patients with a focus on Māori, transition of care and discharge processes, and ED high user patient groups.

In addition work is underway with:

- HB Aged Residential Care Educator and linking their educational programmes to dimensions within the LTC Framework and Service Review Matrix

- The PHO Workforce coordinator to include LTC as part of CME/CNE
- Ensuring Clinical Pathway Programme links into System Level Measure activities; and
- Linking with our People and Quality Team to raise the profile of the LTC Framework when educational days on Quality aspects are planned.

RECOMMENDATIONS

	Key Recommendation	Implementation lead	Champion(s)	Time Frame
1.	Clinical pathways become part of business as usual supported by a sustainable funding resource.	Strategic Services Manager Primary Care LTC Portfolio manager	CMO Primary CMO Secondary	Dec 2018
2.	The CPO program be evaluated to inform a strategic approach to the provision of services that; • reflect national guidelines • focus on equity outcomes • use ASH rates as a success indicator and Target the unenrolled population through a range of mechanisms and programs to address unmet need.	Strategic Services Manager Primary Care Innovations and Development Manager - Health Hawke's Bay	GM Health Hawke's Bay GM Māori Health Ex. Dir. Primary Care	Dec 2018
3.	In relation to Cardiac / Respiratory & Renal / Diabetes Service plans include; • workforce development • care coordination • transition of care assessed against the LTC Service Review Matrix[4] to demonstrate progress to towards improved outcomes	Head of Planning Strategic Services Manager Primary Care LTC Portfolio Manager	Directorate Leads Chief Nursing and Midwifery Officer	Dec 2018
4.	Enhance use of CNS / NP in specific LTC, evidenced by the outcomes achieved to date by Diabetes and Respiratory CNS workforce and engagement with primary care	Directorate leads LTC Portfolio Manager	Chief Nursing & Midwifery Officer	On-going
5.	Increase the weighting that is applied to health award applications in relation to equity.	Clinical Council	CEO	July 2018

[4] LTC Service Review Matrix – the evaluation tool designed to assist with implementation of the HBDHB Long Term Conditions Framework

Comments from the Champion for ASH rates – Dr Mark Peterson CMO Primary

The results for the 0-4 age group in the last period have maintained Hawkes Bay as having lower than average rates for other DHBs. While there is still an equity gap for young children it is relatively low and closing.

The ASH rates for respiratory illness (asthma, pneumonia and lower respiratory infection) are all relatively stable and, other than for Pacifica the equity gap is relatively narrow though not closing as we would wish.

For dental admissions there has been a very significant improvement in Māori rates and the gap has closed considerably. This reflects the success of the Oral Health project and the commitment of those working in this field. Further gains are likely to be achieved once water fluoridation is reliably and consistently in place throughout the whole of the region.

The situation with ASH rates for the 45-65 age group is much less encouraging. For the most part ASH rates are not improving and the equity gap is stubbornly wide.

There are some issues with the national date available to us – most particularly I suspect in the benchmarking graphs with other DHBs. It is hard to believe that overall ASH rates have increased by close to 100% in the space of one year.

With the local graphs the Pacifica data is based on very low numbers and consequently the variation is significant between periods. Despite the data issues with the low numbers it is very hard to ignore the wide disparities between Pacific and Māori and Other.

As noted the wider use of Clinical Pathways should lead to better and more consistent care for most of the ASH conditions. Consistent use should also reduce the equity gap such that treatment offered is the same for all ethnicities.

Most of these conditions do not arise de novo at the time of admission. They are the result usually of other conditions such as diabetes, hypertension, smoking, and hyperlipidaemia. This reflects partly on access primary care and to health promotion and health literacy issues and it is clear that these are not equitable and lead on the large equity gaps in the reported rates.

Dr Mark Peterson
Chief Medical Officer - Primary

RECOMMENDATION:

It is recommended that the Māori Relationship Board and/or Pasifika Health Leadership Group; HB Clinical Council, HB Health Consumer Council; HBDHB Board:

1. **Note** the content of the report
2. **Endorse** the recommendations.

Governance Report Overview

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Performance Framework Exceptions Report Quarter 2 2017/18**
	For the attention of: **Māori Relationship Board, Pasifika Health Leadership Group, Clinical and Consumer Council and HBDHB Board**
Document Owner	Tim Evans, Executive Director, Corporate Services
Document Author(s)	Peter Mackenzie, Business Intelligence Analyst
Reviewed by	Executive Management Team
Month/Year	February, 2018
Purpose	Monitoring
Previous Consideration Discussions	N/A
Summary	Areas of Progress: DNA Rates Areas of Focus: Health Target – Shorter Stays in ED, Mental Health – Section 29 Orders, Long Term Conditions – Diabetes Management.
Contribution to Goals and Strategic Implications	Ensuring the DHB meets/improves performance for our Ministry of Health key performance indicators and local measures outlined in the DHB Annual plan.
Impact on Reducing Inequities/Disparities	This report highlights areas of inequity, comments are provided in relation to programs of work that are underway/planned in order to positively affect equity gaps.
Consumer Engagement	N/A
Other Consultation /Involvement	Comments are supplied from various staff members throughout the DHB including service directors or their delegate, program Leaders and the PHO
Financial/Budget Impact	NA
Timing Issues	NA
Announcements/ Communications	NA

RECOMMENDATION:

It is recommended that the Māori Relationship Board, Pasifika Health Leadership Group Clinical & Consumer Council and HBDHB Board:

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

HBDHB PERFORMANCE FRAMEWORK
Quarter 2 2017/18

Author:	Peter Mackenzie
Designation:	Business Intelligence Analyst
Date:	February 2018

OVERVIEW
The purpose of this paper is to provide the Board with exception reporting on the Hawke's Bay District Health Board's performance on the Statement of Intent (SOI) and the District Annual Plan (DAP).

As this report ends 31st December 2017, the results in some instances may vary to those presented in other reports.

BACKGROUND
The National Health Board (NHB) facilitates DHB performance planning and monitoring within the Ministry of Health. DHB non-financial monitoring arrangements operate within wider DHB accountability arrangements including legislative requirements, obligations formalised via Crown Funding Agreements and other contractual requirements, along with formal planning documents agreed with the Minister of Health/Minister of Finance.

ANNUAL PLAN (AP) 2017/2018
The AP is a statutory requirement that includes the key actions and outputs the DHB will deliver in order to meet Government priorities and Health targets. Through the AP, the DHB has formally agreed to deliver on the performance expectations associated with the measures in the NHB-mandated monitoring framework.

STATEMENT OF PERFORMANCE EXPECTATIONS (SPE) 2017/18
The SPE is produced annually within the context of the four-year Statement of Intent (SOI) 2014-18. The SPE informs the House of Representatives of the performance expectations agreed between a Minister and a Crown Entity. Formal agreement is gained annually through the AP process and actual performance is assessed and reported through the audited HBDHB Annual Report.

HAWKE'S BAY DISTRICT HEALTH BOARD (HBDHB) PERFORMANCE FRAMEWORK
The four dimensions of the non-financial monitoring framework, which was developed by the Ministry as a mandatory framework, will reflect DHB's functions as owners, funders and providers of health and disability services.

The 4 dimensions of DHB performance are:

- *Achieving Government's priorities and targets (Policy priorities)*
- *Meeting service coverage requirements and supporting sector inter-connectedness (System Integration)*
- *Providing quality services efficiently (Ownership/Provider Arm)*
- *Purchasing the right mix and level of services within acceptable financial performance (Outputs/service performance)*

MINISTRY OF HEALTH ASSESSMENT CRITERION

Progress towards each target or measure will be assessed using the following criterion:

Rating	Abbrev	Criterion
Outstanding performer/sector leader	O	1. Applied in the fourth quarter only – this rating indicates that the DHB achieved a level of performance considerably better than the agreed DHB and/or sector expectations.
Achieved	A	1. Deliverable demonstrates targets/expectations have been met in full. 2. In the case of deliverables with multiple requirements, all requirements are met. 3. Data, or a report confirming expectations have been met, has been provided through a mechanism outside the Quarterly Reporting process, and the assessor can confirm.
Partially achieved	P	1. Target/expectation not fully met, but the resolution plan satisfies the assessor that the DHB is on to compliance. 2. A deliverable has been received, but some clarification is required. 3. In the case of deliverables with multi-requirements, where all requirements have not been met at least 50% of the requirements have been achieved.
Not achieved	N	1. The deliverable is not met. 2. There is no resolution plan if deliverable indicates non-compliance. 3. A resolution plan is included, but it is significantly deficient. 4. A report is provided, but it does not answer the criteria of the performance indicator. 5. There are significant gaps in delivery. 6. It cannot be confirmed that data or a report has been provided through channels other than the quarterly process.

KEY FOR DETAILED REPORT

Baseline	Latest available data for planning purpose
Target 2017/18	Target 2017/18
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

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PERFORMANCE HIGHLIGHTS – TOTAL POPULATION

Achievements

- Health Targets – The DHB has remained favourable for the Raising Healthy Kids measure with a Total Rate of 98%, Maori at 97% and Pacific at 100% against a target of 95%.

- Health Target – For Better help to quit smoking in Primary Care we have achieved a total result of 90.9%. We have also seen slight increases in the rate for Maori 88.5% and Pacific 88.8% against the target of 90% (page 12).

- DNA – Overall we have favourably remained at 5.2% which is below the target of 7.5%.

Areas of Progress

- Health Target – For Better help to quit smoking in Primary Care we have seen slight increase in the rate for Maori 88.5% and Pacific 88.8% against the target of 90% (page 12).

- Cervical Screening – We have seen slight increases for the total population, Maori and Pacific ethnicities. The total population result is 77% against a target of 80% (page 17)

Areas of Focus

We continue to focus our efforts in order to make gains with particular emphasis in the following areas:

- Health Target – Shorter Stays in ED is currently at 92.2% against a target of 95% (page 8)

- Immunisation at 4 years – The rate for total has dropped 2.9% and currently sits at 91.3% against a target of 95%, there have also been decrease for Maori by 6% and Pacific 10.2%. (page 14)

- Diabetes Management (HbA1c equal to or less than 64mmols) – The result for the total population is currently 43% against a target of 55%. (page 20)

- Pregnant Women Registered with an LMC by week 12 – There has been a decrease in all ethnicities for Q2 compared with Q1 and the current result for the total population is 57.9% against a target of 80%. The result for Maori is 50% and Pacific 35.3% highlighting inequity. (page 19)

PERFORMANCE HIGHLIGHTS – EQUITY

Achievements

- Immunisation of 2 year olds – The Maori rate is currently 96% and the Pacific rate is 97%, both are similar to the Total rate of 96%.

- Health Targets – The Maori is currently 97% and Pacific at 100% against a target of 95%. They are similar to the Total Rate of 98%

- Better Access to diagnostic service – The rate for Maori accepted for an urgent diagnostic colonoscopy receiving their procedure within two weeks is currently 100%, the rate for Pacific is 100% and the total rate is 94% against a target of 90%

Areas of Progress

- DNA – Both the Maori and Pacific rates of DNA have declined over the Q2 period which is pleasing to see. The Maori declined by 1.4% in Q2 and now sits at 9.1%, the Pacific rate has declined by 1% and now sit at 10.4% against a target of 7.5%.

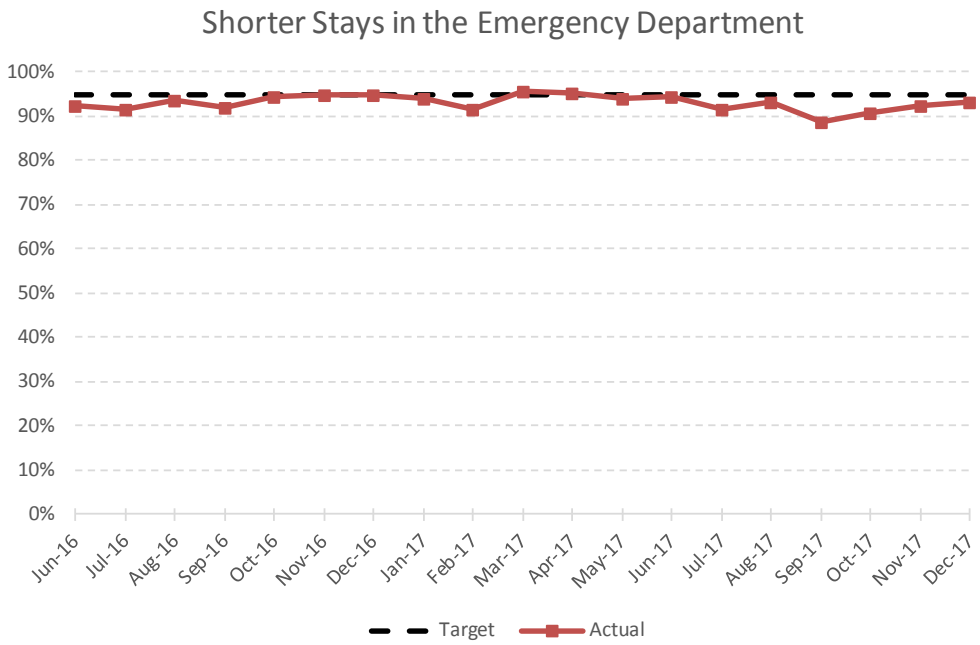
Areas of Focus

- Rate of Section 29 orders per 100,000 population – Maori Rates are currently 384 per 100,000 against the target of <81.5 and are 3 times higher than the non-Maori Rate (page 33)

HEALTH TARGETS

Health Target: Shorter stays in emergency departments
95% of all people attending the Emergency Department will be admitted, transferred or discharged within six hours

Ethnicity	Baseline [1]	Previous result [2]	Actual to Date [3]	Target 2017/18	Trend Direction
Total	94.7%	91.4% (U)	92.2% (U)	≥95%	▲
Maori	94.7%	93.8% (U)	93.5% (U)	≥95%	▼
Pacific	95.7%	95% (F)	94.1% (U)	≥95%	▼
Other	96.5%	89.8% (U)	91.3% (U)	≥95%	▲



Comments:
Several initiatives that have been introduced during the quarter include flexible opening of 10 bed inpatient ward to support periods of high demand, particularly surgical patients. Limited trial of senior nurse after hours (Mon-Fri) in AAU to provide leadership and facilitate pulling medically referred patients from ED to improve patient flow. Implementation of Primary Care model changes to Urgent Care with Registered Nurse resource being supported by St John Paramedic responder and from mid-December ED has increased the number of ED registrars to enhance leave cover and permit consistent rostered numbers across 7 days. During future months we going to increase nursing FTE as identified by CCDM programme, improving nurse: patient ratio, workload allocation and after hour's patient management. We will also ensure completion of PHO/ ED joint program (2 year duration) providing shared plans of care for patients who have high ED presentations.

1 October to December 2016
2 July to September 2017
3 October to December 2017

Health Target: Improved access to elective surgery (discharges)				
Key Performance Measures	Baseline [4]	Actual to Date [5]	Period Target	Target 2017/18 [6]
Elective Surgery				
*Data has not been supplied by the ministry yet. Data and chart will be added in time for the board report				
Comments:				

4 2015/16 target

5 July 2016 to June 2017 Source: Ministry of Health

6 July 2017 to September 2017 Source: Ministry of Health

Health Target: Faster Cancer Treatment – patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer					
Key Performance Measures	Baseline [7]	Previous result [8]	Actual to Date [9]	Target 2017/18	Trend direction
Total					
Maori					
Pacific					
Other					
*Data has not been supplied by the ministry yet. Data and chart will be added in time for the board report					

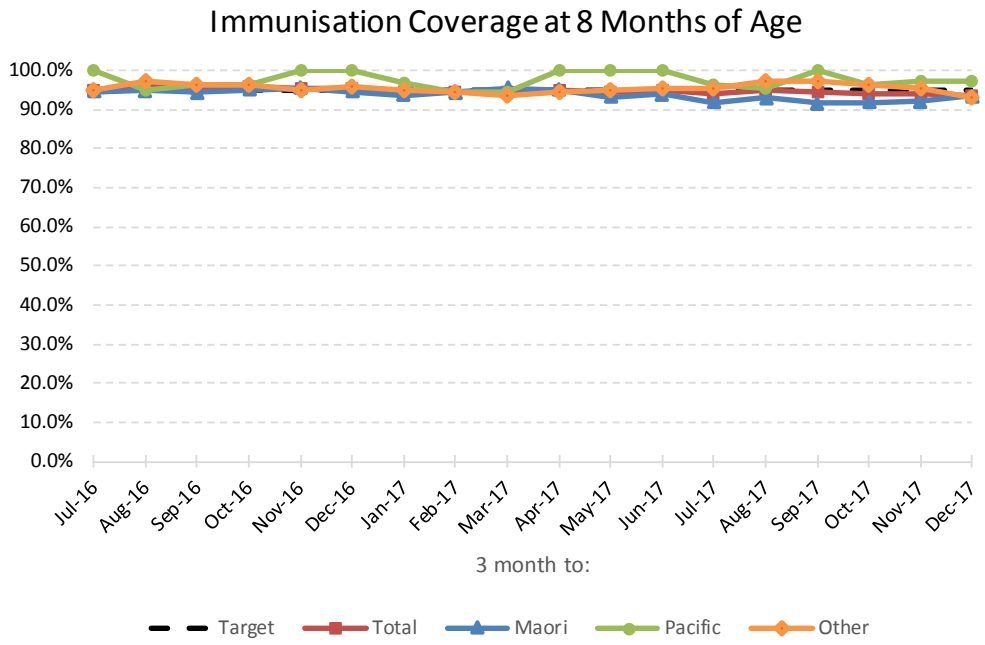
7 6 months to December 2016

8 6 months to June 2017

9 6 months to September 2017

Health Target: Increased immunisation
% of 2 year olds fully immunised

Ethnicity	Baseline [10]	Previous result [11]	Actual to Date [12]	Target 2017/18	Trend direction
Total	95.3%	94.5% (F)	93.6% (U)	≥95%	▼
Māori	94.4%	91.5% (U)	93.4% (U)	≥95%	▲
Pacific	100.0%	100% (F)	97.1% (F)	≥95%	▼
Other	95.9%	97% (F)	93.3% (U)	≥95%	▼



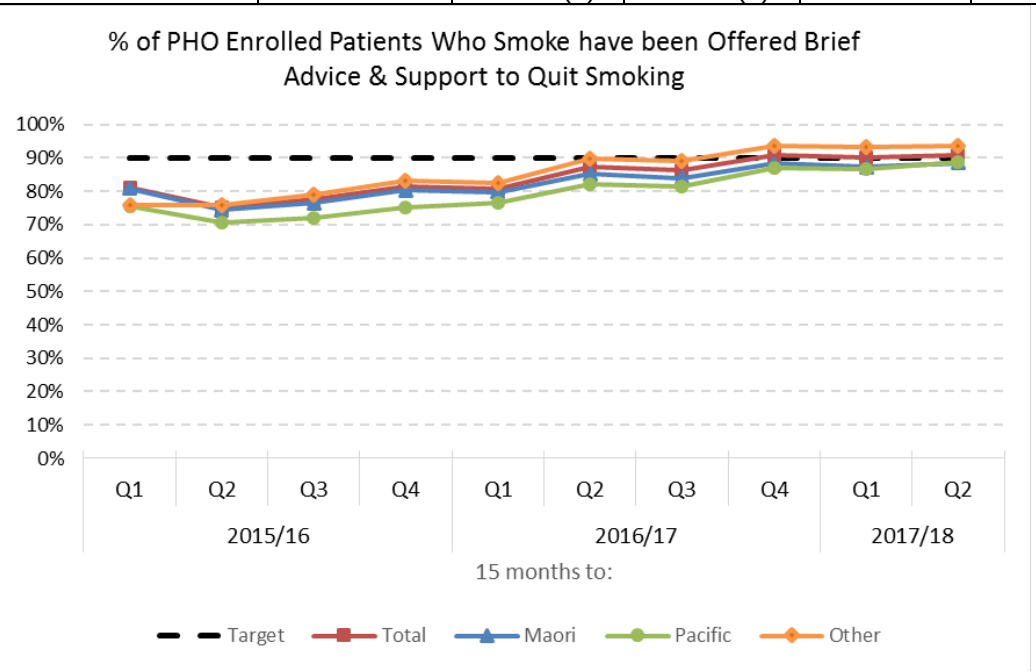
Data Source: National Immunisation Register

Comments:
HB is continuing to struggle to reach the 95% target for our 8 month infants however we are heartened to see that although the overall rate is down the coverage for Maori is equitable this quarter. We continue to have hesitant whanau that have been online and although some of these families do return to having their infants immunised there is often a delay so the timeframe is outside what is recommended. In December we have entered into an agreement with the Kahungunu Executive for whanau in Wairoa to have timelier follow ups when their children are referred to outreach to see if this supports the community in this rural remote area better. This agreement is in place until June 30th 2018. They have a support worker committing 1 day per fortnight to visit and improve access to primary care, answer questions, liaise with the outreach team etc.

10 October to December 2016. Source: National Immunisation Register, MOH
11 July to September 2017. Source: National Immunisation Register, MOH
12 October to December 2017. Source: National Immunisation Register, MOH

Health Target: Better help for smokers to quit – Primary Care
% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months

Key Performance Measures	Baseline [13]	Previous result [14]	Actual to Date [15]	Target 2017/18	Trend direction
Total	87.4%	90.2% (F)	90.9% (F)	≥90%	▲
Māori	85.1%	87.3% (U)	88.5% (U)	≥90%	▲
Pacific	82.2%	86.8% (U)	88.8% (U)	≥90%	▲
Other	89.9%	93.1% (F)	93.6% (F)	≥90%	▲



Source: PHO

Comments:
Activities aimed at further improving the results for quarter 2 include ensuring Smoke-free communication to practices is directed to the Practice Manager & Clinical Nurse Manager unless there is an active Smoke-free Champion within the practice. Health Hawke's Bay continues to fund the Patient Dashboard so practices can see at a glance if the presenting patient has an up-to-date smoking status and has been offered smoking brief advice and cessation support in the past 15 months. Health Hawke's Bay also funds Karo Data Management Limited to provide all 25 practices with monthly reports, which are published on or around the 10th of each month. We are also aiming towards 31 May 2018 with HBDHB and Health Hawke's Bay working together to plan local World Smoke-free Day activities.

13 15 months to December 2016. Source: DHB Shared Services
14 15 months to September 2017. Source: DHB Shared Services
15 15 months to December 2017. Source: DHB Shared Services

Health Target: Better help for smokers to quit – Maternity % of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking					
Key Performance Measures	Baseline [16]	Previous result [17]	Actual to Date [18]	Target 2017/18	Trend direction
Total					
Māori					
*Data has not been supplied by the ministry yet. Data and chart will be added in time for the board report					
Comments:					

16 October to December 2016. Source: DHB Shared Services

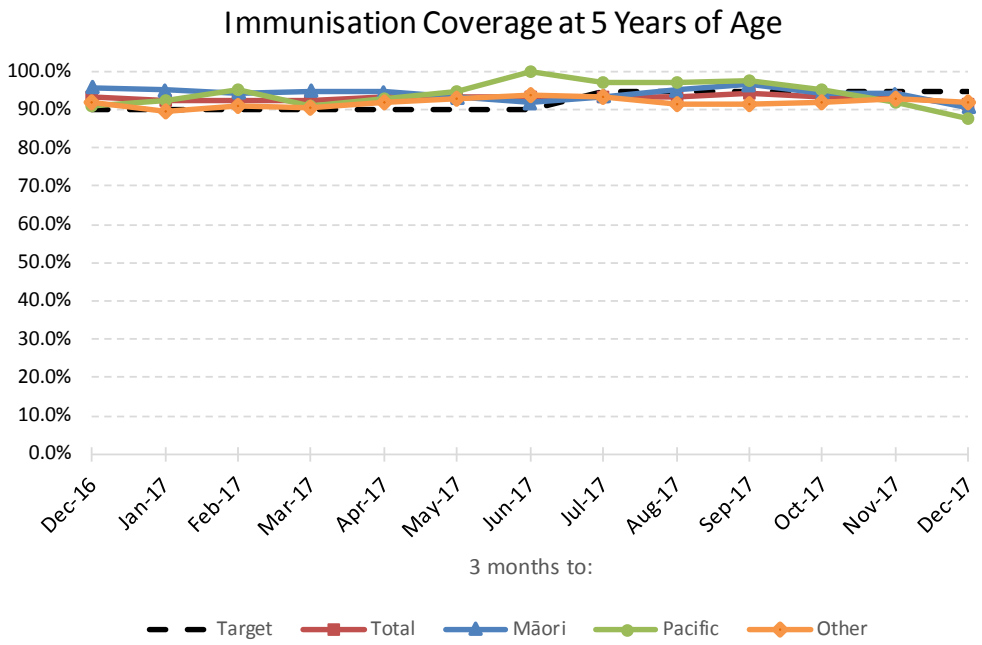
17 April to June 2017. Source: DHB Shared Services

18 July to September 2017. Source: DHB Shared Services

OUTPUT CLASS 1: PREVENTION SERVICES

Increase Immunisation
% of 4 year olds fully immunised

Key Performance Measures	Baseline [19]	Previous result [20]	Actual to Date[21]	Target 2017/18	Trend direction
Total	93.5%	94.2% (U)	91.3% (U)	≥95%	▼
Māori	95.8%	96.7% (F)	90.7% (U)	≥95%	▼
Pacific	91.2%	97.7% (F)	87.5% (U)	≥95%	▼
Other	91.8%	91.6% (U)	92% (U)	≥95%	▲



Data Source: National Immunisation Register

Comments:
We continue to try to capture these children but our resource is stretched and priority goes to the infants and 2 year olds. We struggle to get children coming from overseas with complete schedules from their original country up to date with our schedule particularly for pneumococcal and Hib. These children often come onto our radar later and take a lot of resource both in primary care and outreach. Getting any form of documented immunisation history can be a very time consuming exercise.

19 October to December 2016 . Source: National Immunisation Register, MOH
20 July to September 2017. Source: National Immunisation Register, MOH
21 October to December 2017. Source: National Immunisation Register, MOH

Reduced incidence of first episode Rheumatic Fever Acute rheumatic fever initial hospitalisation rate per 100,000					
Key Performance Measures	Baseline [22]	Previous result [23]	Actual to Date[24]	Target 2017/18	Trend direction
Total	1.9	-	1.9 (U)	≤1.5	*
Māori	7.3	-	4.8 (U)	≤1.5	*
Pacific	0	-	0 (F)	≤1.5	*
Other	1.9	-	1.9 (U)	≤1.5	*
Comments: Awareness raising activities undertaken in the quarter include high levels of ongoing engagement in schools, including updates and contributing to schools newsletters. The Housing Coalition's activities include the launch and delivery of the Ready to Rent programme – which included a comprehensive session on healthy home/rheumatic fever, this programme target those on the Social Housing Register. We continue to raise awareness in all forums we engage with.					

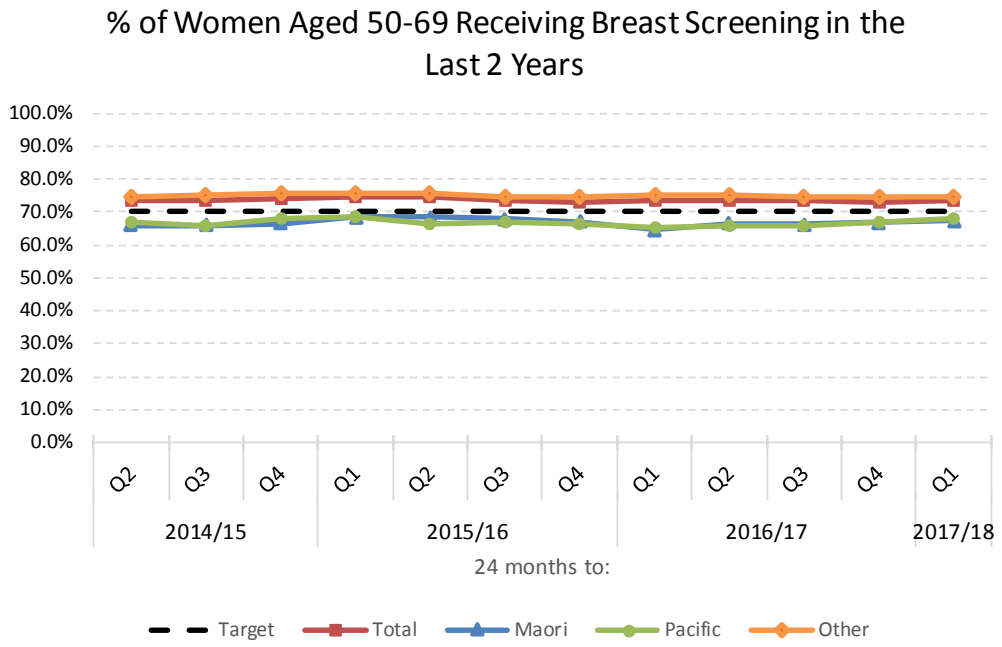
22 July 2015 to June 2016

23 July 2016 to June 2017

24 July 2017 to December 2017(YTD figure)

Improve breast screening rates
% of women aged 50-69 years receiving breast screening in the last 2 years

Key Performance Measures	Baseline [25]	Previous result [26]	Actual to Date[27]	Target 2017/18	Trend direction
Total	73.6%	73.2% (F)	73.4% (F)	≥70%	▲
Māori	64.7%	66.8% (U)	67.4% (U)	≥70%	▲
Pacific	65.4%	66.9% (U)	67.9% (U)	≥70%	▲
Other	75.0%	74.5% (F)	74.6% (F)	≥70%	▲



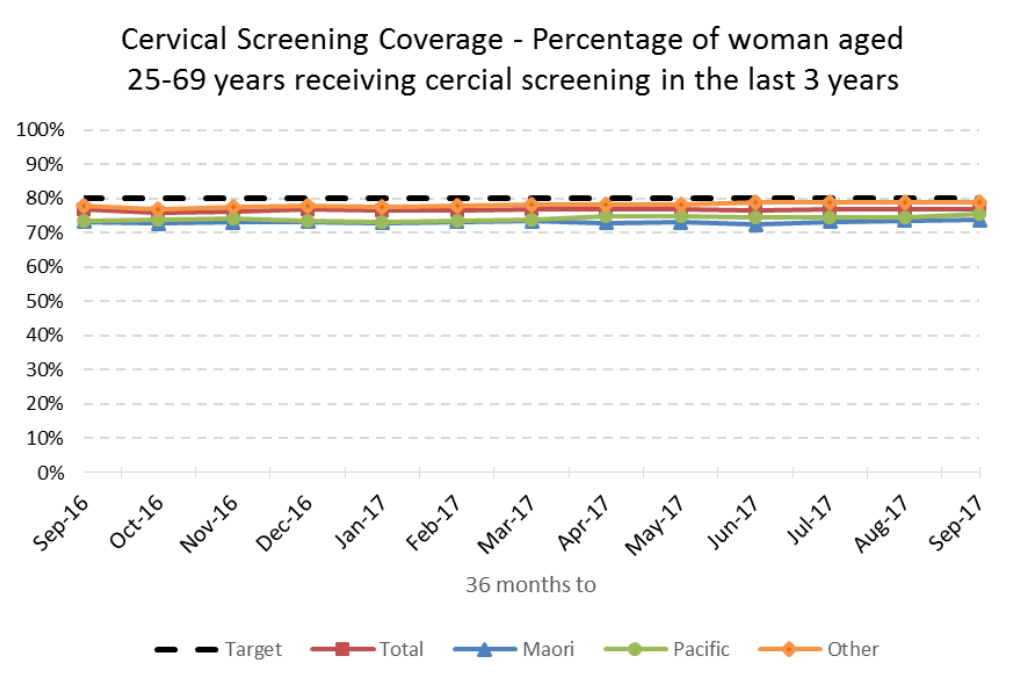
Data Source: BreastScreen Aotearoa

Comments:
The process of contacting BreastScreen Coast to Coast via phone to confirm or rearrange appointments seems to put many women off. Women who have felt discomfort when having had their mammogram talk to others about how it felt, creating a stigma around the process of having a mammogram. Fear of the unknown the result could be cancer, so they will often say they would prefer not to know. In order to improve equity all Hawke's Bay Maori and Pacific women who DNA or do not respond to their appointments for their mammogram are referred to the HBDHB Population Screening team, who then refer women to one of five independent service providers to contact the women and provide support to services, these referral outcomes are monitored every six months. A successful campaign has recently been completed to encourage Maori and Pacific 45-69 who were unenrolled or under screened on the BSA programme, gifting them a $20 Pak n Save gift card on completion of their mammogram. Planning is currently underway for the BSA Mobile visit to Wairoa late January and visit to Central Hawke's Bay in March / April 2018.

25 24 months to December 2016 . Source: National Immunisation Register, MOH
26 24 months to June 2017. Source: National Immunisation Register, MOH
27 24 months to September 2017. Source: National Immunisation Register, MOH

Improve cervical screening rates
% of women aged 25–69 years who have had a cervical screening event in the past 36 months

Key Performance Measures	Baseline [28]	Previous result [29]	Actual to Date[30]	Target 2017/18	Trend direction
Total	76.7%	76.6% (U)	77% (U)	≥80%	▲
Māori	72.8%	72.4% (U)	73.8% (U)	≥80%	▲
Pacific	74.8%	74.4% (U)	75.5% (U)	≥80%	▲
Other	78.9%	78.9% (U)	78.9% (U)	≥80%	—



Data Source: National Cervical Screening Programme

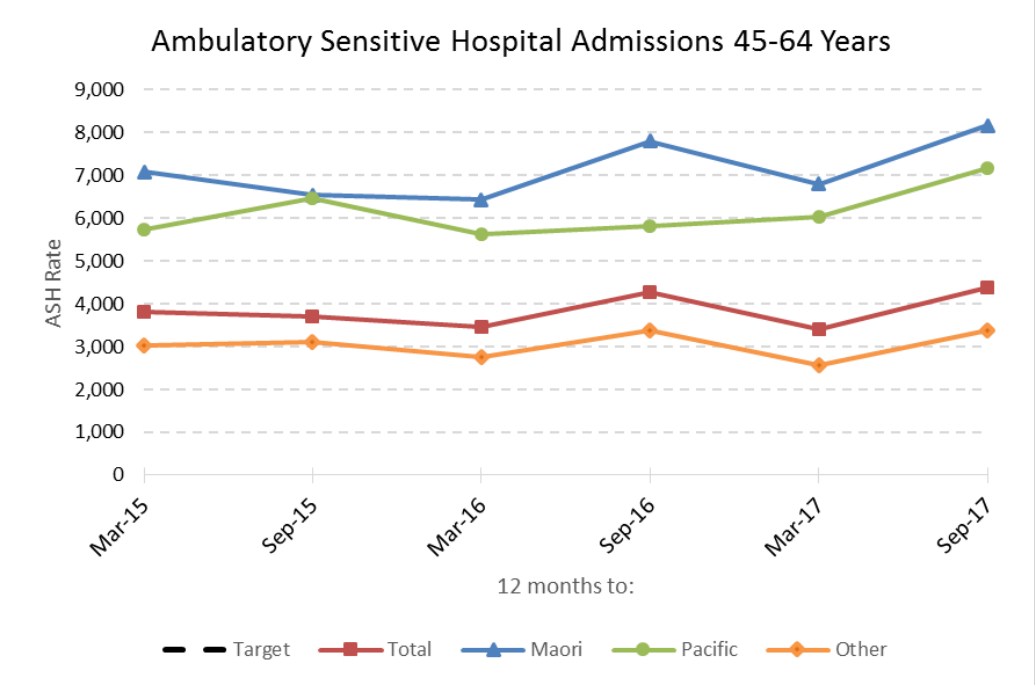
Comments:
Opportunistic smears are to be taken in general practice with more options for women such as after hour's clinics. Some of the barriers to equity include first time women who have never engaged with their GPs and don't know anything about having their smears; they see their doctors as a place to go to only if they are sick. Also not having access to a nurse smeartaker, rather than being told to make another appointment and come back in two or three days because if a woman has decided she will have her smear it is essential that the service is offered 'now'. We are also aware that many women have had a bad experience when having their smear, which causes delays in returning for subsequent smears. In order to improve equity the Pak n Save promotional campaign funded by Health HB, all Maori, Pacific and women living in Quintile 5 will receive a Pak n Save gift card of $20 if they have their smear. HBDHB and Maori Provider Kaiawhina and Pacific community support workers are offering smears to Maori and Pacific women in their homes. Feedback from women who have been screened in their home indicates that it has made a big difference and they wouldn't have had the smear otherwise. Two staff clinics have been held on the Hospital campus, in addition to two clinics per month held at the Napier Health Centre from September to December for Maori and Pacific women.

28 26 months to December 2016
29 36 months to June 2017
30 36 months to September 2017.

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES

Ambulatory sensitive hospitalisation rate per 100,000 45-64 years
Reduce ASH 45-64

Key Performance Measure	Baseline	Previous result [31]	Actual to Date [32]	Target 2017/18	Trend direction
0-4 years: Total	4,129	3,967	4,373	<4,129	▼
0-4 years: Māori	7,636	7,961	8,165	-	▼



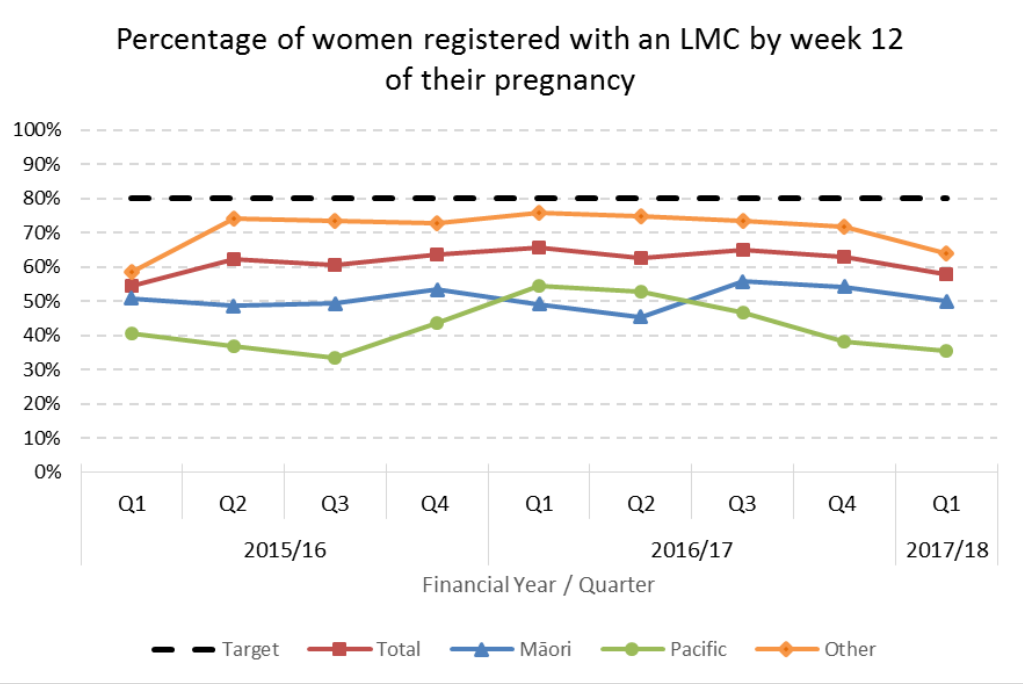
Source: Ministry of Health

Comments:
After looking at the breakdown of the information, Primary Care delivers the CPO Cellulitis pathway for adults, with children not included within this pathway, which may have an effect on the ASH rates for cellulitis. However, within the current diagnosis coding for cellulitis we only include LO3 Cellulitis within the CPO pathway. It appears that in the group of 45-64 there is a reduction in the ASH rate for Māori for cellulitis, whereas the ASH rate is higher for all, though still declining. We will require support from the DHB to understand this further and how we could impact on this further through primary care. More work can also be done with the DHB Team around the standardised evaluation that are included within the graphs.

31 12 months to March 2017

32 12 months to September 2017

More pregnant women under the care of a Lead Maternity Carer (LMC) % of women booked with an LMC by week 12 of their pregnancy					
Key Performance Measures	Baseline [33]	Previous result [34]	Actual to Date [35]	Target 2017/18	Trend direction
Total	65.7%	63% (U)	57.9% (U)	≥80%	▼
Māori	49.2%	54.1% (U)	50% (U)	≥80%	▼
Pacific	54.5%	38.2% (U)	35.3% (U)	≥80%	▼
Other	75.9%	71.8% (U)	63.8% (U)	≥80%	▼



Comments:
Whilst the 'Top 5 for my baby to thrive' campaign had an initial impact in Q3 of the previous year increasing Maori engagement by 10% the results for Q1 of 17/18 remain below the target % for all ethnicities. The campaign continues with ongoing contact with PHO and GP practices across Hawke's Bay and a refresh of the find your midwife website and a DHB telephone contact for women finding it difficult to engage an LMC. A new initiative incorporating a number of equity programmes e.g. smoke free, safe sleep, breastfeeding plus early engagement with a midwife is in the planning stage with the timeline of commencement being March 2018. This works in partnership with Maori Health and our primary and community providers to raise awareness of our community to the importance of early engagement with a midwife to improve wellness and pregnancy outcome.

15

33 October to December *2015.*

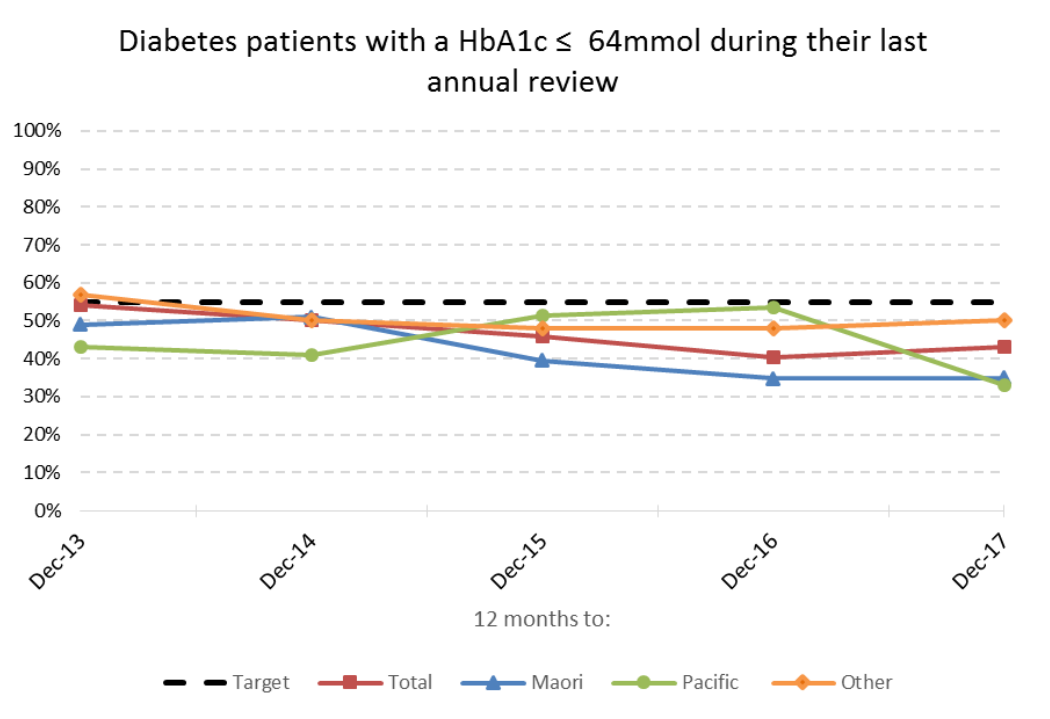
34 April to June 2017.

35 July to September 2017

Improved management of long-term conditions (CVD, Acute heart health, Diabetes, and Stroke)

Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator)

Key Performance Measures	Baseline [36]	Previous result [37]	Actual to Date [38]	Target 2017/18	Trend direction
Total	65.4%	45.9% (U)	43% (U)	≥55%	▼
Māori	46.2%	39.5% (U)	35% (U)	≥55%	▼
Pacific	39.3%	51.3% (U)	33% (U)	≥55%	▼
Other	79.2%	47.9% (U)	50% (U)	≥55%	▲



PHO: Annual Diabetes Checks Data

Comments:

There are encouraging increased referral numbers to Kia Ora Self-Management programme from general practice, processed via electronic form, also focusing on community groups. We are also running Annual diabetes reviews, Smoking cessation education (SLM) and Pre-diabetes programme (400 people to be enrolled), Local resource on nutrition has been developed and circulated to families 'Healthy Eating, Healthy Smile'. There is also new defined HbA1c reports to practices provide risk stratification of practice populations to enable focus on those outside of guidelines

36 January to December 2016

37 12 months to September 2017

38 12 months to December 2017

Improved management of long-term conditions (CVD, Acute heart health, Diabetes, and Stroke) % of the eligible population will have had a CVD risk assessment in the last 5 years					
Key Performance Measures	Baseline [39]	Previous result [40]	Actual to Date [41]	Target 2017/18	Trend direction
Total					
Māori					
Pacific					
Other					
Source: Ministry of Health					
*Data has not been supplied by the ministry yet. Data and chart will be added in time for the board report					

Less waiting for diagnostic services % of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks)					
Key Performance Measures	Baseline [42]	Previous result [43]	Actual to Date [44]	Target 2017/18	Trend direction
Total					
Māori					
Pacific					
Other					
*Data has not been supplied by the ministry yet. Data and chart will be added in time for the board report					
Comments:					

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39 5 years to December 2016. Source: Ministry of Health

40 5 years to June 2017. Source: Ministry of Health

41 5 years to September 2017 . Source: Ministry of Health

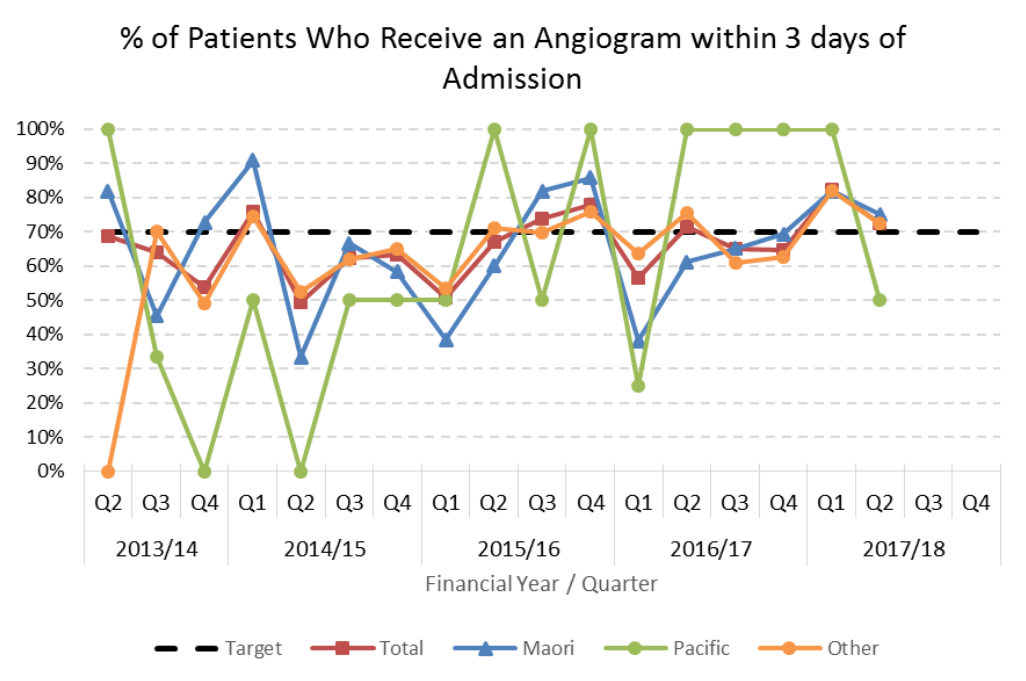
42 October to December 2015. Source: Ministry of Health

43 July to September 2016. Source: Ministry of Health

44 October to December 2016 . Source: Ministry of Health

OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT SERVICES

Patients with ACS receive seamless, coordinated care across the clinical pathway ***% of high-risk patients will receiving an angiogram within 3 days of admission.***					
Key Performance Measures	Baseline [45]	Previous result [46]	Actual to Date [47]	Target 2017/18	Trend direction
Total	71.6%	82.1% (F)	72.4% (F)	≥70%	▼
Māori	61.1%	81.8% (F)	75% (F)	≥70%	▼
Pacific	100.0%	100% (F)	50% (U)	≥70%	▼



Source: ANZACS-QI

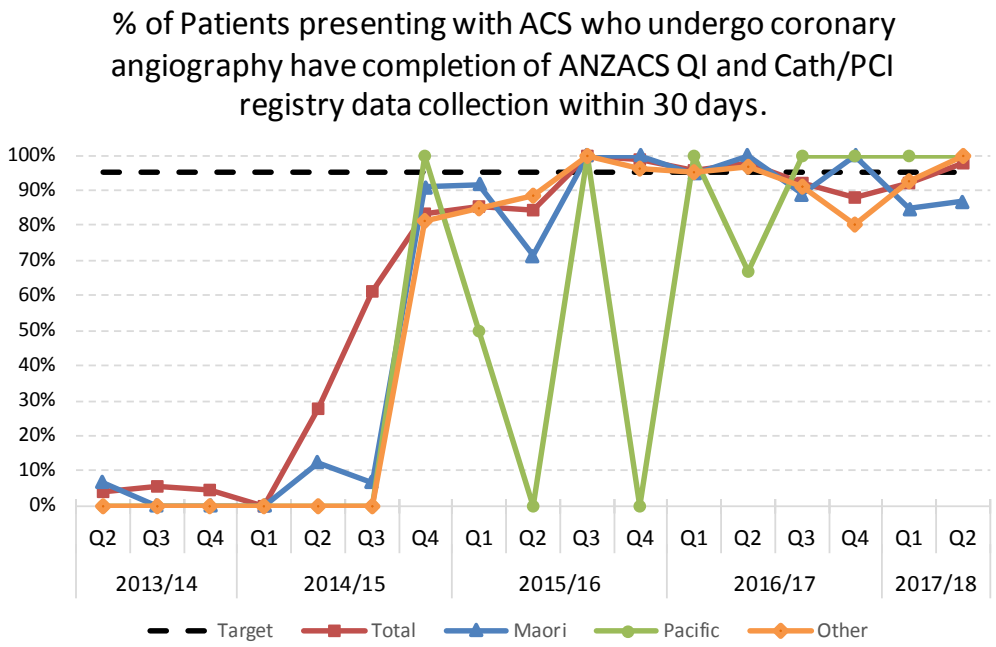
Comments:
Overall the DHB is on target for this indicator. Small numbers for Maori and Pacific result in variability with quarterly performance

45 October to December 2016. Source: Ministry of Health
46 July to September 2017. Source: Ministry of Health
47 October to December 2017 . Source: Ministry of Health

Patients with ACS receive seamless, coordinated care across the clinical pathway

% of patients undergoing cardiac surgery at the regional cardiac centres who have completion of Cardiac Surgery registry data collection within 30 days of discharge

Key Performance Measures	Baseline [48]	Previous result [49]	Actual to Date [50]	Target 2017/18	Trend direction
Total	97.7%	92% (U)	97.5% (F)	≥95%	▲
Māori	100.0%	84.6% (U)	86.7% (U)	≥95%	▲
Pacific	66.7%	100% (F)	100% (F)	≥95%	▬



Source: ANZACS QI

Comments:
Overall the DHB is on target for this indicator. Small numbers for Maori and Pacific result in variability with quarterly performance, 1 more patient for Maori would have pushed them over target. We will keep monitoring cases that do not meet target and ensure lessons are taken forward.

48 October to December 2016. Source: Ministry of Health

49 June to August 2017. Source: Ministry of Health

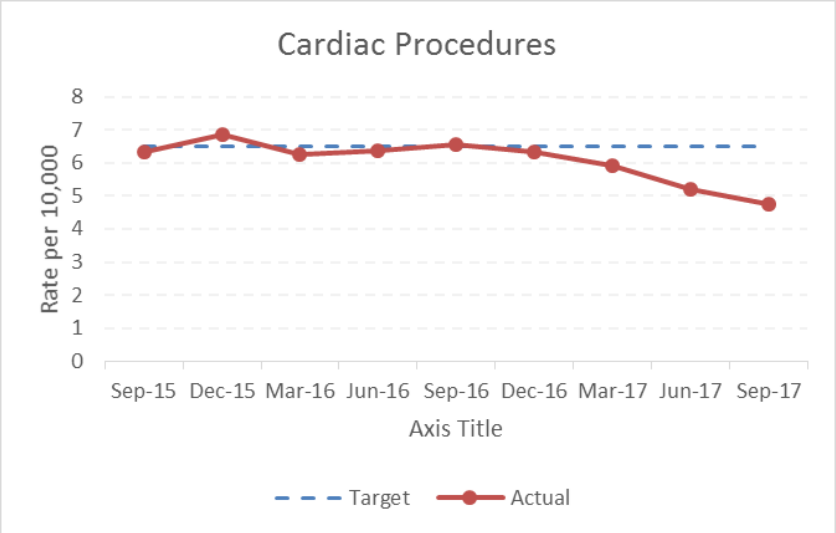
50 September to November 2017 Source: Ministry of Health

Equitable access to care for stroke patients ***% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway***					
Key Performance Measures	Baseline [51]	Previous result [52]	Actual to Date [53]	Target 2017/18	Trend direction
Total	88.1%	84.2% (F)	75.6% (U)	≥80%	▼
Māori	-	-	92.3% (F)	≥80%	*
Pacific	-	-	72% (U)	≥80%	*
Source: HBDHB					
Comments: It is not always clinically appropriate to move patients to the stroke unit, we regularly audit the cases of patients who do not get admitted to the stoke ward to ensure the appropriate care was given. There has been an introduction of monthly emergency policy stroke education meetings with staff, this is with the hope of identifying stroke patients early in their journey through the hospital.					

Equitable access to care for stroke patients ***% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission***					
Key Performance Measures	Baseline [54]	Previous result [55]	Actual to Date [56]	Target 2017/18	Trend direction
Total	-	71% (U)	58% (U)	≥80%	*
Māori	-	-	80% (F)	≥80%	*
Pacific	-	-	50% (U)	≥80%	*
*This is a new indicator and a time series chart will be provided one there are enough data points.					
Comments: There was a confirmed gastro-intestinal outbreak for the month of October through to the month of November which left the stroke ward on lock-down increasing length of time to rehab/discharge.					

Equitable access to surgery -Standardised intervention rates for surgery per 10,000 population					
Key Performance Measures	Baseline[57]	Previous result[58]	Actual to Date [59]	Target 2017/18	Trend direction
Major joint replacement	21.5	21.8 (F)	22.9 (F)	≥21	▲
Cataract procedures	58.7	46.4 (F)	49.7 (F)	≥27	▲
Cardiac procedures	6.6	5.2 (U)	4.7 (U)	≥6.5	▼
Percutaneous revascularization	13.1	12.2 (U)	12 (U)	≥12.5	▼
Coronary angiography services	21.5	21.8 (F)	22.9 (F)	≥21	▲
*Charts only supplied for the Cardiac Procedure as this is the only one that is significantly below the national average.					

51 October to December 2015. Source: Ministry of Health
52 July to September 2016. Source: Ministry of Health
53 October to December 2016 . Source: Ministry of Health
54 October to December 2015. Source: Ministry of Health
55 July to September 2016. Source: Ministry of Health
56 October to December 2016 . Source: Ministry of Health
57 12 months ending December 2015. Source MoH
58 12 months ending September 2015. Source MoH
59 12 months ending December 2016. Source MoH



Source: Ministry of Health

Comments:
Cardiac procedures are demand driven and HB is reliant on Capital & Coast to accept/ pull patients for cardiac surgery and pacemaker implants

15

Shorter stays in hospital Length of stay (days)					
Key Performance Measures	Baseline [60]	Previous result [61]	Actual to Date [62]	Target 2017/18	Trend direction
Acute	2.41	2.46 (U)	2.41 (U)	≤2.39	▲
Elective	1.51	1.58 (U)	1.55 (U)	≤1.54	▲

Source: Ministry of Health

Comments:

60 12 months to September 2016. Source: Ministry of Health
61 12 months to August 2017. Source: Ministry of Health
62 12 months to September 2017 .Source: Ministry of Health

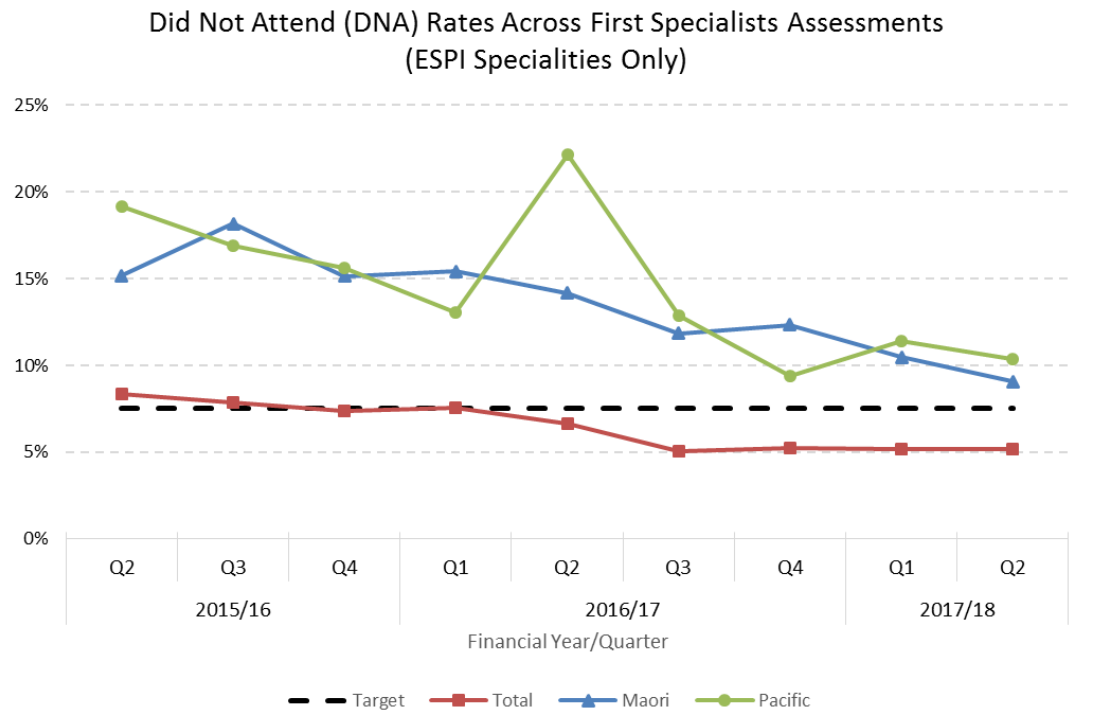
Quicker access to diagnostics					
Key Performance Measures	Baseline [63]	Previous result [64]	Actual to Date[65]	Target 2017/18	Trend direction
% accepted referrals for elective coronary angiography completed within 90 days					
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive),					
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)					
% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date					
Comments: *Data not currently available but will be provided with commentary for the board meeting at the end of February.					

63 December 2015.

64 March 2016.

65 June 2016

Fewer missed outpatient appointments ***Did not attend (DNA) rate across first specialist assessments***					
Key Performance Measures	Baseline [66]	Previous result [67]	Actual to Date [68]	Target 2017/18	Trend direction
Total	6.7%	5.2% (F)	5.2% (F)	≤7.5%	▬
Māori	14.2%	10.5% (U)	9.1% (U)	≤7.5%	▲
Pacific	22.1%	11.4% (U)	10.4% (U)	≤7.5%	▲
Other	3.8%	3.2% (F)	3.6% (F)	≤7.5%	▼



Source: HBDHB

Comments:
The Total DNA rate this quarter is well below our target rate of 7.5%, currently hovering just above 5%. PI continue to flux at around 10% to11% due to the low volume of numbers being seen. What is of particular significance this quarter is the continued decline in DNA rate for Maori, now sitting below 10%. This is a fantastic achievement that is real credit to the Kaitakawaenga and Booking Department.

Key initiatives behind a more equitable DNA rate:

- The newly appointed Kaitakawaenga has established some good preventative DNA process now that he has a good understanding of DHB internal systems.
- Maturity in working relationships between Kaitakawaenga and other key members across the DHB and in the community, in order to target those customers that are having real trouble accessing the DHB services.
- Demographics being monitored more closely – with monthly audits across the DHB, to ensure Demographic details are being updated and confirmed with customers at every presentation.
- Evening phone calling and in many cases Bookers calling customers more than once to confirm their appointments

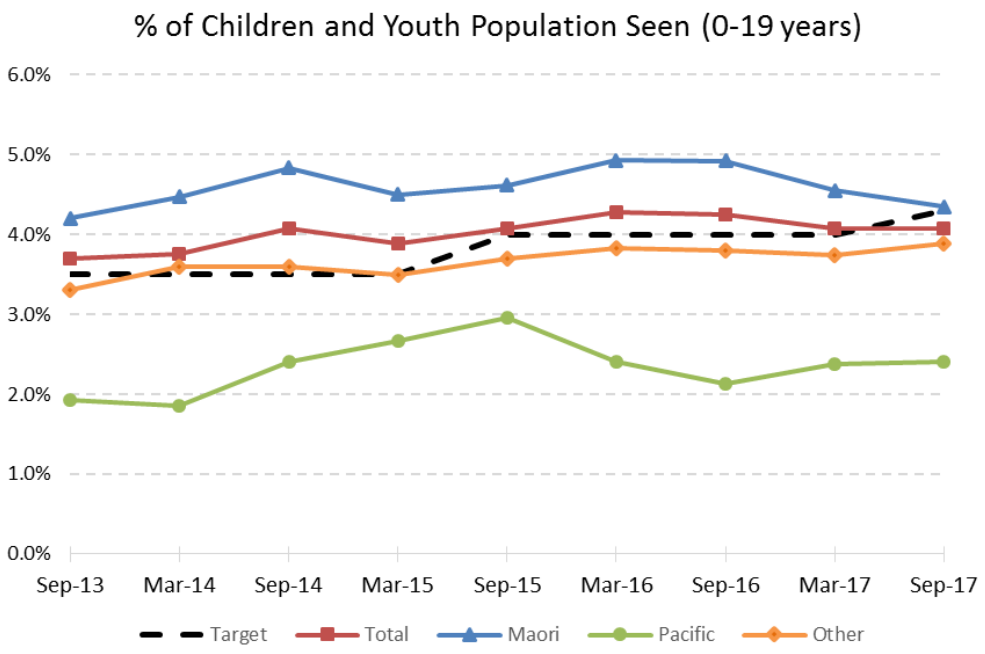
66 October to December 2016. Source: Ministry of Health
67 July to September 2016. Source: Ministry of Health
68 October to December 2016 . Source: Ministry of Health

Whilst we celebrate a good quarter for DNA, we recognise there are several areas that need to be addressed over the coming year in order to reduce DNA further. The 3 key areas where current process needs to be reviewed are:

- Dental - remains the most problematic specialty to access services for Maori and PI, due to the financial element involved.
- School holidays are a real barrier for Maori to access DHB services
- Demographics – how to keep more accurate demographic records for our more transient customers.

Administration services and Maori Health will continue to work in partnership to review the above areas and identify what changes can be made to reduce current barriers and sustain a Maori DNA rate of 7.5% or less.

Better mental health services, Improving access, Better access to mental health and addiction services ***Proportion of the) population seen by mental health and addiction services***					
Key Performance Measures	Baseline [69]	Previous result [70]	Actual to Date [71]	Target 2017/18	Trend direction
Child & youth (0-19)					
Total	4.3%	4.08% (F)	4.07% (F)	≥4%	▼
Māori	4.9%	4.55% (F)	4.34% (F)	≥4%	▼
Pacific	2.1%	2.38% (U)	2.4% (U)	≥4%	▲
Other	3.8%	3.74% (F)	3.88% (F)	≥4%	▲
Adult (20-64)					
Total	5.1%	5.35% (F)	5.46% (F)	≥5%	▲
Māori	9.3%	9.76% (F)	9.85% (F)	≥5%	▲
Pacific	2.2%	3.47% (U)	2.4% (U)	≥5%	▼
Other	3.8%	3.98% (U)	4.08% (U)	≥5%	▲
Older adult (65+)					
Total	1.1%	1.13% (F)	1.14% (F)	≥1.15%	▲
Māori	1.2%	1.09% (F)	1.25% (F)	≥1.15%	▲
Pacific	1.0%	1.29% (F)	0.65% (F)	≥1.15%	▼
Other	1.1%	1.14% (F)	1.13% (F)	≥1.15%	▼



69 12 months to September 2016

70 12 months to June 2017

71 12 months to September 2017

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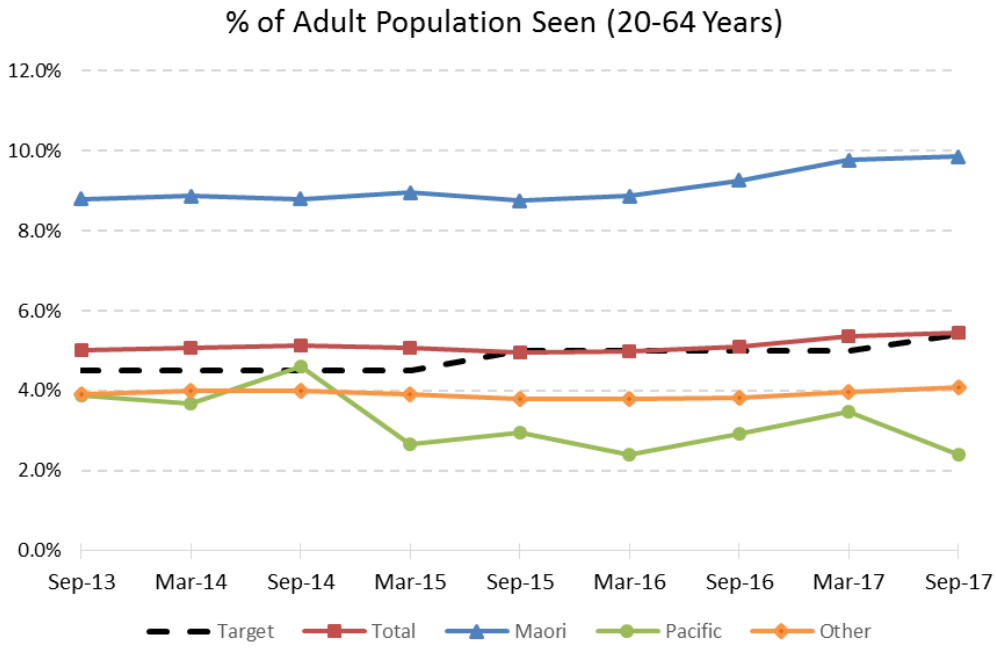
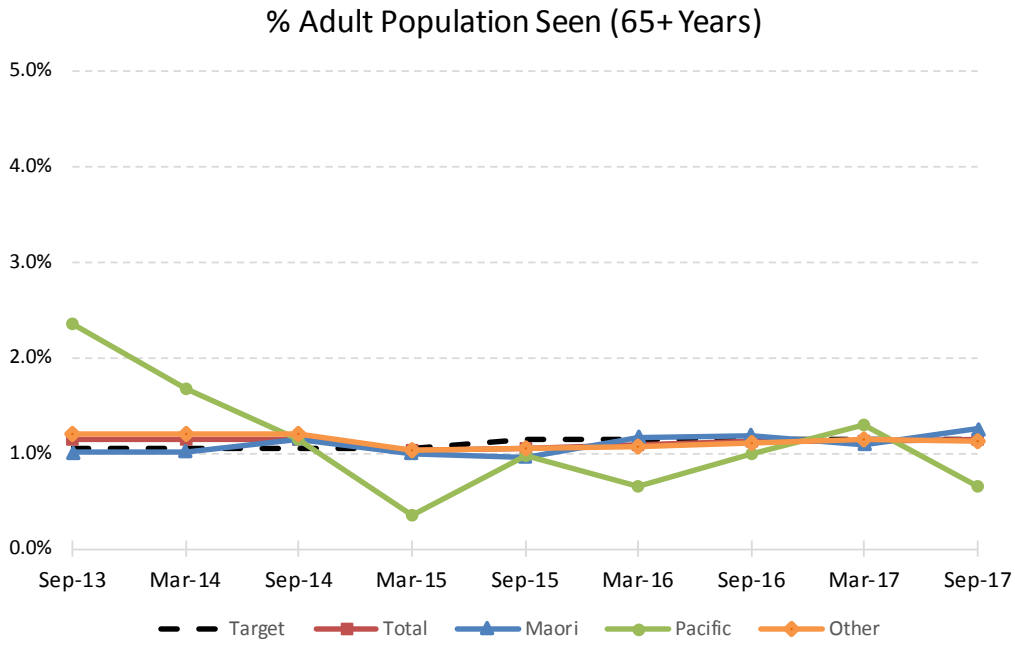
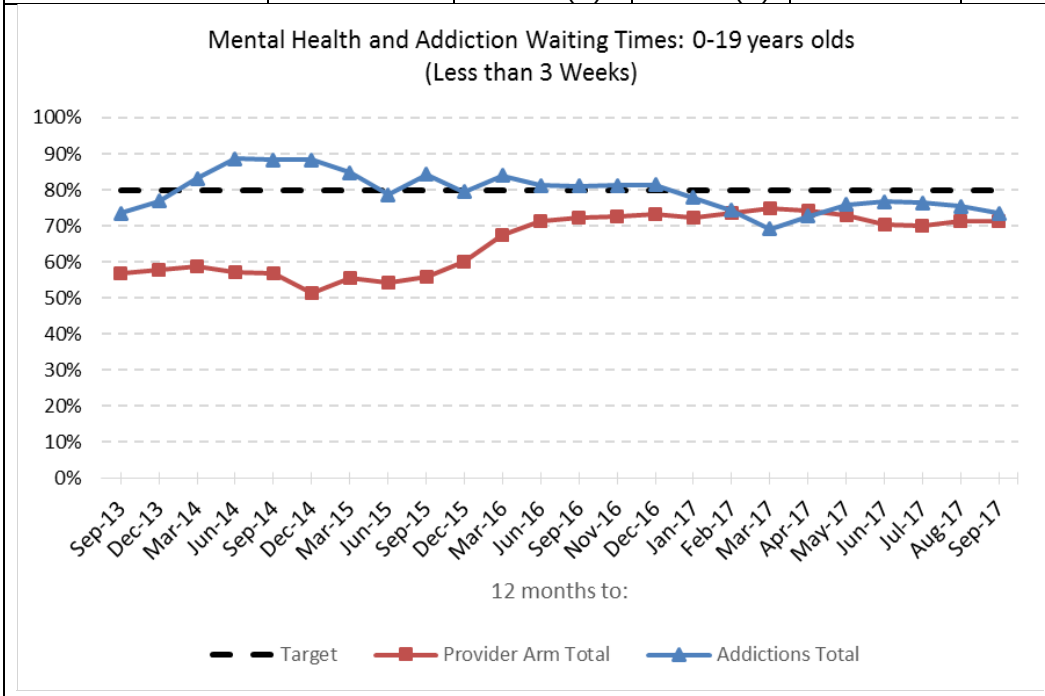
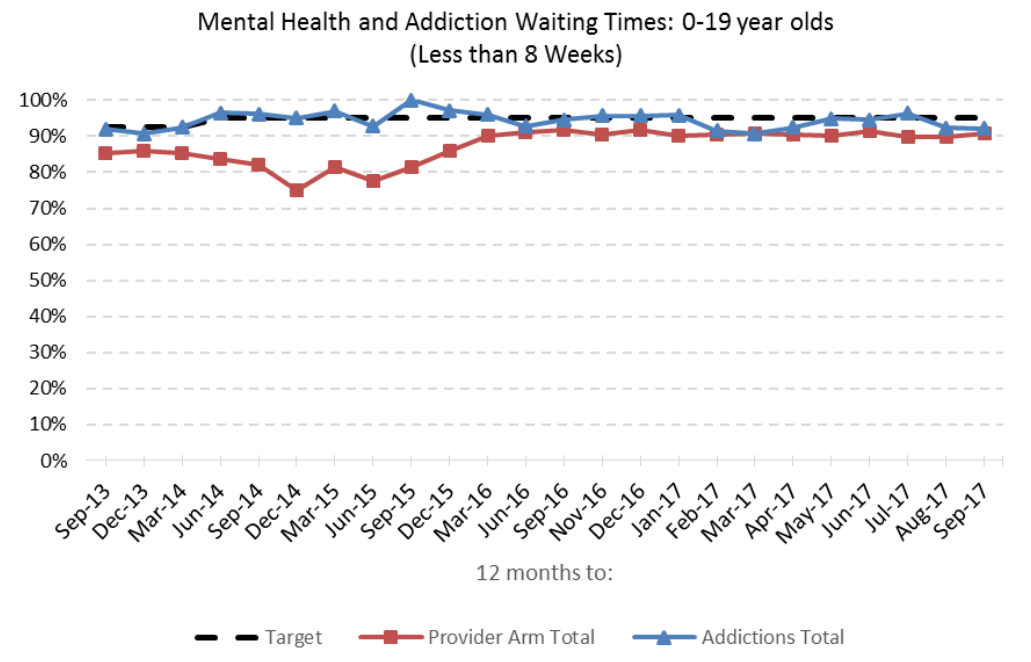




Comments:
While we have not met the current target (which has increased since the last quarter) we have remained fairly constant in our access rates. We continue to meet with relevant stakeholders to ensure access rates are optimised and we are engaging in scoping exercises with populations that have low access rates. Our Maori access rates continue to meet the targets, our Pacific access rates have historically been low and we are working with the HBDHB Pacific Health Team to identify potential barriers to Pacific youth accessing our mental health service.

Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds					
Key Performance Measures	Baseline [72]	Previous result [73]	Actual to Date [74]	Target 2017/18	Trend direction
Mental Health Provider Arm: Age 0-19					
<3 weeks	72.3%	71.5% (U)	71.3% (U)	≥80%	▼
<8 weeks	91.7%	89.8% (U)	90.9% (U)	≥95%	▲
Addictions (Provider Arm & NGO): Age 0-19					
<3 weeks	81.1%	75.4% (U)	73.4% (U)	≥80%	▼
<8 weeks	94.6%	92.3% (U)	92.2% (U)	≥95%	▼





72 12 months to December 2016

73 12 months to June 2017

74 12 months to September 2017

Source: Ministry of Health

Comments:

While we have not achieved the mental health and addictions targets this quarter, neither are more than 10% variance from the target and in particular, the addictions wait time has improved. All the same issues noted by outgoing CAFS manager, Joe Melser, are still affecting our wait times:

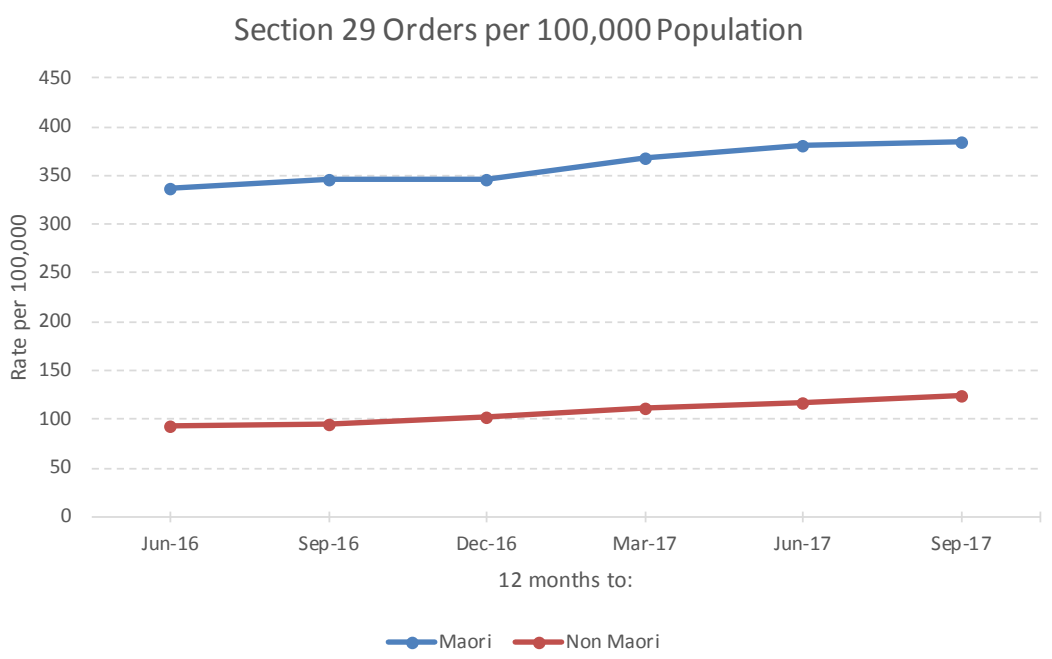
- DNA's, families rescheduling appointments and families unavailability, especially over the Christmas period
- It appears that family contact do not trigger the KPI
- Increase in referral volumes
- Capacity and demand continue to be a mismatch. We have an extra 2.5 FTE in place but staff retention continues to be a problem.

We continue to make telephone contact with families and see young people and their families in a variety of settings to maximise early engagement with our service.

Increasing consumer focus, More equitable use of Mental Health Act: Section 29 community treatment orders

Rate of s29 orders per 100,000 population

Ethnicity	Baseline [75]	Previous result [76]	Actual to Date [77]	Target 2017/18	Trend direction
Non- Māori	95	117.4 (U)	124.1 (U)	≤81.5	▼
Māori	338	381 (U)	384 (U)	≤81.5	▼



Comments:

This is a large difference in rates, though that may represent greater need in Maori consumers, which is being appropriately met through the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992. There is no evidence that the provisions of the MHA with regard to section 29 are being inappropriately used. Therefore due to the statutory requirement of certain criteria in order for a section 29 compulsory treatment order to be made by a Judge the contributing factors to the difference in rates must be that proportionally more Maori patients have mental disorder and at the same time pose a serious danger to the health or safety of themselves or others and/or have a seriously diminished capacity to take care of themselves. For Mental disorder all patients, Maori or non-Maori have access to the best possible treatment for mental disorder. This includes Kaupapa Maori mental health and addictions services. No local study has been carried out into presentation and response to treatment rates in the local population comparing Maori to others.

For dangerousness or incapacity for self-care: The Whanau Tahi one assessment and collaborative Go To Plan allow for recording of risks and mitigating actions to be taken. All patients can be referred to the Needs Assessment and Support Co-ordination (NASC) service for community support services, including support workers and supported accommodation. It may not be appreciated that risk can remain in the long term, even when someone is currently relatively well, either because of the natural history of a particular mental disorder or because the patient has no ability to appreciate that they suffer from a mental disorder and would therefore not accept treatment were it not for the section 29 compulsory treatment order. Again no local study of degree of insight in relation to the use of the mental health act comparing Maori to non-Maori has been carried out. Provider arm services are not resourced to carry out such studies which would need to be academically robust in order to have true value in planning interventions.

75 October to December 2016

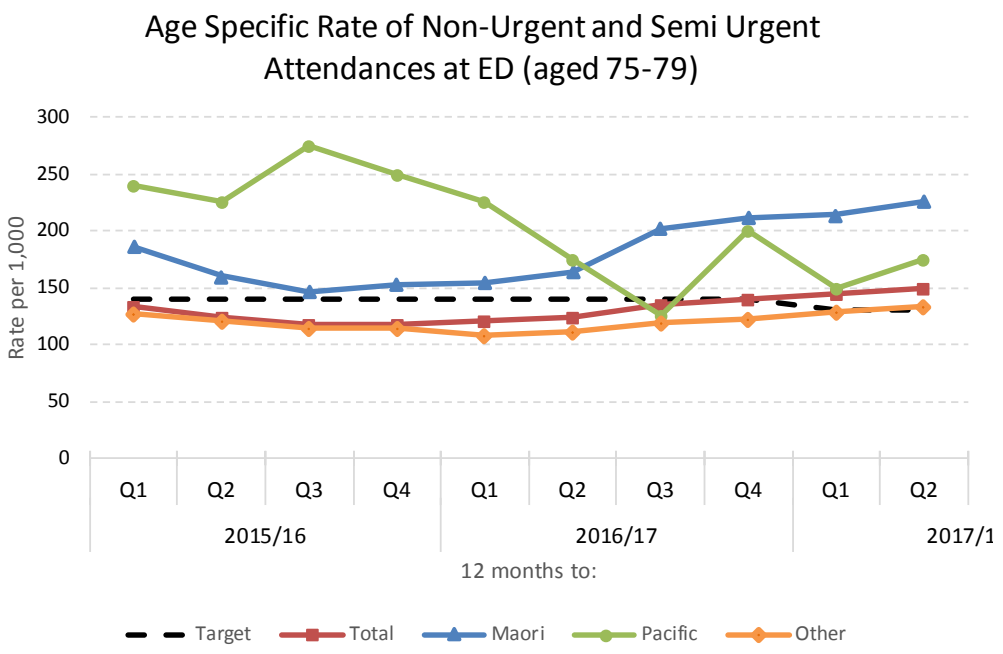
76 12 months to June 2017

77 12 months to September 2017

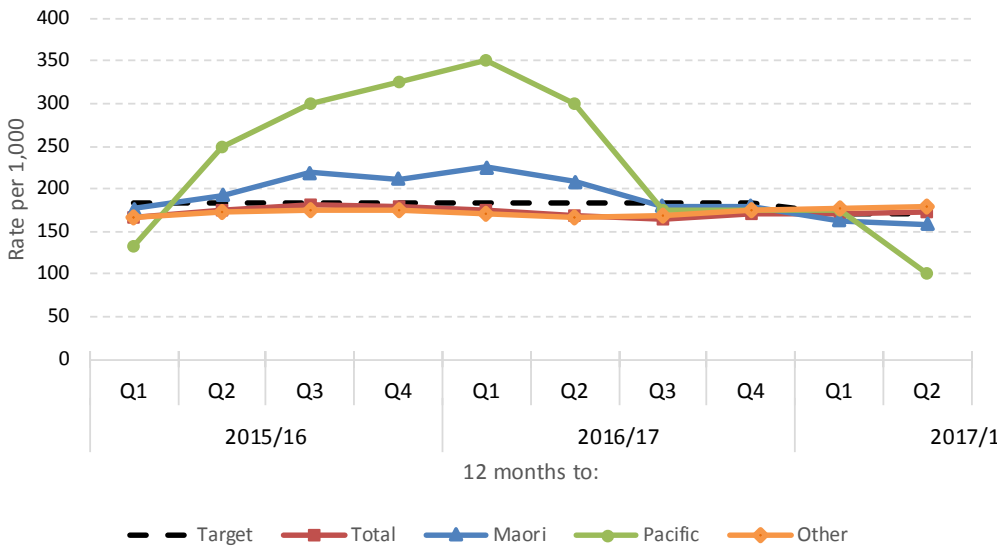
OUTPUT CLASS 4: REHABILITATION AND SUPPORT SERVICES

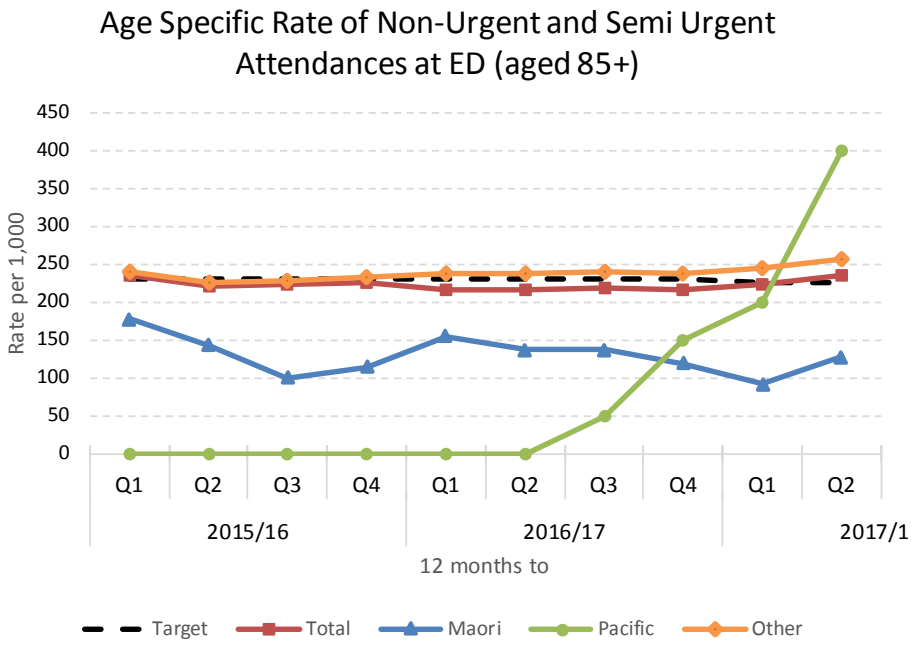
Better access to acute care for older people
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population)

Age Band	Baseline [78]	Previous result [79]	Actual to Date [80]	Target 2017/18	Trend direction
Age 75-79					
Total	124	144.5 (U)	149.9 (U)	≤130	▼
Maori	164.3	214.3 (U)	226.3 (U)	≤130	▼
Pacific	175	150 (U)	175 (U)	≤130	▼
Other	111.2	129.2 (F)	133.8 (U)	≤130	▼
Age 80-84					
Total	208.3	171.7 (U)	173.6 (U)	≤170	▼
Maori	300	162.5 (F)	158.3 (F)	≤170	▲
Pacific	167	175 (U)	100 (F)	≤170	▲
Other	167.8	176.1 (U)	179.5 (U)	≤170	▼
Age 85+					
Total	216.6	222.3 (F)	234.6 (U)	≤225	▼
Maori	136.4	90.9 (F)	127.3 (F)	≤225	▼
Pacific	0	200 (F)	400 (U)	≤225	▼
Other	237.7	243.9 (U)	255.2 (U)	≤225	▼



78 12 months to December 2016
79 12 months to October 2017
80 12 months to December 2017.





Comments:
The engAGE service continues to work with older people in their homes through our community teams to maintain their independence and to prevent unnecessary hospitalisations. Our ORBIT team work in ED/AAU 7am-7pm, 7 days per week. ORBIT arrange early, safe discharge for older people presenting to hospital who are able to return home with increased support. engAGE Intermediate Care beds allow 'step-down' from hospital for older inpatient who are medically well enough to discharge, but who require further medical and allied health input to regain their independence for home. At present there are no engAGE community teams in Wairoa or Central Hawkes Bay.

RECOMMENDATION:

It is recommended that the Māori Relationship Board, Pasifika Health Leadership Group Clinical & Consumer Council and HBDHB Board:

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

ATTACHMENT:

- HBDHB Quarterly Performance Monitoring Dashboard Q2

HBDHB PERFORMANCE FRAMEWORK RESULTS – QTR 2, 2017/18

Health Targets:	Target	Baseline	Total		Maori		Pacific		Other	
Shorter Stays in ED	≥ 95%	95%	92%	*	94%		94%		91%	*
Improved Access to Elective Services	≥ 100%	100%	Awaiting data from Ministry of Health							
Faster Cancer Treatment	≥ 90%	65%								
Increased Immunisation	≥ 95%	0%	94%		93%	*	97%		93%	
Better Help for Smoker to Quit (Primary Care)	≥ 90%	99%	91%	*	89%	*	89%	*	94%	*
Better Help for Smoker to Quit (Pregnant Women)	≥ 90%	89%	Awaiting data from Ministry of Health							
Raising Health Kids	≥ 95%	40%	98%	*	97%	*	100%	*	100%	*

Output Class 1: Prevention Services	Target	Baseline	Total		Maori		Pacific		Other	
Better Help for Smoker to Quit (Secondary Care)	≥ 95%	99%	96%		97%		97%		91%	
% of 2 year olds fully immunised	≥ 95%	95%	96%	*	96%	*	97%		97%	*
% of 4 year olds fully immunised	≥ 95%	93%	91%		91%		88%		92%	*
Acute rheumatic fever initial hospitalisation rate per 100,000	≤ 1.5	1.9	1.9	*	4.8	*	-	*	-	-
% of women aged 50-69 years receiving breast screening in the last 2 years	≥ 70%	74%	73%	*	67%	*	68%	*	75%	*
% of women aged 25–69 years who have had a cervical screening event in the past 36 months	≥ 80%	77%	77%	*	74%	*	76%	*	79%	

Output Class 2: Early Detection and Management Services	Target	Baseline	Total		Maori		Pacific		Other	
% of the population enrolled in the PHO	≥ 90%	97%	98%	*	97%		90%		98%	*
Ambulatory sensitive hospitalisation rate per 100,000 0-4 years	≤ 6822	-	5794		6434		9178		4741	
Ambulatory sensitive hospitalisation rate per 100,000 45-64 years	≤ 4129	-	4373		8165		7168		3388	
% of women booked with an LMC by week 12 of their pregnancy	≥ 80%	66%	58%		50%		35%		64%	
Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator)	≤ 65%	40%	43%		35%	*	33%		50%	
% of the eligible population will have had a CVD risk assessment in the last 5 years	≥ 90%	88%	Awaiting data from Ministry of Health							
% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks)	≥ 95%	95%	93%		-	-	-	-	-	-
% of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks)	≥ 90%	48%	94%	*	-	-	-	-	-	-

Key:

Within 0.5% or Greater than Target
Within 5% of Target
Greater than 5% from Target

*	Favourable Trend from Previous Quarter

OUTPUT CLASS 3: Intensive Assessment and Treatment Services	Target	Baseline	Total		Maori		Pacific		Other	
% of high-risk patients will receiving an angiogram within 3 days of admission.	≥ 70%	72%	72%		75%		50%		72%	
% of patients undergoing cardiac surgery at the regional cardiac centres who have completion of Cardiac Surgery registry data collection within 30 days of discharge	≥ 95%	98%	98%	*	87%	*	100%		100%	*
% of potentially eligible stroke patients who are thrombolysed 24/8	≥ 8%	8%	7%		15%		6%		0%	
% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	≥ 80%	84%	76%		92%		72%	*	0%	-
% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	≥ 80%	58%	58%		80%	*	50%		0%	-
Major joint replacement	≥ 21	21.5	22.90	*	No Ethnicity Data Available					
Cataract procedures	≥ 27	58.7	49.70	*						
Cardiac surgery	≥ 6.5	6.6	4.70							
Percutaneous revascularisation	≥ 12.5	13.1	12.00							
Coronary angiography services	≥ 34.7	39	36.60	*						
Length of stay Elective (days)	≥ 1.47	1.56	0.00	-						
Length of stay Acute (days)	≥ 2.3	2.4	0.00	-						
% accepted referrals for elective coronary angiography completed within 90 days	≥ 95%	-	Awaiting data from Ministry of Health							
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive),	≥ 90%	92%	94%		100%		100%		92%	
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)	≥ 70%	94%	59%		58%		75%		59%	-
% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date	≥ 70%	98%	77%		No Ethnicity Data Available					
Did not attend (DNA) rate across first specialist assessments	≤ 8%	7%	5%	*	9%	*	10%	*	4%	
Proportion of the population seen by mental health and addiction services: Child & Youth (0-19)	≥ 4%	4%	4.1%		4.3%		2.4%	*	3.9%	*
Proportion of the population seen by mental health and addiction services: Adult (20-64)	≥ 5%	5%	5.5%	*	9.8%	*	2.4%		4.1%	*
Proportion of the population seen by mental health and addiction services: Older Adult (65+)	≥ 1%	1.1%	1.1%	*	1.3%	*	0.6%		1.1%	
% of 0-19 year olds seen within 3 weeks of referral: Mental Health Provider Arm	≥ 80%	72%	71%		74%	*	65%	*	71%	
% of 0-19 year olds seen within 3 weeks of referral: Addictions (Provider Arm and NGO)	≥ 80%	81%	73%		62%		100%		86%	
% of 0-19 year olds seen within 8 weeks of referral: Mental Health Provider Arm	≥ 95%	91%	91%	*	92%	*	87%	*	90%	*
% of 0-19 year olds seen within 8 weeks of referral: Addictions (Provider Arm and NGO)	≥ 95%	95%	92%		92%	*	100%		97%	
% of clients discharged will have a quality transition or wellness plan	≥ 95%	0%	0%	-	0%	-	0%	-	0%	-
Rate of s29 orders per 100,000 population	≤ 81.5	90.1	-	-	384		-	-	124.1	

15.1

OUTPUT CLASS 4: Rehabilitation and Support Services	Target	Baseline	Total		Maori		Pacific		Other	
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 75-79 years	≤ 130	124	149.90		226.30		175.00		133.80	*
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 80-84 years	≤ 170	208.3	173.60		158.30	*	100.00	*	179.50	
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 85+ years	≤ 225	216.6	234.60		127.27		400.00		255.16	
% of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan	≥ 95%	100%	100%		100%		100%		100%	
Clients with a CHESS score (Change in Health, End-stage disease, signs and symptoms) of 4 or 5 at first assessment	≤ 14%	10%	12%		No Ethnicity Data Available					
Time from referral receipt to initial Cranford Hospice contact within 48 hours	≥ 80%	100%	98%							
% of older patients given a falls risk assessment	≥ 90%	97%	98%							
% of older patients assessed as at risk of falling receive an individualised care plan	≥ 98%	98%	96%							

Non Reported in Q2

Number of babies who live in a smoke-free household at six weeks post natal	≥ -	No data provided
% of pregnant women who are smokefree at 2 weeks postnatal	≥ 95%	
% of girls fully immunised – HPV vaccine	≥ 75%	Reported in quarter 4
% of 65+ year olds immunised – flu vaccine	≥ 75%	
% of infants that are exclusively or fully breastfed at 6 weeks	≥ 75%	No data provided
% of infants that are exclusively or fully breastfed at 3 months	≥ 60%	
% of eligible pre-school enrolments in DHB-funded oral health services	≥ -	Reported in quarter 3
% of children who are carries free at 5 years of age	≥ -	
% of enrolled preschool and primary school children not examined according to planned recall	≤ -	
% of adolescents(School Year 9 up to and including age 17 years) using DHB-funded dental services	≥ -	
Mean 'decayed, missing or filled teeth (DMFT)' score at Year 9	≤ -	
Acute readmissions to hospital	≤ TBC	Currently not reported
Acute readmission rate: 75 years +	≤ -	
Number of day services	≥ -	No data provided

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:

17. Minutes of the Public Excluded MRB Meeting held 8 November 2017

18. Matters Arising – Review of Actions

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).