Māori Relationship Board Meeting

Date:	**Wednesday, 8 August 2018**
Meeting:	**9.00am to Noon**
Venue:	**Te Waiora (Boardroom), District Health Board Corporate Office, Cnr Omahu Road & McLeod Street, 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:

In Attendance:

Member of the Hawke's Bay District Health Board (HBDHB) Board
Members of the Executive Management Team
General Manager Māori Health
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.

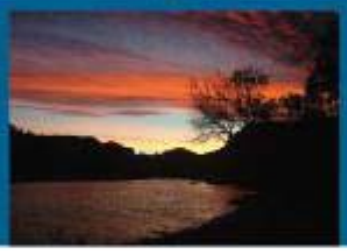
Our values

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 Meetings	
6.	Matters Arising - Review of Actions	
7.	Workplan	
8.	Māori Relationship Board Chair's Verbal Update	
9.	General Manager's Monthly Māori Health Report – Patrick LeGeyt	
10.	Clinical Council Verbal Update – Ana Apatu	
	Section 2: Presentation	
11.	Annual Plan 2018/19 (draft)– Paul Malan	9:50
	Section 3: For Discussion	
12.	HBDHB Performance Framework Exceptions Q4 Apr-June 2018 – Justin Nguma	10:15
13.	"He Ngākau Aotea" Update – George Mackey	10:45
14.	Clinical Services Plan Update – Ken Foote	11:05
15.	Te Ara Whakawaiora - Access (Ambulatory Sensitive Hospitalisation) Rates 0-4 / 45-65 yrs – Jill Garrett and Patrick LeGeyt	11:10
	Section 4: Recommendation to Exclude the Public	
16.	Under Clause 32, New Zealand Public Health & Disability Act 2000	

PUBLIC EXCLUDED

	Section 6: Routine	
17.	Minutes of the Previous Meetings (public excluded)	11.40
18.	Matters Arising - Review of Actions (public excluded)	
	Karakia Whakamutunga (Closing)	
	Followed by a light lunch	

NEXT MEETING:

Wednesday, 12 September 2018, Boardroom, HBDHB Corporate Office
Cnr Omahu Road & McLeod Street, Hastings

Māori Relationship Board Interest Register - 1 July 2018

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	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
	Active	Involved with Waitangi Claim #2687 (involving Napier Hospital land) sold by the Government	Requested that this be noted on the Interest Register	Unlikely to be any conflict of Interest.	The HBDHB Chair	28.03.18
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	Mother in law, Jenny McQueen, Chaplain at Te Matau a Maui		No conflict	The Chair	14.02.18
	Active	Niece, Albie Raihania attending on the NeSP program		No conflict	The Chair	14.02.18
	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
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

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict (if any)	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by:	Date Declared
Dr Fiona Cram	Active	Board Member, Ahuriri District Health Trust (ADHT)	Contribution to the health and wellbeing of Māori in Napier, as per the settlement under WAI692.	Declare an interest and withdraw from any discussions with respect to any contract arrangements between ADHT and HBDHB	The Chair	14.06.17
	Active	Adjunct Research Fellow, Women's Health Research Centre, University of Otago, Wellington	Health research involving data and/or participant recruitment from within HBDHB.	Declare a potential conflict of interest, if research ethics locality assessment requires MRB input.	The Chair	14.06.17
	Active	Director and Shareholder of Katoa Limited	An indigenous research organisation that undertakes research and work for organisations by Maori for Maori.	Declare any potential conflict of interest, prior an discussion on work undertaken for HBDHB and/or health service organisations.	The Chair	11.04.18
	Active	Contract being negotiated with the Ministry of Health for Research work in relation to WAI 2575	Unknown at this time.	Declare any potential conflict of interest, prior an discussion on work undertaken for HBDHB and/or health service	The Chair	13.06.18
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	Health Advisors	Will declare intertest prior to any discussions relating to specific topics	The Chair	1.01.17
	Active	Committee Member, HB Foundation		No conflict	The Chair	1.01.17
	Active	Committee Member, Children' Holding Foundation		No conflict	The Chair	1.01.17
	Active	Trustee, Waipukurau Community Marae		No conflict	The Chair	1.01.17
Beverley TeHuia	Active	Trustee and employed by Kahungunu Health Services	Kahungunu Health Services currently contracts with HBDHB with a number of contracts. Mother and Pepi, Cervical and Breast screening, # Whanau and smokefree pregnant wahine.	Will not take part in discussions about current tenders that Kahungunu Health services are involved with and are currently contracted with.	The Chair	7.11.17
	Active	Employee of Totara Health	GP Practice providing heatlh services	Will declare intertest prior to any discussions relating to specific topics	The Chair	7.11.17
	Active	Committee Member of the Priority Population Committee (PPC)	Health Advisors		The Chair	7.11.17
	Active	Nga Maia O Aotearoa Chair person	The current Chair of Maori Midwives organisation of New Zealand. Providing Cultural Competency to all Midwives and child birth organiser in New Zealand. DHB employed and independent.	Will not take part in discussions about cultural training required of maternity services	The Chair	7.11.17
	Active	Iwi Rep on Te Matua a Maui Health Trust		Will not discuss or take part of discussions where this trust is or interest.	The Chair	28.05.18
	Active	Claimant of Treaty Health Claim currently with the Tribunal; WAI #2575	Is yet to be heard by the Waitangi Tribunal	Unlikely to be a conflict	The Chair	28.05.18

MINUTES OF THE MĀORI RELATIONSHIP BOARD
HELD ON WEDNESDAY 11 JULY 2018, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 9.00AM

PUBLIC

Present:	Ngahiwi Tomoana (Deputy Chair) Ana Apatu Hine Flood George Mackey Dr Fiona Cram Na Raihania Trish Giddens (joined at 9.25am) Lynlee Aitcheson-Johnson (joined at 9.25am)
Apologies	Beverly Te Huia, Heather Skipworth and Kerri Nuku
In Attendance:	Peter Dunkerley (HBDHB Board Member) Patrick Le Geyt (Acting General Manager, Māori Health HBDHB) Kevin Atkinson (Chair, HBDHB) Kevin Snee (Chief Executive Officer HBDHB) *part* Chris Ash (Executive Director Planning and Funding, Primary Care) Chrissie Hape (CEO of NKII) Lillian Ward, PHO Ken Foote (Company Secretary) *part* Claire Caddie (Deputy ED Provider Services) *part* Cheryl Newman (Social Worker) *part* Wietske Cloo (Deputy Service Director of Community, Women & Children) *part* Tiwana Aranui (Kaumātua) Tanira Te Au (Kaumātua Kuia) JB Heperi Smith (Senior Advisor Cultural Competency) Lillian Ward, Project Manager Equity, Health Hawke's Bay
Minutes:	Brenda Crene

KARAKIA

Tiwana Aranui opened the meeting with a Karakia

APOLOGIES

Apologies were noted from MRB members Trish Giddens (arriving late), Beverly Te Huia, Heather Skipworth and Kerri Nuku.

Lillian Ward from the PHO was in attendance as Wayne Woolrich had forwarded his apology.

INTEREST REGISTER

No changes to the interests register were advised on the day and no member advised of any interest in the items on the Agenda.

CONFIRMATION OF PREVIOUS MINUTES

The minutes of the MRB meeting held on 13 June 2018 were approved as a correct record of the meeting considering comments around the minutes captured below.

Moved: **Na Raihania**
Seconded: **Ana Apatu**
Carried

Youth Strategy Action: ensure action is relayed to investigate other service providers in CHB for under 18's as GPs in Waipukarau had not taken this up

Clinical Services Plan: MRB members expressed a view that as they had not read the CSP plan and, as a whole, were not part of CSP design, they could not provide recommendations on who and where to consult, until they had read the plan.

5. MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: MRB Function and ToR review to include Youth. The Youth Council will consider and put forward a representative for consideration. The MRB ToR would need to be amended to reflect any change. Ongoing.

Item 2: Nuka Model Wānanga – Progressing with a meeting being held the following day. Delegation developing a project plan.

Item 3: TAW Mental Health: Pending the release of information from the National Review of Mental Health in October. This item has been captured on the workplan.

Item 4: Clinical Services Plan – Agenda item 14 – remove item.

Item 5: Interest Register actioned – remove item.

Item 6: Feedback on the People Plan was requested in June by Kate Coley (on leave until late August) – remove item.

Item 8: Consumer Engagement Strategy taken forward by Kate's team - remove item.

Item 9: TAW – Oral Health paper feedback from the June report had been requested. If any comments, provide them to Patrick LeGeyt.

Item 11: He Ngakau Aotea (Strategic Priorities) finalised under item 12 and included on respective work plans for consultation.

No item 7 or 10 recorded.

There was further general discussion relating to Māori within the health workforce. In summary:

- Na suggested MRB should not support the "People Plan" as there was no way to achieve the HR KPIs as the Māori workforce gap was too large and the nursing numbers will fail!
- It was advised that much more effort needs to be put into preparing Māori for employment readiness. Four Māori nurses recently dropping out of NEtP recently, was an example of this. This was likely due to lack of home support and/or other social circumstances. Getting a degree was just the start!
- Many of our whanau need to be nurtured and prepared well to seek and retain employment.
- It was highlighted that HBDHB have by far been the highest employers of Māori nurses in NZ, amongst the 20 DHBs. There has been such a push to have Māori in HB employed and gain higher education - but without support. We need to support them all, especially those with management/leadership potential.
- JB advised that under the Turuki programme many do receive cultural support.
- Workforce development was one strand within the NUKA model which needs to be considered.

There were no action items from this discussion.

6. MRB WORK PLAN

The Work Plan was noted.

7. MRB CHAIR'S REPORT

A brief update was provided around the NUKA Model and trips(s) to Alaska"

- The recent trip to Alaska had been very positive and will assist to move planning forward.
- Noted there have been senior medical officers travelling to observe NUKA (independently). We need to be mindful of this group and bring the clinical people into the planning group.

8. GENERAL MANAGER MĀORI HEALTH REPORT

GM Māori Health provided an overview of his report which covered: Māori Health Services including the Health Improvement and Operations Team; Nursing Strategy (including Research Committee, Audit EIT Masters in Nursing and Māori Nurse workforce projections): Tūruki Māori Workforce Development Strategy and the Ngātahi Workforce Development Programme.

The report was taken as read.

Na Raihania questioned the interpretation of te reo Māori terminology in the key domains (pou) within the Ngātahi framework.

Action: GM Māori Health **to confirm the process to determine used in the definition of** te reo Māori terminology in the key domains (pou) within the Ngātahi framework.

A summary of further discussion:

Ngahiwi Tomoana asked GM Māori Health what were the 'burning issues'. There was general discussion around alcohol and drugs, specifically the "**P Epidemic"** and how extremely worrying this is for all New Zealanders. HB do not have a cohesive approach and there is a massive education and planning required. The HBDHB Board have asked management to provide an update in this area.

Foetal Alcohol Syndrome issues within our communities are extremely complex with our children and mokopunas flowing through our schools, going off track and having difficult lives. Parents and family, do not often recognise foetal alcohol signs. Advised that NUKA has the systems and the capacity to change lives.

Lillian advised need to look at **individual problems within whanau** as we are not putting mechanisms in place to get to the grass roots. We continue to work reactively and very much in silos. All agencies need to come on board here. If not, bad behaviours will continue to be the result.

Need to look at what is necessary to **heal the Whare,** from a Māori concepts base. The Government needs to be brave. Costs would be 20% more up front but a lot of funds would be saved at the back end. We need to intervene and be proactive early and the savings will follow – this is a fundamental shift in thinking.

It was advised that the difficulty is with Government requirements which are heavily focused on achieving targets, more electives (more theatres!!) etc **There needs to be a fundamental change in Governments thinking to change and invest at the coal face**. It has been impossible thus far, as when new money comes from Government it comes with more and more demands and criteria which imposes increased costs on all DHBs. If a DHB cannot meet demand they have to outsource at huge cost! Every opportunity needs to be taken to influence politicians.

There were no action items from this discussion.

9. CLINICAL COUNCIL VERBAL UPDATE

Ana Apatu had attended the joint Clinical/Consumer Workshop held on 13 June with the focus on: **Choosing Wisely and Making Prudent Decisions; Person & Whanau Centred Care** as well as the **People Plan.**

- Ana questioned why MRB have a representative sitting as an observer at the Clinical Council table? Kerri Nuku had earlier mentioned that the role of MRB observer appeared to have little value and whether the role should continue.

  Advised this had originally come as a result to monitor allocations of funding reserves through the prioritisation process.
- The biomedical science model is dominant in DHBs. Within HB there are 20 clinical committees reporting through to HB Clinical Council (some mandatory with the number originally being 27).
- South Central's NUKA model is a very balanced model with an organisational focus rather than a hierarchical clinical lobbyist focus. In NUKA Doctors and Nurses are part of flat team structure and not necessarily the leaders within integrated care teams.

PRESENTATION

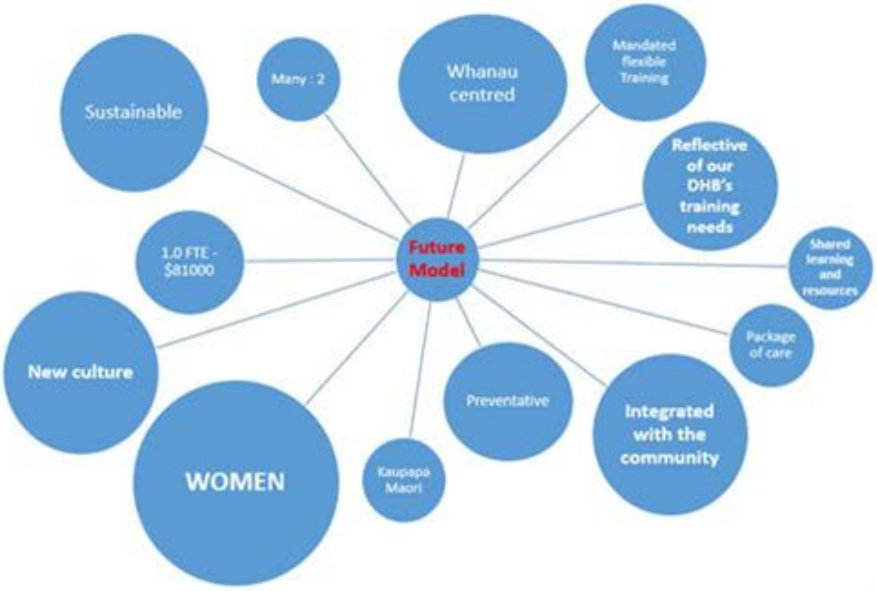
10. VIOLENCE INTERVENTION PROGRAMME (VIP)

An introduction and presentation was provided by Cheryl Newman the Violence Intervention Programme Team Leader. In support were Claire Caddie (Acting Executive Director Provider Services and Wietske Cloo (Acting Services Director for Women, Child and Youth).

In summary:

- An overview of family harm matters/issues was provided which highlighted some very concerning stories.
- HBDHB has a number of policies and procedures and a robust training programme to support staff screening for family harm and abuse and providing suitable follow up. These aren't been routinely and widely adopted, even in situations where harm is evident in injuries. The quality of interventions is a concern also, and reflected in very low disclosure rates.
- Staff lack confidence and become emotionally overwhelmed and it is a constant struggle to focus on in-house improvement in this area. 466 staff have been trained between March 2016 to February 2018 but there has been no significant improvement in our screening and intervention in this same period.

- Hawke's Bay has the highest reported incidence of intimate partner violence in NZ. Women who experience violence are scared, need to know that people care about them and have choices about this occurs.
- Within our Community, we known children just want to be with their families and to be safe! Men often want to stop being violent but lack the skills to do so, and Women want to be in violent free relationships.
- Responses in the community to family harm are growing and evolving. Success has been seen where leadership have taken a strong role in changing the culture of their workforce, partnership with like agencies and targeted specialist staff and teams with smaller workloads. PSEC, Police, Corrections, Whakamana Whanau and Houhou Rongo are some examples.
- VIP quality and improvement actions, the outcomes and current situation were shared, together with **concern about the quality of family violence assessments and lack of sustained change**!
- A mind map was provided of the current model which was: Inconsistent, Isolated, had limited Impact and Training.
- Would like to see a whanau centred care model. The future model needs to focus on women, whanau centred, and be part of a **community response, a new culture and be sustainable.**



He aha te mea nui o te ao?
Maku a ki atu,
He tangata
He tangata
He tangata
Those assaulted are someone's Mother. Someone's Daughter. Someone's Friend.

We cannot continue to be reactive, we need to prevent!

Summary of Feedback:

- Members admired Cheryl and conveyed thanks for her honesty and her will to change things for the better going forward.
- The Wellness Warriors were highlighted as an ideal link. Asked whether those in need of help would open up to Māori led interventions?

  In response: some want to go outside their culture – they just want to have choices.

  Relationship skills around values and behaviours is the foundation here.
- Investing at the coal face, and identifying the needs at the outset is crucial. We also fail within the primary care environment. Some victims will never open up in that environment but Māori can support here. This is about the need for an integrated all-encompassing response of not only support including psychological support as well.
- The issues appear to mirror Work and Income and their inability and lack of confidence to champion what is required within their organisation. An intervention requires leadership at highest level. This is about family wellness and we must ensure we measure outcomes of what is put in place.
- Supporting the Police response and focusing on Tairawhiti DHB and how that has been co-designed to see it their model could be implemented in HB.

- We need the confidence to ask the hard questions!
- Complex issues including multigenerational matters are fuelling the behaviours which result in violence! Integrated responses have been seen in Christchurch and Hamilton, where men go to get healing and support to change.
- Were there screening programmes at schools, to pick up on children in homes were domestic violence was occurring?

There were gems, pockets of knowledge and support offered including by JB Heperi-Smith and MH team as well as the key staff involved with engaging effectively with Māori.

The HBDHB Board Chair advised this was all about providing support. It was encouraging how MRB recognised and embraced the issues and were happy to support and work with the VIP team.

P offences have now overtaken domestic violence offences over the past three months.

Need to identify and understand the issues and how MRB help with this. Keen to see an update on progress to ensure we get closer to the benchmark results. MRB seek regular reporting to come through to ensure progress.

Actions:

- **Offer of support from Māori Health Services and NKII to work with Cheryl and the VIP team to develop a plan to achieve outcomes that can be measured to ensure progress is being made.**
- **Introduce the VIP team to the "Wellness Warriors".**
- **An update on progress will be provided at a future MRB meeting (month to be advised).**
- **The CEO will raise this with other agencies through the Regional Economic Development Strategy (REDs) Intersector Group.**

FOR DISCUSSION

11. HE NGAKAU AOTEA

A presentation entitled He Ngakau Aotea, a roadmap to reducing health inequities in the next 5-10 years was provided by George Mackey. Others involved in the development of this presentation were Na Raihania and Beverly TeHuia.

All acknowledged this is the time for change and we need to be brave to achieve equity. The problem with Māori people happened 200 years ago and the issues are too big for the DHB to fix.

We need to develop a plan and then go out to our Māori people to ascertain what we need to do. This is about reducing health inequities for Māori.

Outcomes - Co-design is process of asking what is needed first. We need to empower whanau to take control of their future.

Where do we start? We have to learn to grow trust and break down the barriers. The key is to have people self-reflect by asking, could I have changed the outcome by handling things differently? What we need to do? What are we doing? Why are we doing this?

We have enough collective money in our region. We need to present this to the NKII Board and to Matariki and take the DHB Board with us. Advised this would be a dual parallel strategy which would assist the DHB fulfil its obligations and the other aspect to develop Iwi led solutions.

Points in the presentation:

- Where to next? We need to talk to our own, hand in hand with the DHB and start populating ideas.
- Advised need to present to DHB – to MoH that this is from Māori and NKII will join. We need to ensure we lock this in place form a Māori perspective.
- Should this be part of the RED's strategy? Matariki includes REDS and Social Inclusion – could be a nice fit. That Board (and its representation) have come a very long way ie, in two years, their understanding has encompassed 20 years, and everyone is accepting of change. .
- We now need a roadmap. A paper will be developed, whanau consulted with.

Feedback:

- The HBDHB Chair advised it would be impossible to see any change within the next 12 months as direction has already been set. We need to identify something that we could potentially implement next year. Probably not the most challenging but identify working in a different way and do it in a reasonably quick time – tweak it and they overlay it onto other areas with actions and timelines.

Lillian Ward suggested the "Whanau Wellness Improvement Programme" could be the programme to align and lock in fairly quickly.

- Advised that the DHB is a funder of services and a willing participant to change service offers. We need to pick one service and work intensively.
- The GM Māori Health stated that MRB members and other Māori stakeholders and whānau had been stating the same issues for some time. It was pleasing to see the strategic commitment to equity, co-design of services with whanau, specific responses to whānau with the greatest unmet need and Nuka system of care themes coming through strongly in both He Ngakau Aotea and CSP. He suggested there needed to be much wider co-design and consultation with key Māori and iwi stakeholders and whanau. Nevertheless, he stated the common must also come through strongly within the development of a HBDHB 5 Year Strategy.
- JB Heperi-Smith acknowledged cultural improvement and the 4 quadrants. We need a system that supports Kaupapa Māori.

Actions

a) MRB noted the presentation was not complete and George would email to members for comment.

b) A plan of action, a clear consultation process and timelines will be developed and provided to MRB for approval.

Moved: Ana Apatu
Seconded: Trish Giddens

12. TE ARA WHAKAWAIORA – SMOKE FREE UPDATE

Due to lack of time, this paper was noted and members advised they supported the next steps as outlined in the report provided.

FOR INFORMATION ONLY (NO PRESENTERS)

13. USING CONSUMER STORIES

This paper had been withdrawn – no discussion

RESOLUTION TO EXCLUDE THE PUBLIC

RESOLUTION

That the Māori Relationship Board

Exclude the public from the following item:

16. Clinical Services Plan First Draft discussion

Moved: Ana Apatu
Seconded: Lynlee Aitcheson-Johnson
Carried

The public section of the MRB meeting closed at 11.30am

Signed: _____
Chair

Date: _____

MAORI RELATIONSHIP BOARD MEETING
MATTERS ARISING (Public)

Action #	Date Issue first Entered	Action to be Taken	By Whom	Month	Status
1	12 May 16	**Review form and function of MRB including a Youth Representative:** NKII and MRB to review MRBs composition giving consideration to a Youth Representative.	CEO NKII	Sept 2017	
	11 July 18	**Consideration for Youth representative on MRB** ongoing.	CEO NKII	Aug 18	Verbal Update
		MRB Terms of Reference: ToR change to include Youth representation.	CEO NKII	Aug 18	Verbal Update
2	7 Sept 17	**Nuka Model Wānanga:** Wānanga at a later date to put forward input into the Nuka Model process.	Patrick LeGeyt		Verbal Update
3	11 July 18	**"He Ngakau Aotea"** MRB noted the presentation was not complete and would be emailed to members, who would in turn provide feedback.	George Mackey	July 18	Actioned
	11 July 18	A plan of action, a consultation process and timelines will be developed and provided for approval by MRB.	George Mackey	July 18	Verbal Update
4	11 July 18	**Ngātahi framework:** GM Maori Health to confirm the process to determine used in the definition of te reo Māori terminology in the key domains (pou) within the Ngātahi framework.	GM Maori Health	Aug 18	Verbal Update

Maori Relationship Board Workplan as at 1 Aug 2018 - subject to change	**EMT Member**	**MRB Meeting Date**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**BOARD Meeting date**
Annual Plan 2018/19 Draft - Presentation	Chris Ash	8-Aug-18	8-Aug-18	9-Aug-18	29-Aug-18
Clinical Services Plan Monthly Update (aug, sep, oct)	Ken Foote	8-Aug-18	8-Aug-18	9-Aug-18	29-Aug-18
HBDHB Performance Framework Exceptions Q4 Feb/May/**Aug 18** Just in time includes Maori and Pasifika	Kevin Snee	8-Aug-18			29-Aug-18
Te Ara Whakawaiora - Access (Ambulatory Sensitive Hospitalisations) Rates 0-4 / 45-65 yrs (local indicator)	Kevin Snee	8-Aug-18	8-Aug-18	9-Aug-18	29-Aug-18
Alcohol Positon Statement	Kevin Snee	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Annual Plan 2018/19 - approved ?	Chris Ash	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Clinical Services Plan Monthly Update (aug, sep, oct)	Ken Foote	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Matariki Regional Development Strategy and Social Inclusion Strategy update (6 mthly) **Sept**-Mar	Kevin Snee	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Te Ara Whakawaiora - Breastfeeding (National Indicator)	Kevin Snee	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Urgent Care (After Hours) Service Update 6mthly (Sept-Mar-Sept)	Wayne Woolrich	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Primary Care Update Presentation	Chris Ash	12-Sep-18			
Clinical Services Plan Monthly Update (aug, sep, oct)	Ken Foote	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
National Mental Health Inquiry	Colin Hutchinson/Claire Caddie	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
"It's hard to ask" (Renal) (up to 30 minutes)	Patrick LeGeyt	10-Oct-18			
Using Consumer Stories Revised ... (not considered in July by governance groups - pulled at the last minute)	Kate Coley / John Gommans	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
Te Ara Whakawaiora - Alcohol and other Drugs (National and Local Indicators)	Kevin Snee	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
Te Ara Whakawaiora - Cardiovascular (National Indicator)	Kevin Snee	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
Te Ara Whakawaiora - Improving Access Indicator	Kevin Snee	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
He Ngakau Aotea - Strategic Priorities for MRB -	Patrick LeGeyt	10-Oct-18	10-Oct-18	11-Oct-18	29-Aug-18
Te Ara Whakawaiora - Mental Health (MRB Action)	Patrick LeGeyt	10-Oct-18			
Health Equity Report	Kevin Snee	14-Nov-18	14-Nov-18	15-Nov-18	28-Nov-18
Establishing Health and Social Care Localities in HB (Mar 18,**Sept)** - update on activity planned	Chris Ash	14-Nov-18	14-Nov-18	15-Nov-18	28-Nov-18
HBDHB Performance Framework Exceptions Q1 **Nov 18** Feb 19 /May/Aug 19	Kevin Snee	14-Nov-18			28-Nov-18
Te Ara Whakawaiora - Access (Ambulatory Sensitive Hospitalisations) Rates 0-4 / 45-65 yrs (local indicator)	Kevin Snee	14-Nov-18	14-Nov-18	15-Nov-18	29-Aug-18
Te Ara Whakawaiora "Smokefree update" (6 monthly May-**Nov**) each year	Kevin Snee	14-Nov-18	14-Nov-18	15-Nov-18	28-Nov-18
People Plan (6 monthly - **Dec**, Jun)	Kate Coley	5-Dec-18	5-Dec-18	6-Dec-18	19-Dec-18
HBDHB Performance Framework Exceptions Q2 Nov 18 **Feb 19** /May/Aug 19	Kevin Snee	13-Feb-19			27-Feb-19
Te Ara Whakawaiora - Improving Access Indicator	Kevin Snee	13-Feb-19	13-Feb-19	14-Feb-19	27-Feb-19
Ngatahi Vulnerable Children's Workforce Development - annual progress **Feb 19**	Colin Hutchinson/Claire Caddie	13-Feb-19	13-Feb-19	14-Feb-19	27-Feb-19
Establishing Health and Social Care Localities in HB (**Mar** 19,Sept**)** 6monthly	Chris Ash	13-Mar-19	13-Mar-19	13-Mar-19	27-Mar-19
Matariki Regional Development Strategy and Social Inclusion Strategy update (6 mthly) Sept-**Mar**	Kevin Snee	13-Mar-19	13-Mar-19	14-Mar-19	27-Mar-19
Urgent Care (After Hours) Service Update 6mthly (Sept-Mar-Sept)	Wayne Woolrich	13-Mar-19	13-Mar-19	13-Mar-19	27-Mar-19

MĀORI RELATIONSHIP BOARD
CHAIR'S REPORT

Verbal Update

HAWKE'S BAY District Health Board Whakawāteatia	**GM Māori, Monthly Māori Health Report**
	For the attention of: **Māori Relationship Board**
Document Owner:	Patrick LeGeyt, General Manager (GM) Māori Health
Month:	July 2018
Consideration:	**For** Information

9

RECOMMENDATION

That the Māori relationship Board:

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

THIRD IWI LED DELEGATION TO SOUTH CENTRAL FOUNDATION, ALASKA, USA

From 15 - 22 June 2018, Ngāti Kahungunu Iwi Inc (NKII) led a third delegation, consisting of HBDHB, Health HB PHO, Te Taiwhenua o Heretaunga and NKII governance, management, and clinicians attended the Core Concepts Training and 8th Annual Nuka System of Care Conference hosted by South Central Foundation (SCF) in Alaska, USA.

The insights and learnings of previous Hawkes Bay delegations have been influential in socialising and shaping strategy and approaches in forging a new path ahead in the way care - and notably primary health and social care – is delivered. However, there is a growing expectation, with the level of investment of delegations to SCF, that some specific tangible initiatives needed to be produced.

The third delegation sought to identify key aspects of the Nuka System of Care that could be transferrable to the HB health system. The following aspects of the Nuka System of Care have been identified by the third delegation as potentially transferrable towards the health care system in HB:

1. Core Concepts Training
2. Consumer Co-Design
3. Integrated Care Teams in primary care
4. Behaviourists in primary care
5. Traditional Wellbeing approaches

Nuka and HB Health System Context

It is evident that both SCF and HBDHB operate in different contexts. SCF is an Alaskan native owned health care organisation, under the tribal authority of Cook Inlet Region, located in Anchorage, Alaska, USA. They provide a broad spectrum of primary health care and related services but also jointly own and manage, with the Alaska Tribal Health Consortium, the Alaska Native Medical Centre, which includes a 150-bed hospital providing inpatient, specialty and tertiary medical services. Most of the hospital services are available to the entire Alaska Native and American Indian population of Alaska. The SCF geographical service area covers

172,844 square kilometres in Alaska. SCF employs 2,161 staff, has annual operating budget of US$350m (NZ$473m), and services 55,000 customer owners across Alaska.

Hawkes Bay health care system is a mix of government owned (secondary/tertiary) and privately owned (primary care) providers. HBDHB, via direct funding from Ministry of Health (MOH), is the primary funder of health services in Hawkes Bay with smaller contributions from the MOH, ACC, Insurance and consumers. Primary health care is largely delivered by independent general practice providers, geographically spread across HB, that provide a limited set of services. The health system in HB employs around 5,000 people, serves the total population of HBDHB region of 155,000 people with annual DHB budget of $560m.

Description	South Central Foundation	HB Health System
Ownership	Alaskan tribal ownership 'customer-owners'	Government owned (secondary/tertiary) Privately owned (primary care)
Population	55,000 Alaskan native and American Indian peoples	155,000 (76% NZ European, 26% Māori, 4% Pacific, 4% Asian)
Geographic area (sq. km)	172,844	14,164
Funding (total)	US$350m (NZ$473m)	NZ$560m
Funding (source)	Medical insurance 53% Federal government funded 43% Grants 6%	MOH funded 90% Fee for Service 5% ACC 5%

Key Features of Nuka System of Care – Are they transferrable?

Despite the key differences in organisational ownership structures, funding sources and population there are key features of the Nuka system that can be transferred to the HB context. The HBDHB Clinical Services Plan (CSP) - *Transforming Our Health System - Clinical Services Plan: the next 10 years*, establishes a firm commitment 'to prioritising and designing services to meet the needs of populations with the poorest health and social outcomes' by, amongst other things, 'incorporating the guiding principles of the Nuka System of Care, whilst giving primacy to Māori indigenous thinking, values and solutions'.

Customer Owners – Consumer Co-Design Partnerships

A key driver of transformation in any health system is enabling the voice of the consumer to codesign health system and services. Twenty years ago, SCF embarked upon whole-system transformation and redesign and was largely drawn from asking the people what they wanted from a health care system. SCF employed over 10 strategies to listen to the customer-owners and conducted extensive interviews, surveys and focus groups with community members and tribal leadership about the shortcomings of the old system and ideas for change.

The people told SCF they were tired of unfriendly and rude staff, long waiting times and seeing different health professionals every time. They wanted to be treated with courtesy, respect their opinions and understand their culture. They wanted access to services when they needed them, access their own consistent provider, culturally appropriate care and traditional healing, improved facilities and direct input into redesigning healthcare. The 'Nuka System of Care' emerged completely from community feedback and formed the basis for SCF operating values and principles.

HBDHB, whilst not daring a 'whole of system redesign', has embarked on committing to improving the health system, especially for those most in need, with consumer feedback from The Big Listen, Korero Mai and the development of the Clinical Services Plan (CSP). The CSP promises to include 'the voice of the consumer' in service redesign and ultimately aims to work *with* whānau rather than doing *to*, and *for*, them. Moreover, person and whānau centred care

will become a core principle of service commissioning and the norm of 'the way we do things in HB'. These key principles point towards a transformation of the HB health system.

Core Concepts – Whakawhanaungatanga/Respectful Relationships

In response to customer-owner feedback, all SCF leadership and staff receive intensive and continuous training in organisational values and culture. SCF reinforces organisational philosophy with a three day Core Concepts training, which is run quarterly and focuses on developing behaviours and actions needed to deliver its mission and Nuka care model. As part of SCF's Administration Support Training Programme, reception staff spend a total of seven weeks in orientation and training before they start work in their greeting customer owner roles. All new staff go through a week long orientation into the Nuka system of care, SCF philosophy, ways of working as well as Alaskan Native people and cultures. New staff then spend six to nine months in mentoring programmes to support their transition.

In HB, consumers have also feedback about respectful relationships with their providers and the need for greater understanding of their culture. HBDHB aims to improve organisational culture based the HEART values and behaviours. There are a number of key investments, strategies and trainings aimed at improving culture and cultural competency, including the The Big Listen, HBDHB People Strategy, Effectively Engaging with Māori Training and Relationship Centred Practice. However most of these approaches are not core training, are delivered in siloes and not integrated.

Building upon Effectively Engaging with Māori and Relationship Centred Practice Training, we also have an opportunity to develop our own Hawkes Bay version of 'core concepts' – Whakawhanaungatanga/Respectful Relationships. Induction/Orientation Day into the health workforce is the opportunity to train new staff in the 'way we do things around here'. Similarly, staff already employed in the health system would also be expected to undergo regular core concepts training. The orientation period would need to be extended to at least 2 days and should include other health organisations (NGOs, GPs etc.).

Integrated Care Teams – Evolving Primary Care

Alaskan Native people prefer holistic approaches when addressing illness and health. Primary care is therefore delivered with smaller 'Integrated Care Teams' (ICT), with a strong emphasis on long term relationships. Customer owners choose their own primary care teams and stay with them to ensure continuity of care.

ICT work in shared open spaces that helps foster greater team work. ICT's include primary care GPs, nurse who coordinates care, medical assistant, an administrative assistant and behavioural health consultant. ICT's ensure customer owners see the right person – the GP for new issues, the nurse coordinator for monitoring and the pharmacist for prescriptions. It circumvents the GP as the bottleneck that limits access to care. Every two ICT have full access tribal doctors or traditional healers as well as nurse practitioners, chiropractors, midwives, massage therapists, acupuncturists, dieticians, pharmacists and specialists.

Same day appointments are guaranteed for customer owners. In order to achieve this SCF broadened its communications channels with customer owners, reducing its reliance on face-to-face consultations and increasing use of phone, text and email. The teams use face to face for more serious issues and phone consultations for minor ailments, and use of phone, text and email for routine monitoring and some preventative screening. From 2008 to 2015, SCF experienced a 25% decrease in visits to the primary care centre with customer satisfaction rates at 96%.

In HB, Integrated Care Teams feature heavily within the CSP – Evolving Primary Care. The CSP states that primary care will incorporate the principles of Nuka ICT teams with

multidisciplinary teams providing integrated health and care services in primary care centres and the community.

Behavioural Health Services

A key part of ICT teams is the inclusion of behavioural health practitioners. Behavioural Therapists work across a broad range of health needs from teenage life skills development, individual counselling and therapy, addiction services (detox, residential, counselling etc.), crisis support to chronic mental illness case management support. The major condition presenting to behaviour therapists is Attention Deficit Hyperactivity Disorder (ADHD), which is also most common for Māori children.

Behavioural Health services are organised around brief intervention, focused intervention and long term intervention approaches according to assessed need. Brief interventionists only have 3-4 booked appointments per day, with provision made for walk-ins and ensuring customer-owners have guaranteed appointments on the day.

In HB, the CSP identifies the growing need for integration of 'behaviourists' within primary care. Similar to Nuka, Behaviourists will become a key part of primary care teams as a better first line mental wellbeing service, providing early intervention as part of holistic primary care services and, ultimately, reducing referrals to specialist services. It is an opportunity to increase equity, providing direct support for the most vulnerable people.

Traditional Wellbeing

SCF recognised that in order to influence health outcomes that afflicted their community – chronic disease, addiction, domestic violence, child abuse and neglect etc. – they needed to influence choices and change behaviour. This required a greater understanding and application of Alaskan native culture or 'native wisdom'. Native wisdom recognises that, for Alaskan Native people, social, cultural and spiritual connectedness is not separate from, but rather, integral to physical health.

Native wisdom informs service design approaches to be targeted towards families and communities rather than individuals. It encourages traditional cultural practices, including their spiritual and social dimensions, as best practice for working with Alaskan Native people. It stresses that a system owned by the customers will at its core be culturally competent because they are the designers and decision makers.

SCF place high value on culture and traditional healing. Over many years, SCF explored and researched traditional healing approaches and how these could be incorporated into the accredited medical environment. Traditional healing programmes started in SCF behavioural health programmes and were gradually transitioned into a tribal services division where they were able to be accessed by both behavioural health and medical practice areas. Tribal doctors, appointed by a council of elders, hold the same status as medical doctors.

SCF, within their signature programmes – Learning Circles, Traditional Healing Clinics and Wellness Warriors Initiative, were developed in response to what the community identified as their top needs in which trauma related issues rank highest.

'Talking Circles', first developed in behavioural health to connect to those with mental health, trauma, substance abuse and juvenile justice issues, developed into 'Learning Circles' where small groups of customer owners share an interest and desire for personal growth in an area of common interest. They create an intentional, safe and supportive network where relationships are built and learning opportunities from each other are provided.

Traditional Healing Clinics, combines culture with healing and go into deeper trauma related issues to address physical, mental, emotional and spiritual healing. Traditional healers aim to

treat the multigenerational trauma the customer owner carries from their own history. It consists of counselling therapy and conflict resolution, massage/pain therapy and traditional cleansing through prayer or ceremonial song or dance and traditional herbal medicine.

Family Wellness Warriors also helps address historical trauma or intergenerational trauma related to family violence, child abuse and child neglect. It is an intensive training and education programme focused on those that have been harmed as well as the have caused or are at risk of causing harm. It incorporates traditional spiritual practices into the healing process. In addition to raising awareness of these issues and their causes, the programme relies on personal testimony as a strategy for healing and healthy relationship training with counselling provided by therapists. Results have demonstrated improvements for participants across a number of indicators

All of these indigenous approaches need to be explored more within the HB context. We have very successful similar wellbeing approaches in HB such as Iron Māori, Patu, Tai Timu and Rongoa Māori with limited investment from the health system. These need to be supported further as well as other more traditional tikanga based initiatives such as mau rakau and kaka haka etc. A tikanga Māori approach to family violence, addiction and adverse traumatic experiences needs further exploration.

TE ARA WHAKAWAIORA REVIEW

Māori Health Service has finalized a draft report on the Performance of the Indicators under Te Ara Whakawaiora (TAW) Programme since its inception.

Māori Health Service has also initiated a TAW mini-survey to gather information from selected members of MRB, the Clinical Council and Consumer Council on the TAW reports and the Indicator Championship Role. The information will help determine the future of this role in supporting improvement of Māori health outcomes and reducing disparities in the district.

NEW SUDI INITIATIVE

Māori Health, with support from the Child Health team is implementing a Cot Bank initiative. The Cot Bank is the first of its kind in Aotearoa New Zealand, and is Hawke's Bay DHB's response to maintain a vigilant and equitable approach to SUDI. The Cot Bank will help minimise barriers to access for whānau with limited or no means to provide a safe safe sleep environment for pēpi once they have outgrown the wahakura/pēpi pod. The intended health outcomes of the inclusion of safe sleep devices for older pēpi are:

- A reduction in preventable deaths of older pēpi due to SUDI,
- Improved access to safe sleep devices for older pēpi, and
- Support for disadvantaged and at risk whānau.

The Cot Bank has had generous support from community businesses and providers willing to support this initiative. EIT has offered to refurbish donated cots at no cost, Placemakers have offered supplies needed to fix cots, and Habitat for Humanity has offered to store the cots. The implementation aspects are still being worked through, but anticipate the programme to be up and running by 1 September 2018.

KAUPAPA MAORI MATERNAL HEALTH PROGRAMME UPDATE

HBDHB is developing a kaupapa Māori Maternal Health Programme ('the Programme'). A Steering Group has been established and the first meeting held. A scan and analysis of current services and relevant literature has been completed. A matrix has been developed to give consideration to how ngā uarā me ngā whanonga (HBDHB core values) might be reflected in the development of this programme and importantly how they align with Kaupapa

Māori principles of health and well-being. This matrix will be the pou upon which the programme is developed and implemented.

The next stage is to gather whānau perspectives to find out what māmā and their whānau think about a Kaupapa Māori maternal health programme, and to gather information about their pregnancy experiences. A total of 82 interviews are planned (62 māmā interviews and 20 whānau) from across Wairoa, Napier, Hastings, and Central Hawkes Bay. Eligible māmā will be identified via HBDHB maternity data. This component of the project has been registered with the HBDHB audit office. Interviews will be carried out during August, with draft findings presented to the Steering Group in September.

REGIONAL SEXUAL HEALTH PLAN UPDATE

A regional sexual health plan is being developed via a partnership approach between Population Health, Māori Health, and Strategic Services, with strategic direction and oversight from the Sexual Health Clinical Governance Group. Current activities include: development of an intervention logic that aligns with HBDHB priorities for equitable health outcomes, and the Ministry of Health's draft sexual and reproductive health plan. Plans are also underway for engaging with whanau and gathering consumer perspectives to inform the development of the plan.

HBDHB DRAFT SUSTAINABILITY POLICY

The Māori Health Improvement team have recently engaged with Facilities Management Department to discuss the HBDHB draft sustainability policy. The facilities management department sits within the Health Services Division. It provides a number of support services to assist in the delivery of health services, primarily maintenance, grounds, biomedical engineering, sustainability, service contracts, capital projects, property management, fleet services and travel plan. Facilities manage $200m worth of the DHB assets and manage and deliver large multi-million dollar portfolio of capital projects. HBDHB will foster a culture of environmental sustainability and encourage leadership in sustainability throughout the organisation.

Many elements of kaitiakitanga align with the concept of sustainability by acknowledging the mauri and wairua when it comes to our natural resources and environment. The HBDHB recognises its responsibility to tangata whenua to act together as kaitiaki in the active management of our operations in an environmentally sustainable way - The purpose of this policy is to provide a vision and a set of principles to guide our actions to support sustainability and improve our environmental performance. In the context of this policy, sustainability refers to environmental sustainability.

HBDHB has selected five areas of focus based on potential financial, equity and efficiency, social and environmental impacts. The intent is to increase resilience and implement both mitigation and adaptation strategies underpinned by cost benefit analysis, co-benefits and financial savings. The following sections outline the policies for each of these areas are overlapping and should not be viewed in isolation.

Energy and Carbon Management

HBDHB will prioritise energy efficiency from the outset to manage ongoing energy costs and environmental impact. Unnecessary utilisation and waste will be managed and limited in order to reduce pollution and carbon emissions. It will use or procure renewable energy whenever feasible. Ongoing operational costs will be considered alongside initial capital expenditure with a primary focus on total cost of ownership (whole-of-life view).

Sustainable Waste Management

HBDHB seeks to minimise waste generated and therefore costs and environmental impacts. Waste management procedures will seek to improve efficiency, reduce waste, increase re-use and recycling, provide safe and appropriate management of waste for disposal and will not compromise the safety of any person or have an adverse effect on the environment.

Sustainable Water Management

HBDHB will implement water conservation strategies whenever possible including technologically proven devices in all new buildings and refurbishments. Water consumption will be considered in the purchase of new equipment by evaluating water efficiency labelling against other factors.

Sustainable and Efficient Buildings and Site Design

Green building principles have the potential to reduce operation and maintenance costs and reduce the environmental impact of the HBDHB and will therefore strive to increase efficiency, cost-effectiveness, flexibility and adaptability, optimise site potential and minimise building footprints, impervious areas and development of the hospital site. Site design will consider sustainable transportation including site circulation for vehicles, bicycles and pedestrians.

Sustainable Transportation and Travel Management

HBDHB seeks to significantly reduce the carbon emissions of commuting, patient travel and avoidable business travel to reduce its emission profile of travel by promoting and supporting the use of alternative modes, carpooling and active transport and requiring the purchase or lease of electric or hybrid vehicles when financially viable.

MAORI WORKFORCE DEVELOPMENT ACTION PLAN

Māori Health have set up a steering group to review Māori workforce components, set priorities and timeframes to support realistic achievement of 4 key areas within strategy:

1. Increase both the Māori representation in our workforce
2. Increase the number of Māori leaders in our workforce
3. Build the Capability and capacity of our Māori workforce
4. Improve the cultural capability of existing workforce

Some of the actions from the meeting have been:

- Review of the Turuki and Health Work force funding to better align with Māori workforce strategy. Increased focus on leadership development and growth will be a priority change.
- Meeting with Professional Development coordinator to support components of workforce strategies within nursing growth. Key area discussed in developing future leaders with knowledge and understanding of equity and engaging effectively with Māori.
- Establish Māori workforce strategy budget and explore the delivery of equity workshops and Māori leadership wānanga to support the overall Māori workforce strategy.

Maori Health have been invited to support HR develop a Values Based Recruitment. This is an opportunity to intentionally implement the four objectives outlined in the Māori Work Force Action Plan to imbed into the recruitment process.

Intentional approach to imbed in the recruitment process (notes for first meeting)

- What efforts are being made by HR and Managers to recruit and increase Māori representation in our workforce
- Are the hiring Managers "walk the talk" in their approach to attract, hire and retain Māori staff
- Is there a recruitment target set as part of their annual KPIs
- At what level should this target be set, who will monitor and reinforce this?
- That all interview panels include a Māori Health / Māori representative.
- That the application of Tikanga Māori be implemented and be the norm for all interview panels.
- Cultural training for Māori representatives on interview panels.
- Integrate HBDHB values into the recruitment process – example do we hire purpose to fit "core values".

Māori Health have partnered with Dr Kate Robertshaw, Director of Medical Training, to support cultural development within their own spaces, to help further develop cultural competency within SMO and RMO.

- Increase the number of SMOs to participate Engaging Effectively with Māori training
- Capture new SMOs from overseas for a cultural induction with Māori Health Kaumatua before contract start date / pōhiri.
- Flexible Cultural training for SMOs and RMO within their environment.

NGĀTAHI WORKSHOP

The launch was held on the 24 July at Pukemokemoke marae in Maraenui. An excellent turnout with over 140 attendees. Keynote speakers, included Dr Leyland Ruwhiu (Oranga Tamariki), providing further insight into the kaupapa and the required workforce necessary to work with vulnerable families.

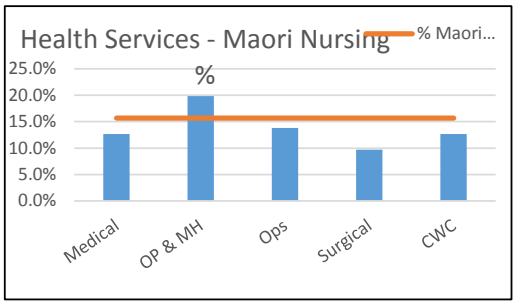
A workshop supporting feedback in development of work streams, completed within the wānanga to identify and provide critique and further suggestions to include in the delivery of the 3 work streams to this large diverse workforce group.

MĀORI NURSING WORKFORCE

Hawkes Bay DHB current Māori nursing workforce. (2028 need 450 approx.)

- May Māori Nursing workforce– 13% - Aim 15.68% No 210/1619
- June Māori Nursing workforce- 12.7% - Aim 15.68% No 201/1622

Health Services - Māori Nursing %	**Māori**	**Total**	**%Māori**	**Māori Target**	**Gap**
Medical Directorate	58	458	12.7%	15.68%	14
Facilities	0	0	0.0%	15.68%	0
Old Person, MH, AH & Options	30	151	19.9%	15.68%	-6
Operations Directorate	42	304	13.8%	15.68%	6
Surgical Directorate	32	330	9.7%	15.68%	20
Communities, Women & Children	48	379	12.7%	15.68%	11
Health Services - Māori Nursing % Total	**210**	**1622**	**12.9%**	**15.68%**	**45**



FSA DNA Reduction Support.

The Monthly FSA DNA (ESPI Specialities) rate was 14.4%.
The following is a breakdown of DNA support provided for the month:

Pre-emptive Calls – 235
Confirmed Appointments – 150
Re-scheduled Appointments – 13
Home Visits – 29
Messages Left – 42
Not Contacted – 33

Safe Sleep Programme.

The following is a breakdown of what supports the acting Safe Sleep Programme Coordinator provided for mums:

Wahakura Issued – 23
Pēpi-pods Issued – 2
Training Sessions – 2

HB CLINICAL COUNCIL

Verbal Update

ANNUAL PLAN 2018/19 (draft)

Presentation

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Performance Framework Exceptions Report Quarter 4 2017/18**
	For the attention of: **Māori Relationship Board, Pasifika Health Leadership Group, Clinical and Consumer Council and HBDHB Board**
Document Owner	Anne Speden, Executive Director, Corporate Services
Document Author(s)	Peter Mackenzie, Business Intelligence Analyst
Reviewed by	Executive Management Team
Month/Year	August, 2018
Purpose	Monitoring
Previous Consideration Discussions	N/A
Summary	Areas of Success: Health Target – Raising Healthy Kids, Immunisations at 2 years of age. Areas of Progress: Health Target – Shorter Stays in ED Areas of Focus: 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 and/or Pasifika Health Leadership Group Clinical & Consumer Council and HBDHB Board:

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

HBDHB PERFORMANCE FRAMEWORK
Quarter 4 2017/18

Author:	Peter Mackenzie
Designation:	Business Intelligence Analyst
Date:	August 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 30st June 2018, 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

Table of Contents

PERFORMANCE HIGHLIGHTS – TOTAL POPULATION

Achievements

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

- The number of B4 school checks carried out for the year exceeded the target at 100%

Areas of Progress

- Health Target – Shorter Stays in ED has improved from 89% in the previous quarter to 91% however this is still below the target of 95% (page 8)

- Immunisation at 4 years – The overall rate has increase by 1.3% and is currently 93% compared to the target of 95% (page 14)

Areas of Focus

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

- DNA – Overall we have favourably remained at 6.5% which is below the target of 7.5% however both Maori (12.3%) and Pacific (16.6%) have increased over the previous 2 quarters and sit significantly above the target.

- 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)

- Better access to Mental Health – There has been a decline in access across the age groups 0-19 and 65+. 0-19 is currently 3.86% against the target 4% and 65+ is currently 1.12% against the target of 1.15% (page 24)

PERFORMANCE HIGHLIGHTS – EQUITY

Achievements

- Immunisation of 2 year olds – The Maori rate is currently 95% and the Pacific rate is 98%, both are above to the Total rate of 94%.

- Health Targets Healthy Kids – The Maori is currently 100% and Pacific at 100% against a target of 95%. They are the same at the Total Rate of 100%

- Access to Mental Health: Maori results for all age groups (0-19, 20-64, 65+) are favourable to target

Areas of Progress

- Health Target – Shorter Stays in ED increase from 90% in the previous quarter to 94%, narrowly missing the 95% Target (page 8)

Areas of Focus

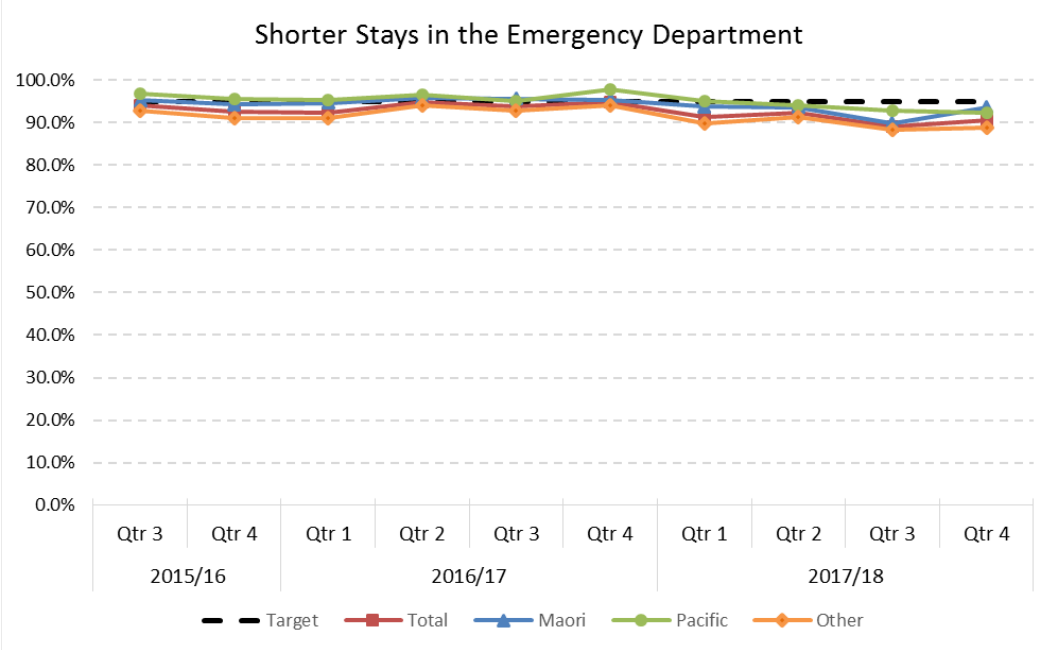
- Rate of Section 29 orders per 100,000 population – Maori Rates are currently 398 per 100,000 against the target of <81.5 and are 3 times higher than the non-Maori Rate (page 26)

- DNA – Both the Maori and Pacific rates of DNA have increased over the Q4 period which is disappointing to see. The Maori increased by 2.1% in Q4 and now sits at 12.3%, the Pacific rate has increased by 2.6% and now sit at 16.6% against a target of 7.5%.

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%	89% (U)	91% (U)	≥95%	▲
Maori	94.8%	90% (U)	94% (U)	≥95%	▲
Pacific	94.8%	93% (U)	92% (U)	≥95%	▼
Other	91.6%	88% (U)	89% (U)	≥95%	▲



Data Source: HBDHB

Comments:
The work the DHB has done this quarter to support the Shorter Stays in EDs health target includes the recruitment, orientation and implementation of 4th Nurse Practitioner (NP) to independent practice. This enables additional coverage and extended hours of the Fast track role at front of house on an extended basis but does not provide 7 day a week extended hours. The extension of NP hours provides early senior nursing assessment and decision making, improving patient clinical safety in the waiting room when the department is at or over capacity. There has been funding to open an additional 10 bed inpatient ward to support periods of high demand, particularly surgical patients. Also additional nursing FTE (as an outcome of CCDM program) has enabled introduction of after-hours senior nurse in Acute Assessment Unit (Mon-Fri) focusing on pulling acute medical patients from ED and development of cross-team relationships after hours. There is ongoing daily monitoring and reporting of ED6 breaches and collaborative analysis by specialty groups. There is also renewed organisational focus on acute patient flow with executive sponsorship of a Fit for Winter program. Stronger organisational focus on specialty response to ED and discharge processes including the provision of senior nursing resource into the discharge lounge and re-establishment of the long-stay patient rounds also aims to tackle the ongoing issues.

1 October to December 2016
2 January to March 2018
3 April to June 2018

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:				

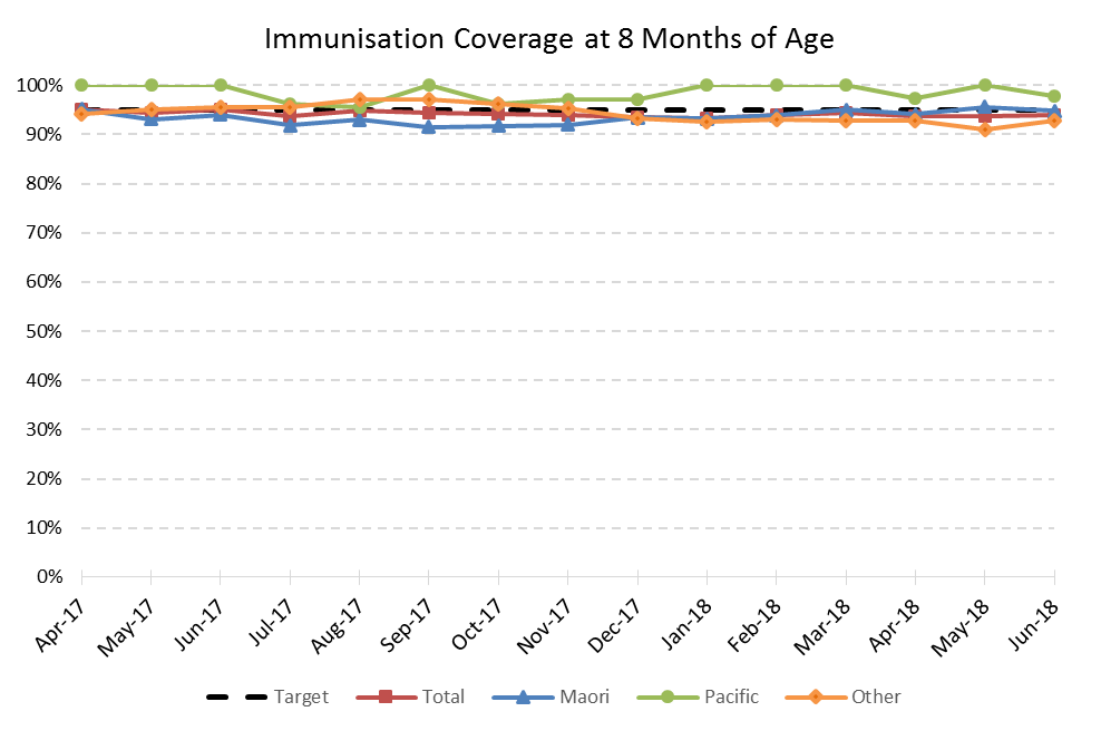
4 2015/16 target

5 July 2016 to June 2017 Source: Ministry of Health

6 July 2017 to June 2018 Source: Ministry of Health

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

Ethnicity	Baseline [7]	Previous result [8]	Actual to Date [9]	Target 2017/18	Trend direction
Total	93.3%	94% (U)	94% (U)	≥95%	—
Māori	92.6%	96% (F)	95% (F)	≥95%	▼
Pacific	100.0%	100% (F)	98% (F)	≥95%	▼
Other	93.3%	91% (U)	91% (U)	≥95%	—



Data Source: National Immunisation Register

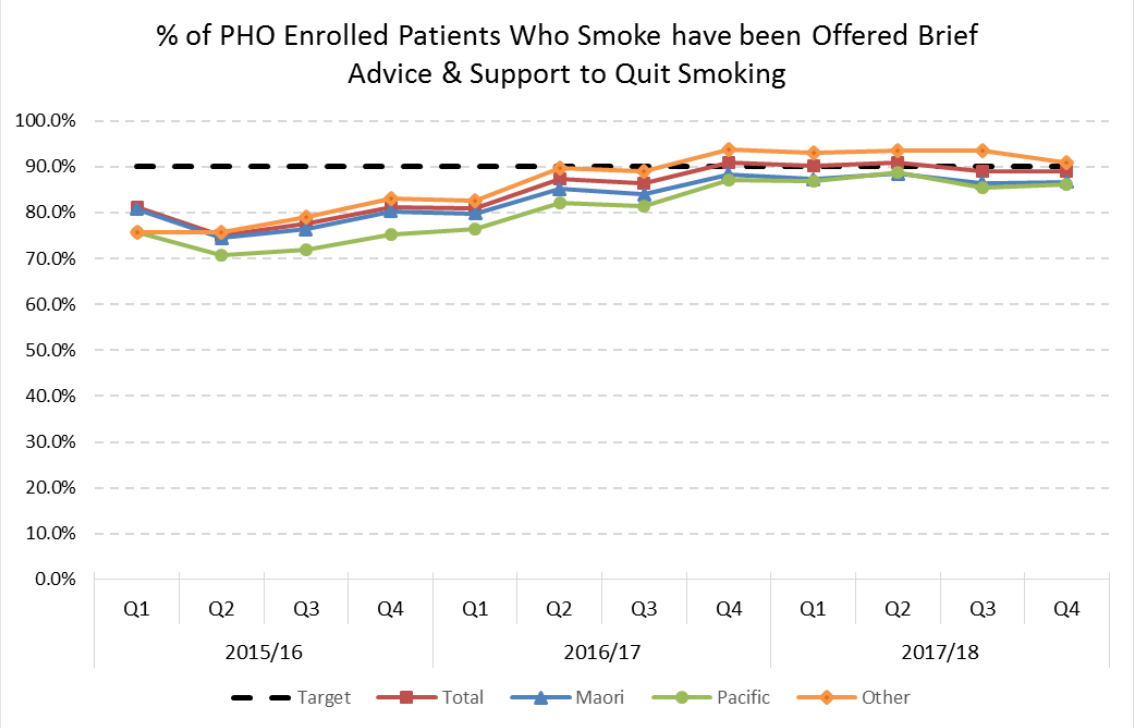
Comments:
We are pleased that we have achieved equity again this quarter, however we are slightly under the Ministry target. We continue to have good communication between all immunisation providers which helps us achieve this result. It has been a hard quarter with the schedule change and influenza vaccinating impacting on general practice and all immunisation providers. All families have who declined have had conversations with trusted health professionals or the HBDHB Immunisation team to assist them with their decision making.

7 October to December 2016. Source: National Immunisation Register, MOH
8 January to March 2018. Source: National Immunisation Register, MOH
9 April to June 2018. 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 [10]	Previous result [11]	Actual to Date [12]	Target 2017/18	Trend direction
Total	81.2%	88.9% (U)	89% (U)	≥90%	▲
Māori	80.8%	86.5% (U)	86.7% (U)	≥90%	▲
Pacific	75.7%	85.4% (U)	86.2% (U)	≥90%	▲
Other	75.7%	93.6% (F)	90.9% (F)	≥90%	▼



Source: PHO

Comments:

Health Hawke's Bay Health Intelligence Team have developed patient lists of current smokers who have not had smoking brief advice recorded in the last nine months, so practices can identify patients before they become overdue. Health Hawke's Bay ran a "Smoking Cessation Promotion" in General Practice to encourage doctors and nurses to update smoking status and offer smoking brief advice and cessation support in May and June. The practice that sent in the most cessation support forms got Pak n Save vouchers. The main barrier is being unable to contact people, of those unable to be updated, 44% unanswered phone call attempts, 26% disconnected phone, 21% not phone number and 3% living elsewhere.

10 15 months to December 2016. Source: DHB Shared Services

11 15 months to March 2018. Source: DHB Shared Services

12 15 months to June 2018. 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 [13]	Previous result [14]	Actual to Date [15]	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: The Smokefree Coordinator for Maternal and Child Health has continued communication via email and at two Maternity Refresher days in the last six months with the DHB Midwives and LMCs in Hastings and Wairoa Hospitals about the importance of ensuring all boxes are ticked on the Maternity Booking Form: 1-Smokefree Status 2-Brief Intervention Given and 3 -Referred to Quit Services. Reviewing the data has highlighted that a small number of Midwives are failing to tick the Brief Intervention Given box, yet answer the Referred to Quit Services box. This indicates a smokefree conversation was conducted and Brief Intervention given. The issue could be the word "Intervention" which suggests Nicotine Replacement Therapy given or a referral sent rather than having a conversation. This quarter we have ran several initiatives/activities including Tame Your Taniwha 8 week team challenge ran from 2nd April to 31st May. Smokefree presentations at 2 Maternity Refresher day courses for DHB Midwives and LMCs and weekly Maternity ward visits encouraging referrals to the Wahine Hapu programme					

13 October to December 2016. Source: DHB Shared Services

14 January to March 2018. Source: DHB Shared Services

15 April to June 2018. Source: DHB Shared Services

OUTPUT CLASS 1: PREVENTION SERVICES

Better Help for Smokers to Quit Number of babies who live in a smoke-free household at six weeks post-natal					
Key Performance Measures	Baseline [16]	Previous result [17]	Actual to Date [18]	Target 2017/18	Trend direction
Total	65.0%	68%	66%	-	▼
Māori	41.0%	47%	41%	-	▼
Pacific	71.0%	67%	65%	-	▼
Other	85.0%	87%	84%	-	▼
Comments: This indicator is new for 2017/18 and is intended to set up a baseline for the next financial year as a SLM (system level measures). It has been included in the report for reference only.					

12

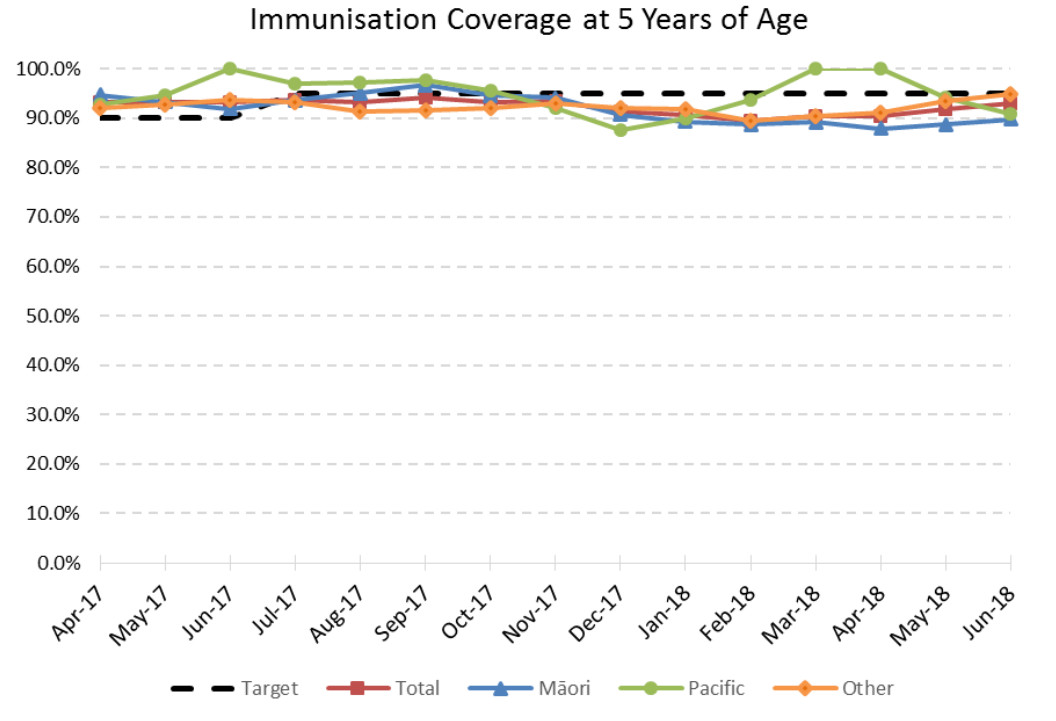
16 6 months to December 2016. Source: DHB Shared Services

17 6 months to June 2017. Source: DHB Shared Services

18 6 months to December 2017. Source: DHB Shared 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	93.9%	91.7% (U)	93% (U)	≥95%	▲
Māori	95.1%	88.66% (U)	89.8% (U)	≥95%	▲
Pacific	96.2%	94.1% (U)	90.9% (U)	≥95%	▼
Other	92.9%	93.5% (U)	94.9% (F)	≥95%	▲



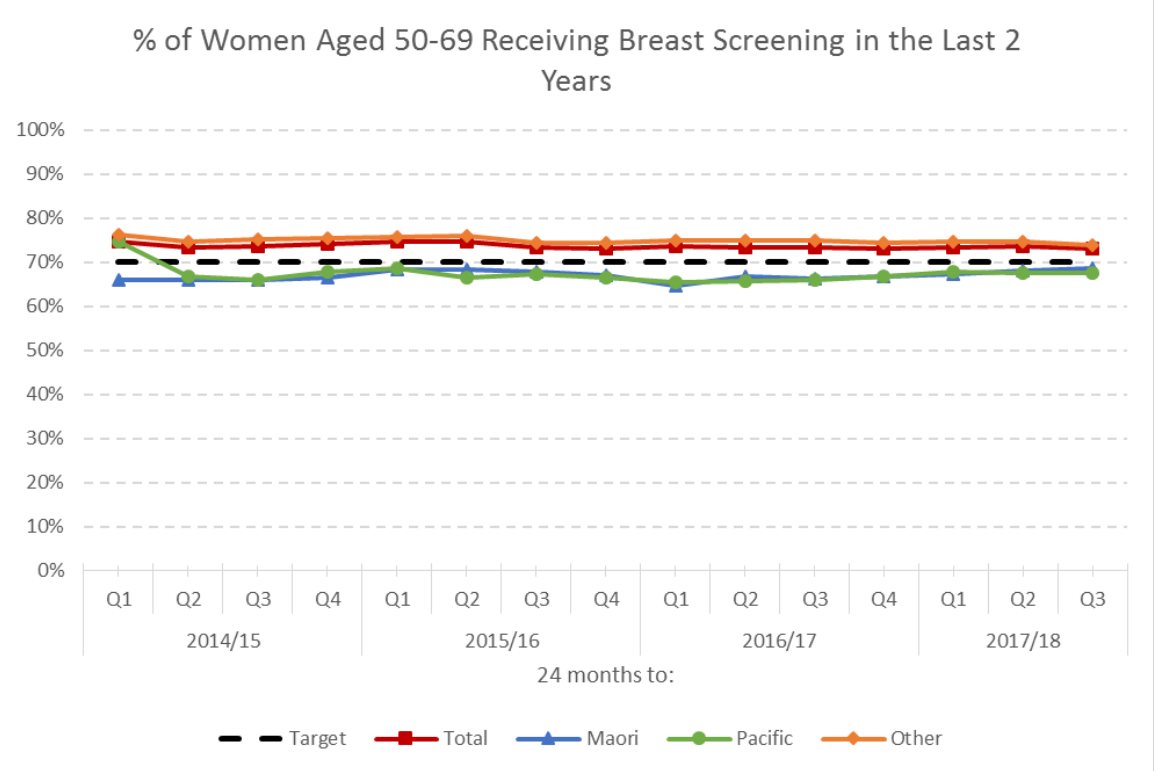
Data Source: National Immunisation Register

Comments:
There has been improved this quarter however inequity remains for Maori. We continue to have less time to put into our 4 year olds due to schedule changes and influenza. Tracking 4 year olds continues to be challenging - we work closely with B4SC but due to resource we struggle to increase coverage for this group of children.

19 October to December 2016 . Source: National Immunisation Register, MOH
20 January to March 2018. Source: National Immunisation Register, MOH
21 April to June 2018. Source: National Immunisation Register, MOH

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

Key Performance Measures	Baseline [22]	Previous result [23]	Actual to Date[24]	Target 2017/18	Trend direction
Total	74.7%	74% (F)	73% (F)	≥70%	▼
Māori	68.4%	68% (U)	69% (U)	≥70%	▲
Pacific	66.5%	68% (U)	68% (U)	≥70%	—
Other	76.0%	75% (F)	74% (F)	≥70%	▼



Data Source: BreastScreen Aotearoa

Comments:

The Breast Screening mobile visited Wairoa for two weeks late January / February, and then it was in Waipukuaru for 6 weeks from early March through to April. Planning for these visits began in September last year with Michelle Quinn from BSCC and Annette Davis, Team Leader Population Screening meeting with the team from Kahunugunu Executive – Wairoa and Te Taiwhenua o Heretaunga – Waipukurau to discuss the pending visits. Priority women 45-69 from Wairoa and Waipukurau identified as unscreened were sent invite letters to enrol and have a mammogram whilst the BSA mobile was in town and if they did on confirmation, they would receive a grocery gift card. Forty five Maori women enrolled in Wairoa and 23 in Waipukurau plus three Pacific women. BSCC sent through the lists of priority women who hadn't confirmed their appointments (DNR) to the Population Screening team, these were then forwarded to the relevant ISP, plus daily DNA lists were forwarded on. In both areas the BSA Mobile visit was a success, Wairoa had a DNA rate of 6% and Waipukurau 4%. We continue to receive referrals for priority women who have DNA'd their appointment at the fixed sites, and these are in most cases referred on to our ISP providers. Michelle Quinn, Primary Nurse Co-ordinator regularly attends our ISP meetings and Steering Group meetings, plus we are in regular contact with Susan Cook, Data Manager at BSCC and her team. Although the official data only cover the period up to March 2017 we are aware that we have achieved coverage for Maori in April.

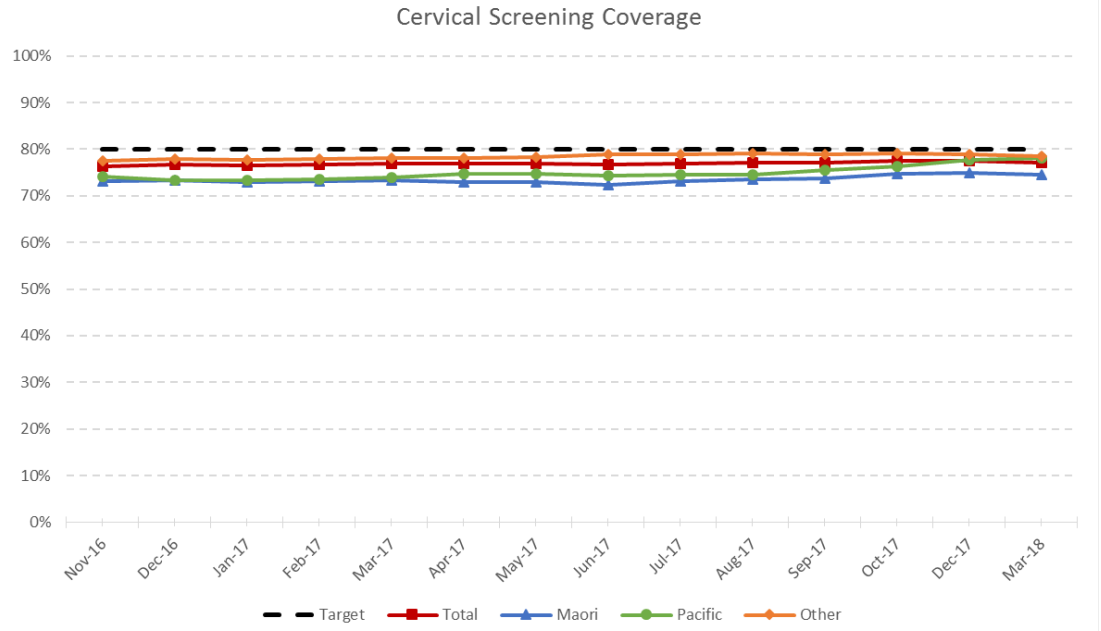
22 24 months to December 2016 . Source: National Immunisation Register, MOH

23 24 months to December 2017. Source: National Immunisation Register, MOH

24 24 months to March 2018. 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 [25]	Previous result [26]	Actual to Date[27]	Target 2017/18	Trend direction
Total	75.8%	77% (U)	77% (U)	≥80%	—
Māori	74.1%	75% (U)	75% (U)	≥80%	—
Pacific	71.2%	78% (U)	78% (U)	≥80%	—
Other	76.5%	79% (U)	79% (U)	≥80%	—



Data Source: National Cervical Screening Programme

Comments:

We participated in the International Cultures day, promoting both breast and cervical screening, HPV and smoke free messages. We're continuing to find avenues to connect with our Asian community here in Hawke's Bay. We have launched twice monthly cervical screening clinic at the Napier Health Centre, advertising via the DHB Facebook page, and our local community paper and He Ngakau Hou, offering free smears to women 30 and over never or lapsed screening. The only queries we received were from over 70 year olds querying if they needed to continue screening. We have returned to contacting Maori and Pacific women on the lists from Maraenui Medical Centre and the Doctors Napier, plus we now have a list of 300 Pakeha women who are 30 and over and either unscreened or under screened to contact. We met with the Clinical Nurse Manager and Lead Nurse smear taker at The Doctors-Napier to discuss recalling at 33 months plus a referral process for Maori and Pacific who haven't responded by 35 months. The implementation of recall at 33 months is in place but supporting and referring women on who haven't responded by 35months would entail too heavy a burden to administer. Focus will continue to support priority women who are unscreened or under screened. We are still engaging with first time women who have never engaged with their GPs and don't know anything about having their smears or have not received a recall; they see their doctors as a place to go to only if they are sick. We are still running 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, or with the women's general practice. Feedback from women screened in their home, is continuing to tell us that they are feeling, safe, more relaxed and finding the experience better all round and they state that it has made a big difference and they wouldn't have had the smear otherwise.

25 26 months to December 2016

26 36 months to December 2017

27 36 months to March 2018.

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES

Reduce ASH 45-64 Ambulatory sensitive hospitalisation rate per 100,000 45-64 years					
Key Performance Measure	Baseline	Previous result [28]	Actual to Date [29]	Target 2017/18	Trend direction
45-64 years: Total	3510	4373 (U)	4384 (U)	-	▼
45-64 years: Māori	6310	8165 (U)	7965 (U)	≤3510	▲
Source: Ministry of Health					
Comments: Overall 45-64 ASH rates for Maori has improved within the last 12 month period and the DHBs national ranking improved (for Maori). Equity gap still sits at 3 times that of other for Maori however and the overall rate is still higher than the national rate. All activities are tracking against planned actions. Success areas in the 0-4 ASH are being used to inform project approaches. Extension of the CPO programme is currently being proposed to assist in building capacity and recognising capability within primary care.					

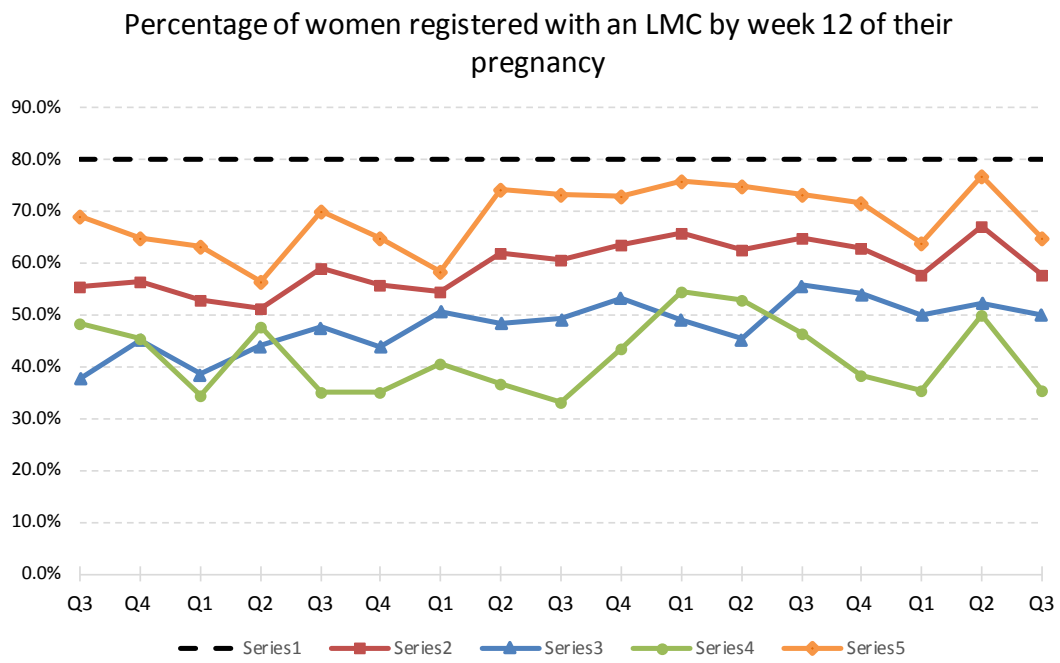
12

28 12 months to September 2017

29 12 months to March 2018

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 [30]	Previous result [31]	Actual to Date [32]	Target 2017/18	Trend direction
Total	54.5%	67% (U)	68% (U)	≥80%	▲
Māori	50.7%	52% (U)	50% (U)	≥80%	▼
Pacific	40.6%	50% (U)	35% (U)	≥80%	▼
Other	58.5%	77% (U)	65% (U)	≥80%	▼



Comments:
The 'Top 5 for my baby to thrive' 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 commenced in 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.

30 October to December *2016.*
31 April to June 2017.
32 July to September 2017

Better oral health % of adolescents (School Year 9 up to and including age 17 years) using DHB-funded dental services					
Key Performance Measures	Baseline [33]	Previous result [34]	Actual to Date [35]	Target 2017/18	Trend direction
Total					
Māori					
Pacific					
Other					
*Data has not been confirmed yet. Data and chart will be added in time for the board report					
Comments: Data Source: Titanium Oral Health System					

12

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	41..4%	43% (U)	43% (U)	≥55%	—
Māori	37.8%	49% (U)	49% (U)	≥55%	—
Pacific	45.5%	30% (U)	31% (U)	≥55%	▲
Other	91.7%	35% (U)	35% (U)	≥55%	—

PHO: Annual Diabetes Checks Data

Comments:

HHB Have delivered 8 courses this last six months with a focus on Long Term conditions, Diabetes, of which Pre - Diabetes programme 117 participants have been canvased to attend Kia Ora programme. Currently discussing possibilities of developing diabetes repository to capture data from retinal screening and podiatry services which are currently received by HBDHB. All Practice DCIP plans have been finalised and approved October 2017 as part of annual process. Two quarterly Practice Nurse Champion's meetings have been held and a further Education Sessions are currently being planned for October 2018. All practices receive monthly reporting providing an update of HbA1c bandings for their practice diabetes population which include details of patient due for annual review, overdue, coming due HBDHB Specialist services have completed a review of CNS capacity and capability. Paper prepared for Funding request to support additional resources

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					

12

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 [42]	Previous result [43]	Actual to Date [44]	Target 2017/18	Trend direction
Total	68.7%	55.2% (U)	58.9% (U)	≥70%	▲
Māori	60.0%	66.7% (U)	60% (U)	≥70%	▼
Pacific	100.0%	100% (F)	66.7% (U)	≥70%	▼
Other	75.0%	63% (U)	58.1% (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 Improvements in almost all areas noted, however underperformance due to ongoing capacity and IDF continue to negatively influence this. Regional contingency plans in place to continue to manage blowouts, and equity of care is being addressed in these plans.					

Shorter stays in hospital Length of stay (days)					
Key Performance Measures	Baseline [45]	Previous result [46]	Actual to Date [47]	Target 2017/18	Trend direction
Acute	2.55	2.39 (U)	2.39 (U)	≤2.3	▬
Elective	1.66	1.52 (U)	1.55 (U)	≤1.47	▼
Source: Ministry of Health					
Comments: We are disappointed to see that the acute ALOS has remained the same as the previous period and Elective has increase slightly. Length of stay for general medicine and orthopaedic specialties had the greatest number of excess bed days. We continue to work on several initiatives within the hospital looking at reducing the length of stay with 'FLOW'					

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 2016. Source: Ministry of Health

43 July to September 2017. Source: Ministry of Health

44 October to December 2017 . Source: Ministry of Health

45 12 months to September 2016. Source: Ministry of Health

46 12 months to August 2017. Source: Ministry of Health

47 12 months to September 2017 .Source: Ministry of Health

and '4000 bed Days'. Improving our systems and process to discharge patients from our inpatient wards by focusing on increased earlier in the day discharges and how we manage patients who have longer stays and Ensuring our processes are effective in managing patients with frailty from presentation in ED, through their patient journey on to discharge.

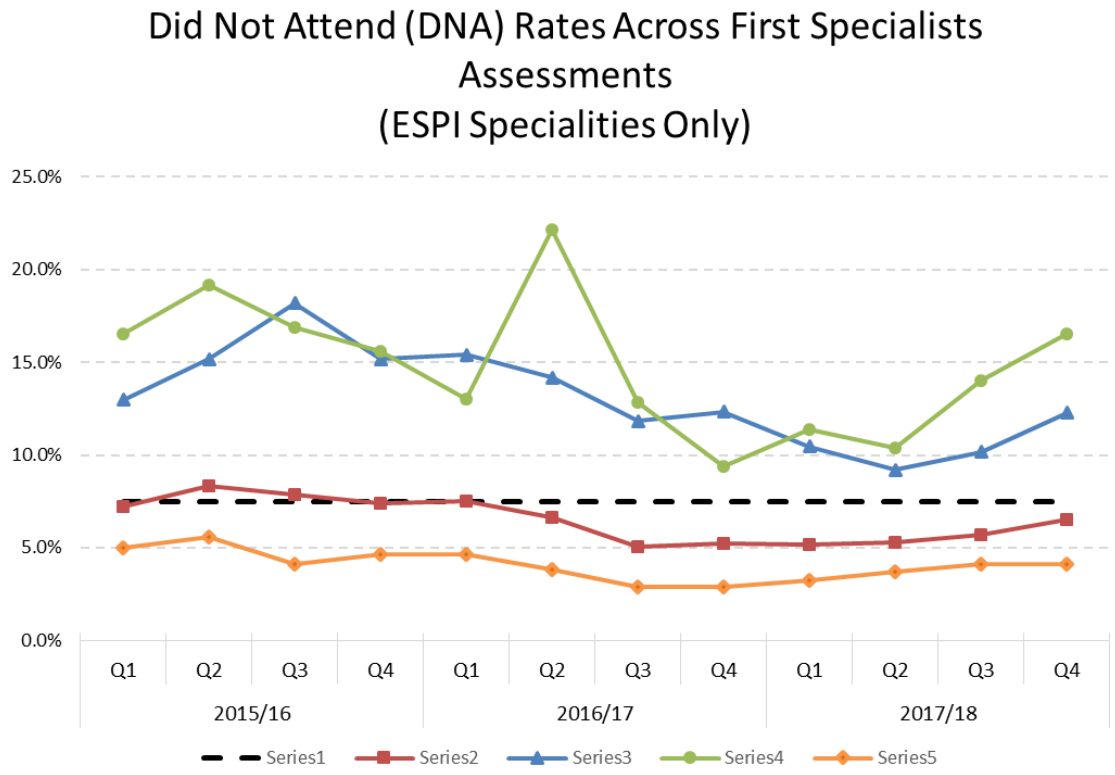
Quicker access to diagnostics					
Key Performance Measures	Baseline [48]	Previous result [49]	Actual to Date[50]	Target 2017/18	Trend direction
% accepted referrals for elective coronary angiography completed within 90 days					
% of people accepted for an urgent diagnostic colonoscopy will receive 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 August.					

48 December 2015.

49 March 2016.

50 June 2016

Fewer missed outpatient appointments ***Did not attend (DNA) rate across first specialist assessments***					
Key Performance Measures	Baseline [51]	Previous result [52]	Actual to Date [53]	Target 2017/18	Trend direction
Total	8.1%	5.7% (F)	6.5% (F)	≤7.5%	▼
Māori	14.9%	10.2% (U)	12.3% (U)	≤7.5%	▼
Pacific	18.3%	14% (U)	16.6% (U)	≤7.5%	▼
Other	5.3%	4.1% (F)	4.1% (F)	≤7.5%	—



Source: HBDHB

Comments:
High work levels for Outpatient Bookers means they have less time to engage with patients, thus phoning and confirming / reminding patients of their bookings is slowly becoming a lower priority for the Booking team. Unfortunately Switchboard are no longer assisting the Outpatient Booking team with evening calling to remind patients of appointments – and this may also now be impacting negatively on the DNA rates. Dental, General Surgery and Paediatrics continue to be the problem areas for DNA and generally children will continue to be rebooked following a DNA, and there are examples this quarter where children have been counted as DNA multiple times in dental and Paediatrics. As part of Customer Focused Booking, a working group has been formed and is currently analysing the data behind the DNA patients over the last year to better understand the profile of our patients who continue to DNA. Next steps are to survey this group, to get a better understanding from our target group as to what the real barriers are from the patient perspective that is stopping them from utilising the services at the HBDHB.

51 October to December 2016. Source: Ministry of Health
52 July to September 2016. Source: Ministry of Health
53 October to December 2016 . Source: Ministry of Health

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 [54]	Previous result [55]	Actual to Date [56]	Target 2017/18	Trend direction
Child & youth (0-19)					
Total	4.1%	4.07% (F)	3.86% (U)	≥4%	▼
Māori	4.6%	4.3% (F)	4.12% (F)	≥4%	▼
Pacific	3.0%	2.4% (U)	2.12% (U)	≥4%	▼
Other	3.7%	3.88% (F)	3.67% (U)	≥4%	▼
Adult (20-64)					
Total	4.9%	5.46% (F)	5.39% (F)	≥5%	▼
Māori	8.8%	9.84% (F)	9.78% (F)	≥5%	▼
Pacific	3.0%	2.4% (U)	2.12% (U)	≥5%	▼
Other	3.8%	4.08% (U)	4.02% (U)	≥5%	▼
Older adult (65+)					
Total	1.0%	1.14% (F)	1.12% (U)	≥1.15%	▼
Māori	1.0%	1.25% (F)	1.33% (F)	≥1.15%	▲
Pacific	1.0%	0.64% (U)	0.58% (U)	≥1.15%	▼
Other	1.1%	1.13% (F)	1.09% (U)	≥1.15%	▼
Data Source: HBDHB					
Comments: While we have not met the current target across all ethnicities Maori have remained favourable to target. We have remained fairly constant in our access rates and 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 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.					

54 12 months to September 2016

55 12 months to June 2017

56 12 months to September 2017

Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds					
Key Performance Measures	Baseline [57]	Previous result [58]	Actual to Date [59]	Target 2017/18	Trend direction
Mental Health Provider Arm: Age 0-19					
<3 weeks	60.1%	74.6% (U)	72.2% (U)	≥80%	▼
<8 weeks	81.5%	92.1% (U)	92.2% (U)	≥95%	▲
Addictions (Provider Arm & NGO): Age 0-19					
<3 weeks	84.2%	74.5% (U)	73.2% (U)	≥80%	▼
<8 weeks	99.5%	91.5% (U)	92.8% (U)	≥95%	▲
Source: Ministry of Health					
Comments: We have started to refine our processes by creating more appointments slots so that we can meet the demand and we are also refining our pathways to make it easier for clients to be seen faster (<3Wks).Improvements in our processes to reduce DNA rates (DNA's impact on our waiting times) are also aimed at having a positive impact on the results. We are working closely with Pacific and Maori cultural teams to reduce DNA rates and we are actively trying to recruit more staff.					

12

5712 months to December 2016

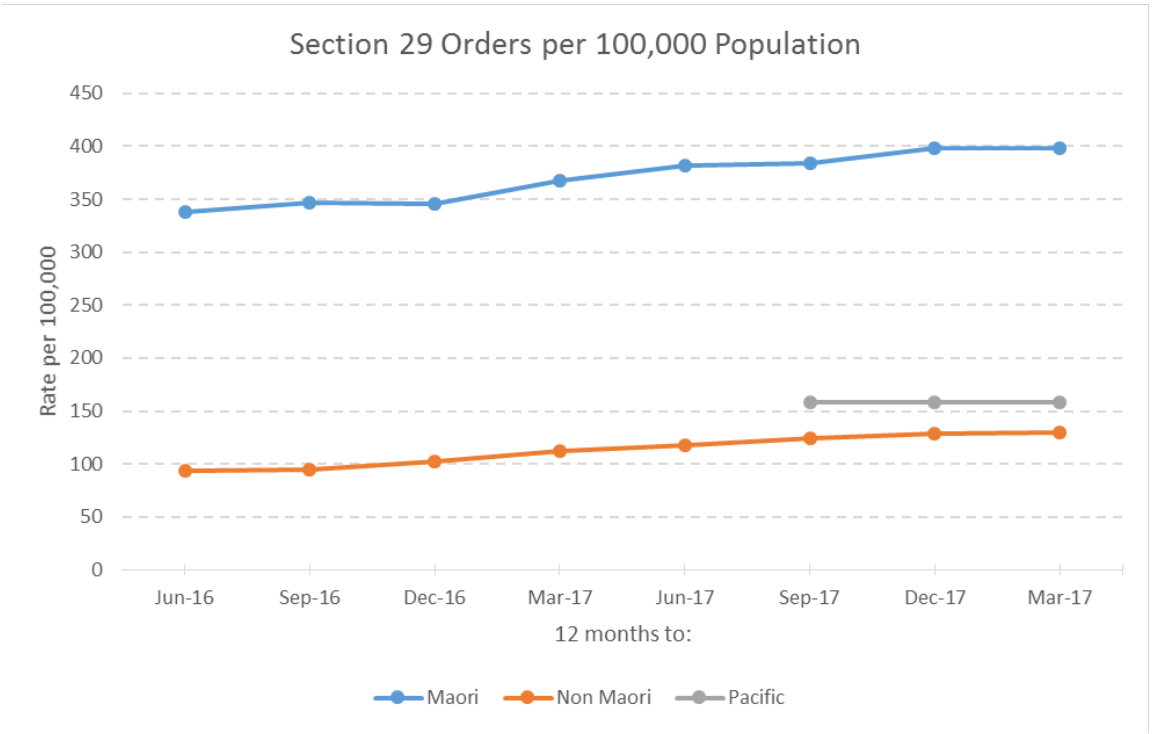
58 12 months to June 2017

59 12 months to September 2017

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 [60]	Previous result [61]	Actual to Date [62]	Target 2017/18	Trend direction
Non- Māori	97	129 (U)	130 (U)	≤81.5	▼
Māori	196	398 (U)	398 (U)	≤81.5	—
Pacific	93.4	159 (U)	159 (U)	≤81.5	—



Data Source: Ministry of Health

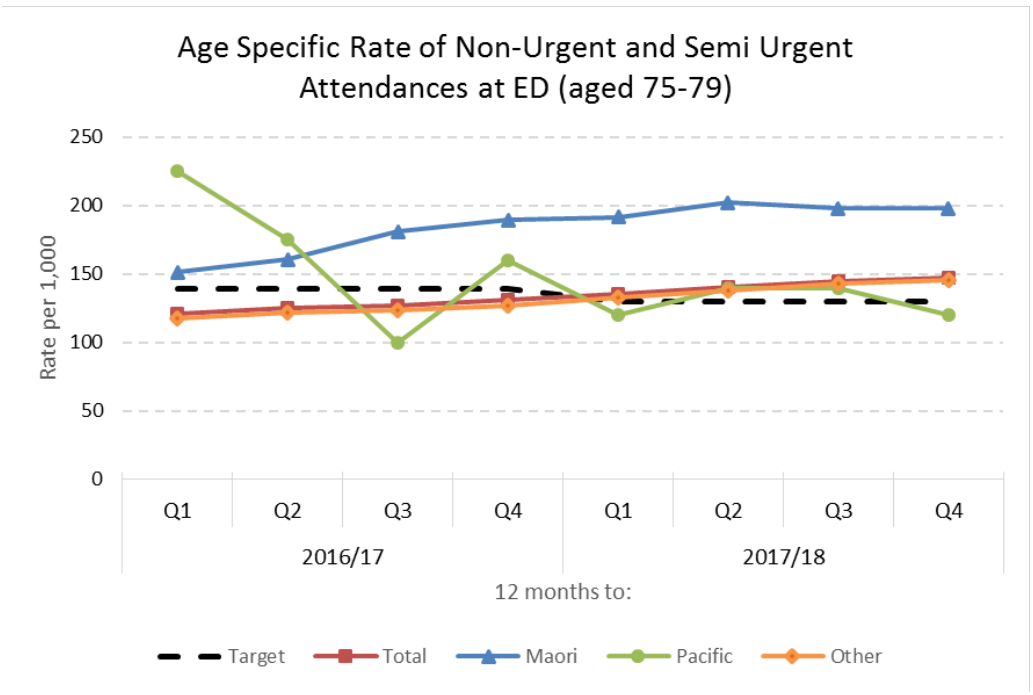
Comments:
I would expect a slight reduction for Hawkes Bay over the next Quarter as we have just done an intensive review of all clients on a CTO order at TTOH, putting an additional 0.5 FTE for one month into TTOH. There were 43 clients under a community treatment order out of the 215 clients open to TTOH, which is 20% of their population. We managed to bring this number down to 35. This is still a considerable number of clients but we are in the process of starting a multidisciplinary review of all cases both in TTOH and in the DHB community teams on an indefinite community treatment order with the aim to reduce the number of clients under the MHA. To get through all clients involved we probably will require about a year. The process will involve a multidisciplinary approach with a strong cultural and social focus, with family involvement.

60 October to December 2016
61 12 months to June 2017
62 12 months to September 2017

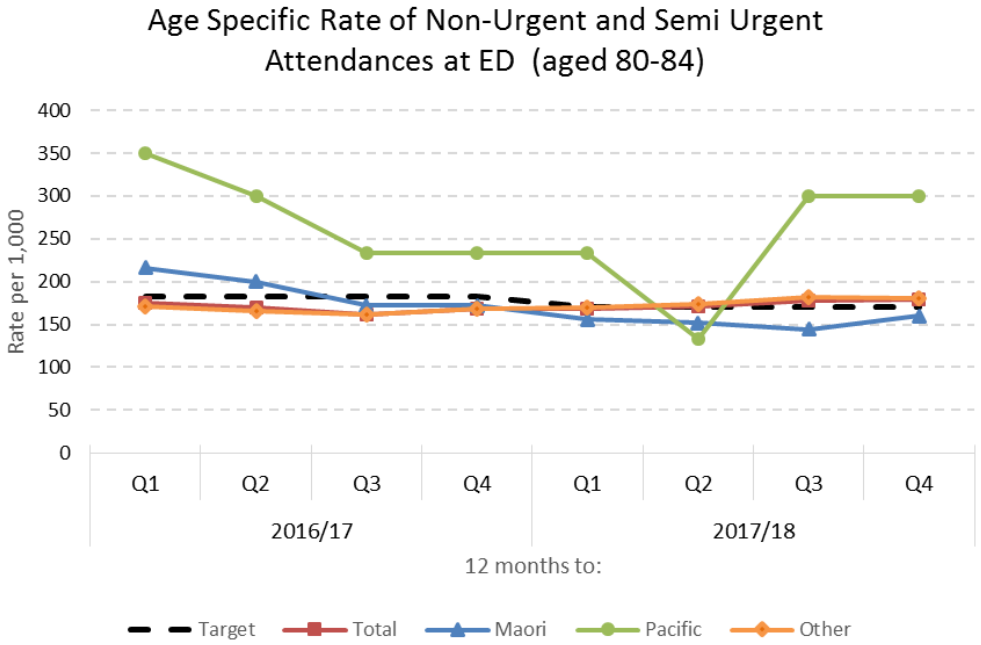
OUTPUT CLASS 4: REHABILITATION AND SUPPORT SERVICES

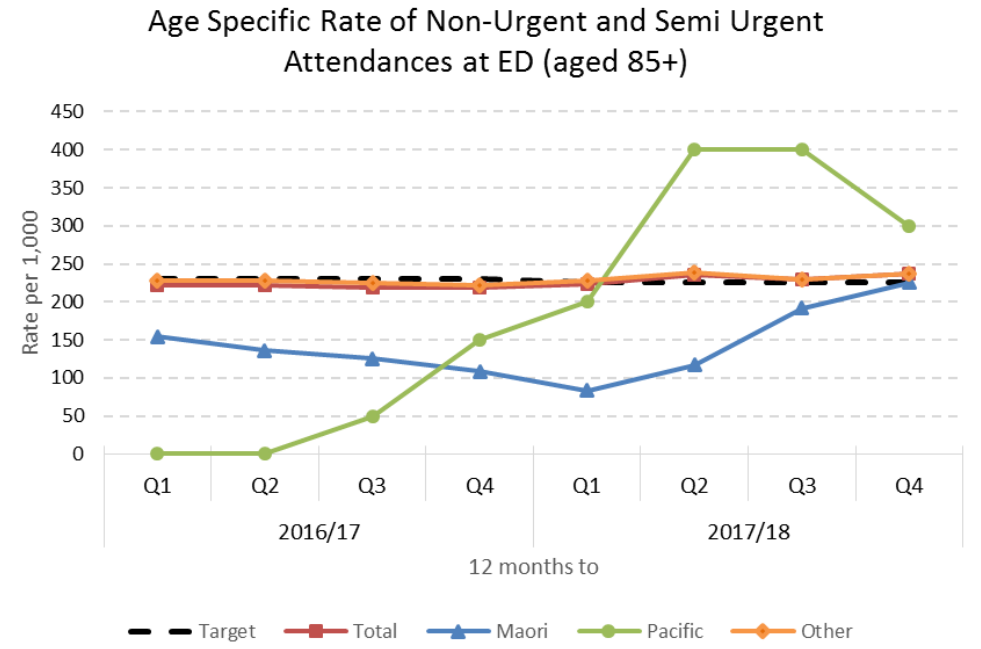
Better access to acute care for older people
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population)

Age Band	Baseline [63]	Previous result [64]	Actual to Date [65]	Target 2017/18	Trend direction
Age 75-79					
Total	136.5	145 (U)	147 (U)	≤139.5	▼
Maori	144.4	197.9 (U)	197.9 (U)	≤139.5	—
Pacific	-	140 (U)	120 (F)	≤139.5	▲
Other	-	143.3 (U)	145.3 (U)	≤139.5	▼
Age 80-84					
Total	178.9	178.3 (F)	178.8 (F)	≤183.1	▼
Maori	208	144 (F)	160 (F)	≤183.1	▼
Pacific	-	300 (U)	300 (U)	≤183.1	—
Other	-	181.4 (F)	180.8 (F)	≤183.1	▲
Age 85+					
Total	229.2	228.7 (F)	237.1 (U)	≤231	▼
Maori	153.8	191.7 (F)	225 (F)	≤231	▼
Pacific	-	400 (U)	300 (U)	≤231	▲
Other	-	229 (F)	237.2 (U)	≤231	▼



63 12 months to December 2016
64 12 months to October 2017
65 12 months to December 2017.





Comments:
Once again, the graphs show an upward trend in ED attendances in the 75-79 year age group. ED presentations in 80-85 and 85+ are largely stable. Services across the health sector are stretched, and anecdotally there is a feeling that numbers of people with complexity of medical and social conditions is increasing. The stability of ED attendances for 80+ may be due to the work which engAGE is doing with to support older people in the community, preventing them from presenting to ED in crisis as they are better supported to manage at home.

RECOMMENDATION:
It is recommended that the HBDHB Board, Executive Management Team, Māori Relationship Board and Pasifika Health Leadership Group:
1. **Note and appropriately act on the contents of this report**

ATTACHMENT:
- HBDHB Quarterly Performance Monitoring Dashboard Q3

HE NGAKAU AOTEA

Verbal update

13

CLINICAL SERVICES PLAN

Verbal Update

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora (TAW): Access (Ambulatory Sensitive Hospitalisations) (ASH) Rates 0-4 & 45-64 years**
	For the attention of: **Māori Relationship Board, HB Clinical Council; HB Health Consumer Council and HBDHB Board**
Document Owner	Dr Mark Peterson, Chief Medical Officer - Primary
Document Author(s)	Marie Beattie, Portfolio Manager - Integration Jill Garrett, Strategic Services Manager – Primary Care
Reviewed by	Executive Management Team
Month/Year	July 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 – a targeted approach over the winter period has been implemented. Further considerations are required to sustain this going forward. • Immunisation – despite some challenges this quarter equity in immunisation rates has been maintained. • Oral health – carries free statistics have been sustained over the past 12 months and utilisation of services has improved slightly. Addressing patient experience and engagement with services has been key in shifting the performance within this programme. • Child healthy homes programme – referrals continue into the programme with the addition of external stakeholders providing supplementary services. • Skin Programme – proactive approach to reducing presentations is in progress. Extra support required to close equity gaps in this area- see recommendations. **ASH 45-64**: rates for Māori have improved in the last 12 month period both within our own DHB and the Hawke's Bay District Health Board (HBDHB) performance nationally, however ASH rates for Māori still remain twice the rate of "Other." There is still significant work to be done to address this inequity. • ASH will remain a measure with associated activities as part of the System Level Measure (SLM) Improvement Plan. The focus has been to provide a range of initiatives to support Māori in engaging with a/their primary care provider and having support in place to sustain a good relationship for continuity of care. • There is a need to examine patient journeys in greater depth to understand trends in the utilisation of services, readmission

15

	patterns; the menu of services that the patient does or does not have a relationship with and where coordination of care can be more greatly enhanced using Multi-Disciplinary Team (MDT) approaches. This work is beginning to take shape, and forms part of the programme of work listed under the SLMs Improvement Plan. More detail of specific programmes of work is provided in the body of this report. • The work of the people and quality team in building capacity across the organisation in Institute of Healthcare Improvement (IHI) methodology tools, inclusive of tracer auditing, will assist in using patient journeys of care to reinforce areas of best practice and highlighting areas for improvement. Linking this with patient experience survey data will be helpful in the future as it is made more available to DHB. • Review of the Coordinated Primary Options (CPO)[1] programme and scoping of a revised and expanded model will be presented to the Executive Management Team (EMT) the first week in August. The draft has already been completed. Key areas that the paper highlights is the need to have a focused approach to equity if the programme is to be beneficial in significantly contributing to reduced ASH rates (across all age bands). • Collaborative Clinical Pathways provide the foundation of best practice that underpins CPO and work in Long-term Conditions (LTCs). HBDHB has secured access to an interim tool provided through the Midlands Network that provides continued access to pathways while a replacement vendor to Map of Medicine is selected. HBDHB will form part of the Central Region Request For Proposal (RFP). The aim is to be operating off the new pathways platform in January 2019. • There is now a Nurse Practitioner Heart Failure (Intern) in role. Working relationships with primary care is commencing and alignment with respiratory initiatives has begun. Cardiac conditions have shown little improvement with the exception of Congestive Heart Failure in the last 12 month period. • The Nurse Led Respiratory Programme continues to reinforce a MDT approach and a whānau based approach to care. Significant shifts have been achieved for Māori in relation to COPD in the past 12 months. • Formalised planning for the implementation of the HBDHB LTCs framework was delayed due to recruitment into the Portfolio Manager role, however operational work with renal, diabetes, respiratory services have continued with targeted approaches to care coordination, transitioning of care supported by Clinical Nurse Specialists (aka two – LTC framework)

[1] Coordinated Primary Options CPO is the delivery of services, by a recognised health professional within a primary care or community care setting, that would otherwise have been delivered by a secondary-hospital based service inclusive of outpatient services, ED provided services, and inpatient delivered services. Established in 2003 as an initiative to reduce hospital admissions by providing alternative management options in primary care. In 2009 utilised as a vehicle for the transition of services from secondary to primary care and from 2015 the addition of integrated (HHB and HBDHB) services. CPO supports and is supported by collaborative clinical pathways. Thus they are mutually beneficial – one team, smart system, mitigating risk associated with parallel/isolated clinical process.

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:

That the Māori Relationship Board, HB Clinical Council, HB Health Consumer Council and HBDHB Board:

1. **Note** the content of the report
2. **Endorse** the actions being taken
3. **Support** recommendations made by EMT (31 July 2018)

   Provide quarterly updates against activities that;
   - contribute to the Te Ara Whakawaiora indicators
   - are reported against as part of the System Level Measures Improvement Plan
     - Keeping Children out of Hospital and Using Health Resources Effectively.

HAWKE'S BAY
District Health Board
Whakawāteatia

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

Author(s):	Marie Beattie. Portfolio Manager - Integration Jill Garrett, Strategic Services Manager – Primary Care
Designations:	As above
Date:	**July 2018**

OVERVIEW

Te Ara Whakawaiora (TAW) is an exception based report, drawn from Approved Mental Health Professional (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 ASH Hospitalisations: 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	July 2018

MĀORI HEALTH PLAN INDICATOR

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

ASH reflect hospital admissions for conditions which could potentially be prevented by early access to treatment in primary 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 socio-economic 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).

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?

SLMs

The Introduction of the SLMs; 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. ASH rates are included in two SLMs.

- ASH 00-04yrs is reported against under the SLM - 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[2]. 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 two to five 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) [3]

0 – 4 years

For the 2017 year the contributory measures regarding the SLM of Reduced ASH rates for 0-4 years as agreed by Health Hawke's Bay (HHB) and HBDHB 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 Chronic Obstructive Pulmonary Disease (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)
- 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 CPO programme – Hospital Discharge pathway for Māori – Pasifika and Q4 and Q5.

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

1. HAWKE'S BAY DISTRIBUTION AND TRENDS

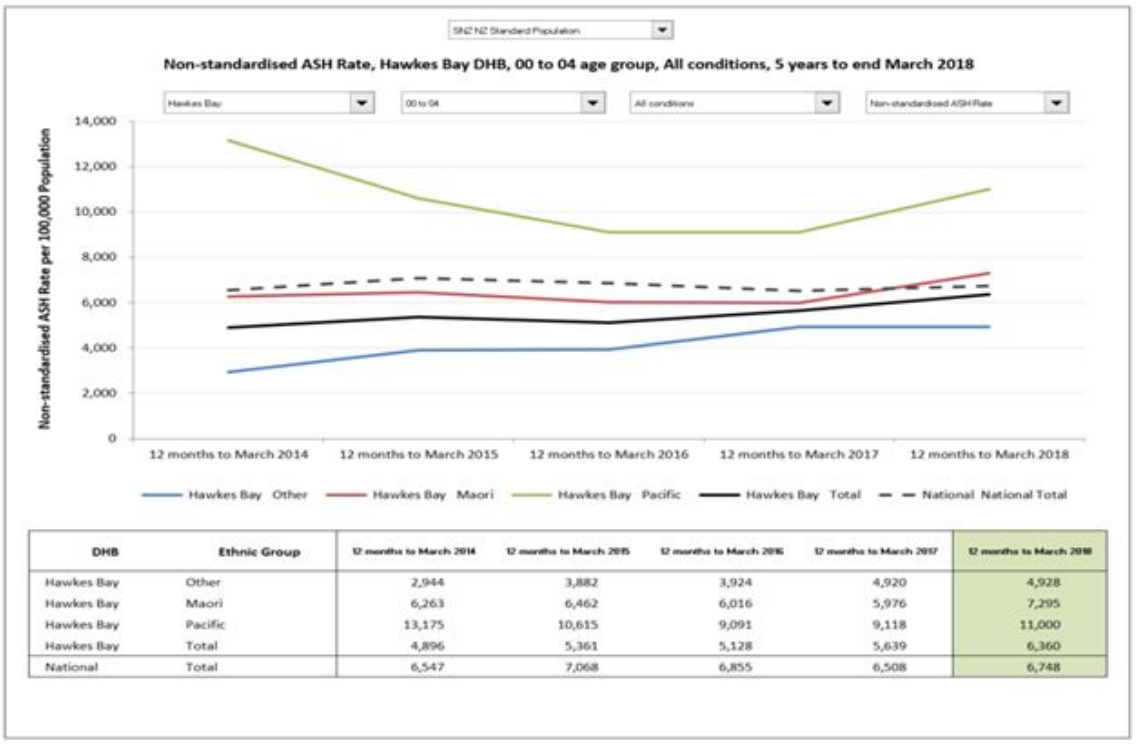
0-4 YEAR AGE GROUP

For the 2017-18 year the contributory measures regarding the SLM of Reduced ASH rates for 0-4 years as agreed by HHB and the HBDHB are:

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

The 2018 top three ASH conditions for tamariki Māori 0 – 4 years were: Upper and ENT respiratory Infections, Gastroenteritis/dehydration and asthma.

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



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	2,944	3,882	3,924	4,920	4,928
Hawkes Bay	Maori	6,263	6,462	6,016	5,976	7,295
Hawkes Bay	Pacific	13,175	10,615	9,091	9,118	11,000
Hawkes Bay	Total	4,896	5,361	5,128	5,639	6,360
National	Total	6,547	7,068	6,855	6,508	6,748

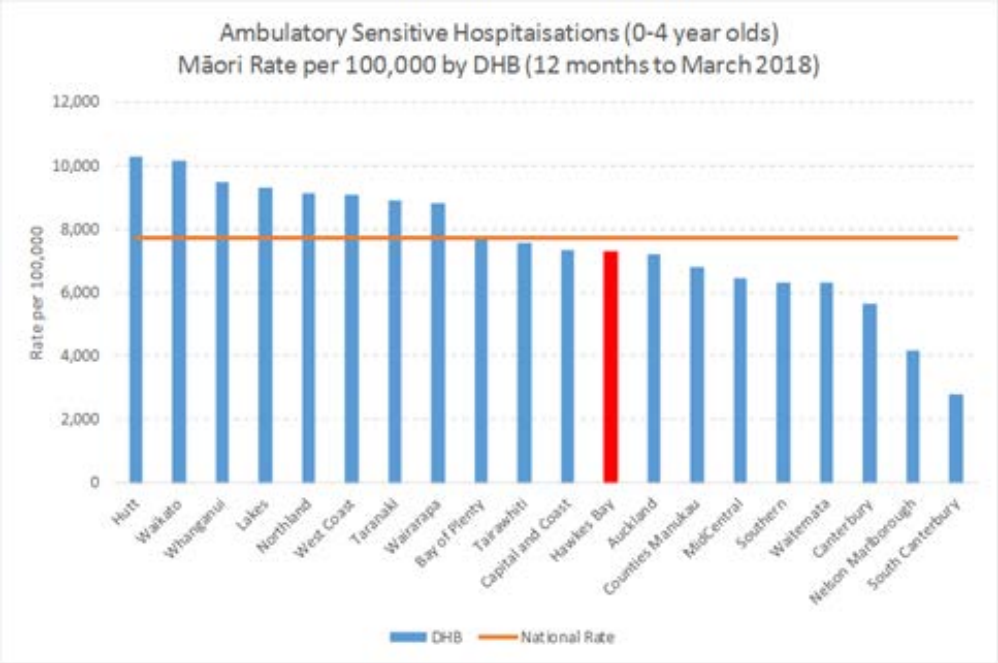
Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	179	231	226	276	272
Hawkes Bay	Maori	305	316	293	297	364
Hawkes Bay	Pacific	83	69	60	62	77
Hawkes Bay	Total	567	616	579	635	713
National	Total	-	-	-	-	-

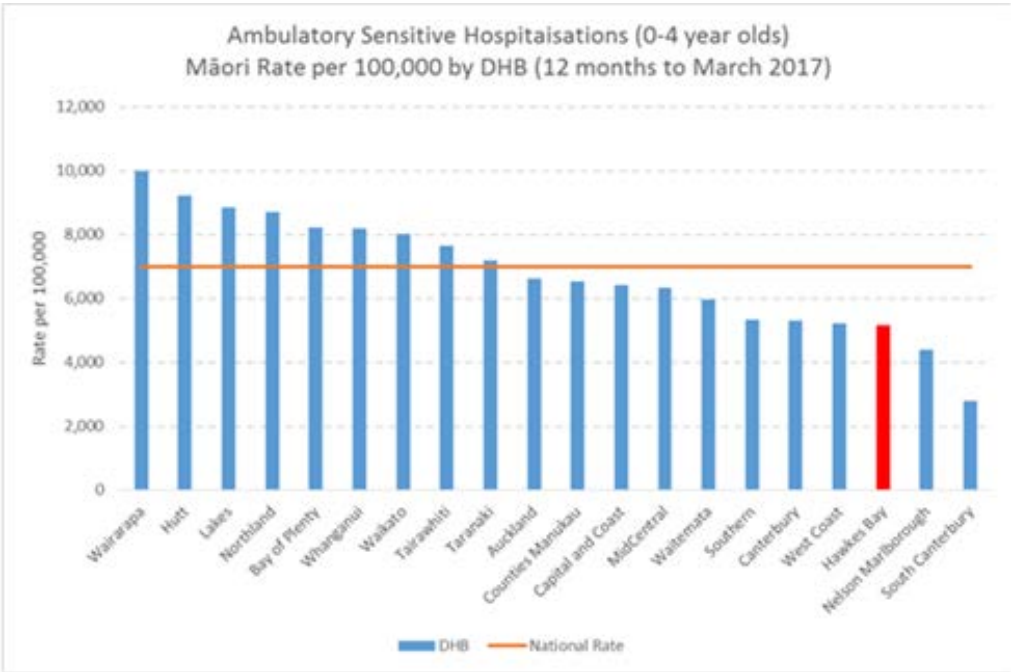
Data Analysis

As at March 2018 Hawke's Bay tāmariki have lower ASH compared to national rates with the total ASH Rate for HB at 6,360 compared to the national rate of 6,784. Although this is positive HB has seen its overall ASH rate increase in the past 12 months by 11%.

Hawke's Bay Māori ASH rates 0-4 age group 12 months to March 2018 – Benchmark against DHBs



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



Data Analysis

In the 12 months to September 2018 the Hawke's Bay Māori rate was 94% of the National Rate which is an improvement from the previous 12 month period of 99.9% of the national rate. We have remained the 9th 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.

Asthma

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	362	672	538	802	688
Hawkes Bay	Maori	1,006	1,288	1,109	1,026	1,323
Hawkes Bay	Pacific	2,698	1,538	455	1,324	2,714
Hawkes Bay	Total	760	983	779	933	1,097
National	Total	1,318	1,323	1,350	1,286	1,264

Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	22	40	31	45	38
Hawkes Bay	Maori	49	63	54	51	66
Hawkes Bay	Pacific	17	10	3	9	19
Hawkes Bay	Total	88	113	88	105	123
National	Total	-	-	-	-	-

Data Analysis

Hawke's Bay ASH rates for Asthma has increase by 17.6% or 18 cases. Both Māori (1,323) and Pacific (2,714) are both above the national rate of 1,264. Although small numbers for Pacific, the 19 cases over the 12 month period is more than double from the previous period.

Pneumonia

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	148	235	313	303	127
Hawkes Bay	Maori	493	429	390	423	421
Hawkes Bay	Pacific	1,111	1,231	1,515	441	429
Hawkes Bay	Total	345	374	416	364	277
National	Total	531	633	669	561	587

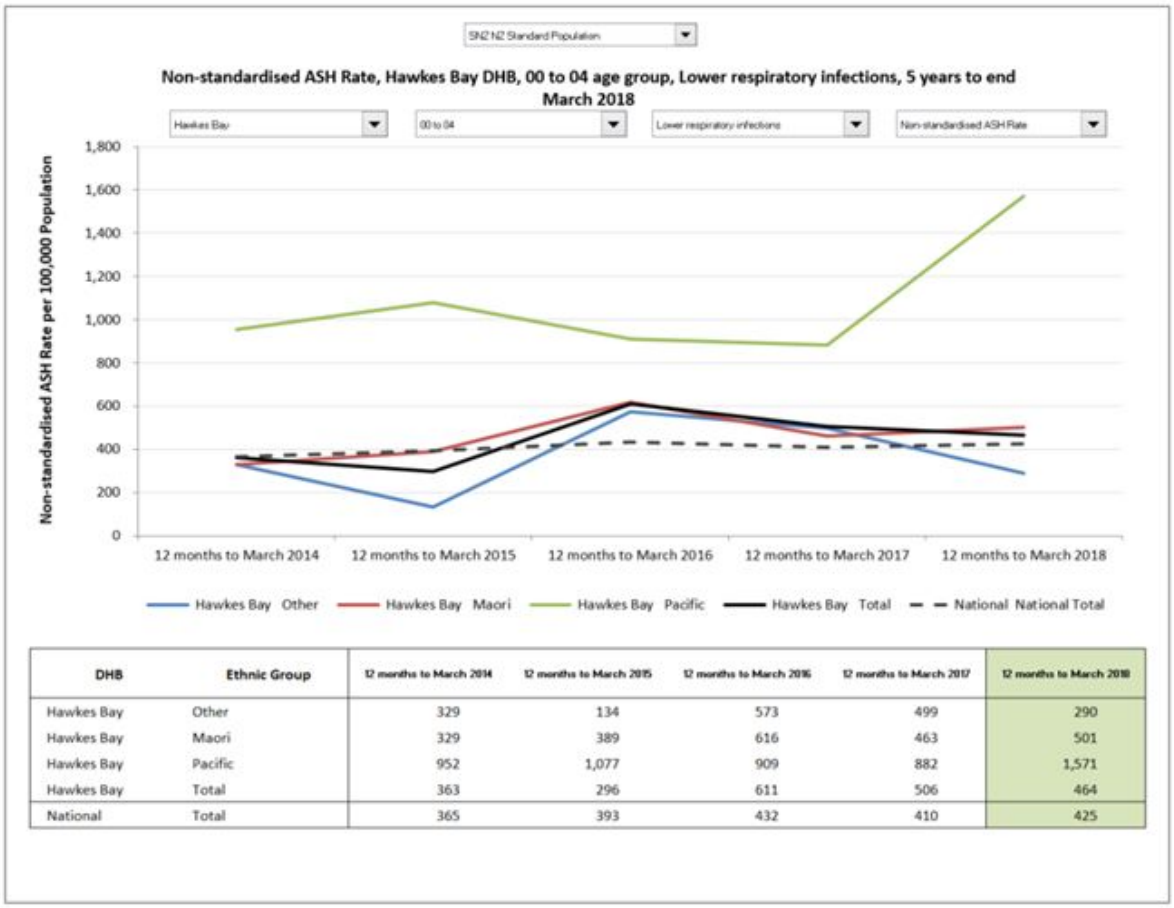
Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	9	14	18	17	7
Hawkes Bay	Maori	24	21	19	21	21
Hawkes Bay	Pacific	7	8	10	3	3
Hawkes Bay	Total	40	43	47	41	31
National	Total	-	-	-	-	-

Data Analysis

Hawke's Bay ASH rate for Pneumonia (277) is below the national rate (578). The number of events has dropped from 41 cases in the 12 month period to March 2017 to 31 in the 12 month period to March 2018.

Lower Respiratory Infections



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	329	134	573	499	290
Hawkes Bay	Maori	329	389	616	463	501
Hawkes Bay	Pacific	952	1,077	909	882	1,571
Hawkes Bay	Total	363	296	611	506	464
National	Total	365	393	432	410	425

Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	20	8	33	28	16
Hawkes Bay	Maori	16	19	30	23	25
Hawkes Bay	Pacific	6	7	6	6	11
Hawkes Bay	Total	42	34	69	57	52
National	Total	-	-	-	-	-

Data Analysis

The Hawke's Bay ASH rate for Lower Respiratory Infections (464) is above the National rate (425). The Hawke's Bay rate has decreased by 8% however the number of Pacific cases doubled from the previous period from 6 to 11.

Programme Analysis

Child Healthy Homes Programme (CHHP): *Susan Stewart – Team Leader Child Health Team*
The Child Healthy Housing team continues to provide a quality programme with positive feedback from whānau regarding: their homes being warmer, drier and healthier; children being sick less often; increased knowledge about how to keep their home warmer and dryer. More housing interventions and services have been sourced and established, such as Tumu timbers supply of firewood, Alsco linen supplies, as well as the extensive support form established housing suppliers, such as curtain bank, Christian Love link, and insulation provider.

All respiratory ED and paediatric discharge summaries as well all appropriate ICD codes are triaged for eligibility, as a result there is better referral information flow from secondary care services to the CHHP.

To date, a total of 974 referrals have been received since the inception of the CHHP. Whānau have received a total of 3497 interventions to promote warm dry homes and reduce transmissible diseases. These interventions have included, but not limited to: curtains (320 homes); beds (363); 234 WINZ Full and Correct Entitlement Assessments (FCEA); 177 homes insulated; and, 68 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.

HBDHB/Housing coalition funding has been approved to undertake a pilot programme (75 families) 2018/19 with Habitat for Humanity to undertake minor housing repairs as well as complete building structural assessments as appropriate.

Respiratory Programme (0-4): *Charrissa Keenan Māori Health Gains Adviser*
Māori Health have developed a package of health initiatives to provide added support to tamariki Māori and their whānau via Well Child/Tamariki Ora Services ('WC/TO'). These initiatives include: a community-based Māori lactation service, an Oranga Niho[4] support service focusing on oral health education and facilitating access to dental care, and a respiratory support service for tamariki under 5 years old and their whānau. WC/TO services are positioned well to deliver such support because of their relationships with whānau and strong linkages across the health, education, and social sectors. Underlying this package of health initiatives is HBDHB's commitment to reduce inequities in hospital admissions for tamariki aged under five years and to improve Māori child health outcomes.

Increased Respiratory Support for tamariki and their whānau
The WC/TO Respiratory Support Service ('the Service') was developed following recommendations by the ASH Respiratory Working Group (RWG) to improve access for young children at risk of, or experiencing, a respiratory illness. This recommendation was based on a 2017 review of ASH respiratory care pathways that identified: 1) there is no specific child respiratory service currently delivered in Hawke's Bay; 2) children are 'bolted on' to the adult respiratory programme; and, 3) there is a general lack of confidence among the primary care workforce when providing respiratory care to young children. Despite this gap in service delivery, the ASH RWG has been advised that there is no funding available to invest in a children's respiratory support service.

To minimise the impact of respiratory illness on young children over the winter period, Māori Health, with input and direction from the ASH RWG, is working with WC/TO services to provide added respiratory support. The service targets Māori and Pacific tamariki, and children living in high deprivation areas. The focus of the service is to: 1) prevent hospital admissions by identifying tamariki with respiratory needs via the WC/TO Core Check; and, 2) provide increased support to whānau whose tamaiti has been admitted to hospital for a respiratory related illness. The Service provides in-home respiratory education and support for whānau to help manage their child's respiratory illness. The service also establishes linkages between whānau with their primary care provider, and where needed, referral to specialised respiratory support services. Due to limited funding the service is presently only short term till October 2018.

Immunisation 0-4: *Fiona Jackson Immunisation Co-ordinator*
We are pleased that we have achieved 94% overall for this target with equity maintained. We continue to have good communication between all immunisation providers which helps us achieve this result. It has been a hard quarter with the schedule change and influenza vaccinating impacting on General Practice and all immunisation providers. This has limited families' access to General Practice in some instances. Of the 31 children declined or not complete - 12 identified as Māori, 15 European and 2 Pacific with the opt-off ethnicities unknown.

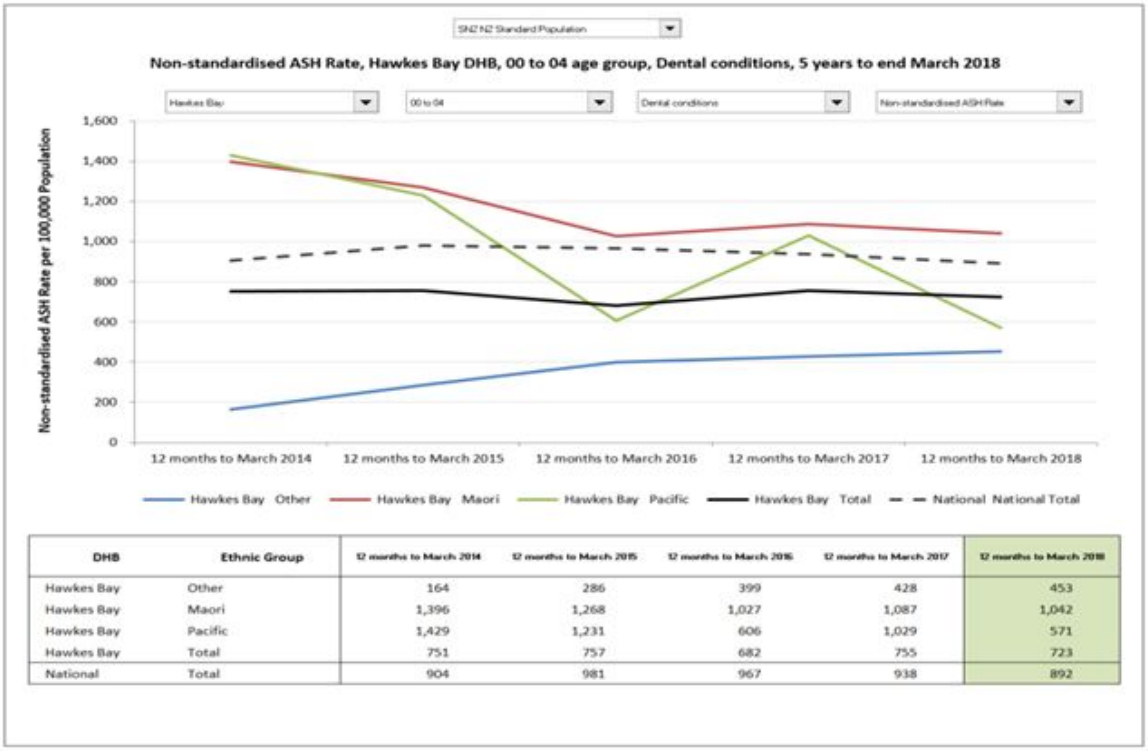
This quarter we have had 15 whānau decline immunisations. All of the above families have had conversations with trusted health professionals or the HBDHB Immunisation team to assist them with their decision-making. Housing is having an impact on finding whānau for the outreach team

[4] Dental programme for children.

and this is impacting being able to get children immunised as efficiently as we'd like. We do have a number of transient families that take time to locate.

High pneumococcal immunisation coverage in children under five will be having a significant impact on the declining admissions for pneumonia in the 0 – 4 year age group. While hospitalisations for respiratory infections aged under 5 years have been increasing in New Zealand, hospitalisations for pneumonia has declined significantly since the implementation of the pneumococcal conjugate vaccine programme.

Dental



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	164	286	399	428	453
Hawkes Bay	Maori	1,396	1,268	1,027	1,087	1,042
Hawkes Bay	Pacific	1,429	1,231	606	1,029	571
Hawkes Bay	Total	751	757	682	755	723
National	Total	904	981	967	938	892

Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	10	17	23	24	25
Hawkes Bay	Maori	68	62	50	54	52
Hawkes Bay	Pacific	9	8	4	7	4
Hawkes Bay	Total	87	87	77	85	81
National	Total	-	-	-	-	-

Data Analysis

The ASH rates for Pacific (571), Other (453) and Total (723) are all below the national rate of 892. Māori is currently 16.8% higher than the National rate and has decrease slightly from the previous period.

Programme Analysis

Oral Health: *Wietske Cloo – Acting Service Director Community Women and Children*
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:

- Progress in the year shows that as a result of the appointment of a Kaiawhina position within the Community Oral Health Service (COHS) 515 tamariki have been re-engaged with the COHS

- WC/TO 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. There is great collaboration between services. Oral health is now part of WC/TO Quality improvement framework (supported by TAS)

- Close collaboration with the Early Childhood Education/Te Kohanga Reo/ Pasifika language nests to provide staff and whānau with better oral health information and support, inconjuction with healthy start strategy and plan to reduce obesity. Building on B4SC resources

- The 'water-for-kids' project which has made the Paediatric ward implement a fizzy free environment for children in hospital from 1 March 2018- evaluation is underway

- The Te Roopu Matua – Māori consumer, community leaders group 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 Hawke's Bay to increase the focus on oral health in the Whānau Wellness Programme, and planning to implement 'Lift the Lip' in two high needs GP practices
.
- 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 general anaesthetic dental procedure. The final report with recommendations is finalised. Findings 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.

- In general, Pasifika research results also inform the project for year 2, data monitoring of progress has improved and with that enrolment ethnicity data. The gains made in Carries Free has been sustained and utilisation of services has improved slightly.

Next steps

- Community champions supporting kaiawhina
- Fluoride varnish standing order for more practitioners
- Increasing awareness of the service
- Water only policies in settings - e.g. churches, Early Childhood Education (ECE)
- Collaborate with primary care and population health & Māori Health & WC/TO

Gastroenteritis/Dehydration

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	872	1,328	694	1,248	1,304
Hawkes Bay	Maori	780	1,186	678	946	962
Hawkes Bay	Pacific	1,111	2,308	758	1,176	1,000
Hawkes Bay	Total	846	1,323	691	1,110	1,133
National	Total	1,270	1,520	1,020	994	1,082

Events

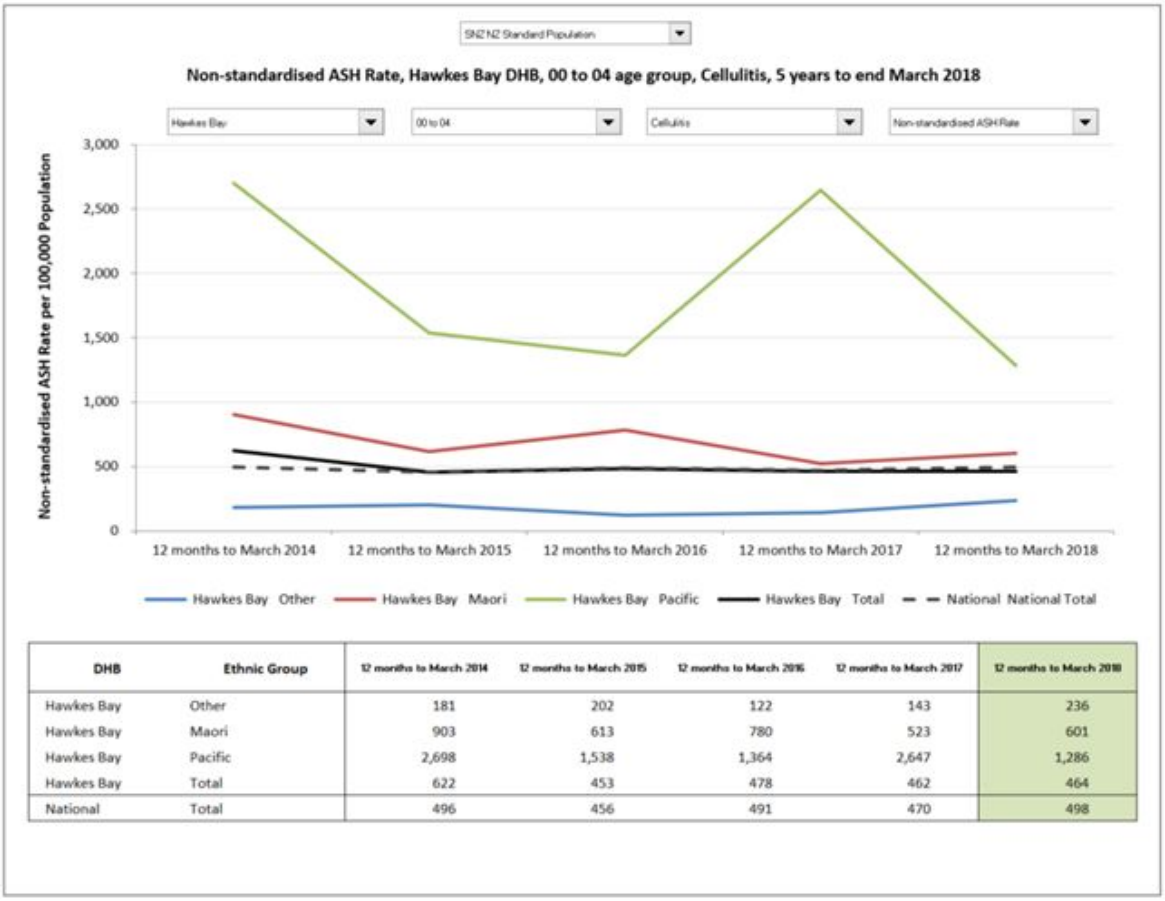
DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	53	79	40	70	72
Hawkes Bay	Maori	38	58	33	47	48
Hawkes Bay	Pacific	7	15	5	8	7
Hawkes Bay	Total	98	152	78	125	127
National	Total	-	-	-	-	-

Data Analysis: **(Peter)**

Hawke's Bay ASH rate for Gastroenteritis/Dehydration (1,133) is above the national rate of 1,082. The rate for Hawke's Bay has increased slightly to 1,133 from the previous period 1,110, this was an aditinoal 2 cases over the time period.

Strategies to address this particular ASH rate were mooted however, concerns were raised. Space constaints in primary care facilities to carry out intravenous rehydration of children under five and clinical concerns from departmental paediatricians meant this was not progressed.

Cellulitis



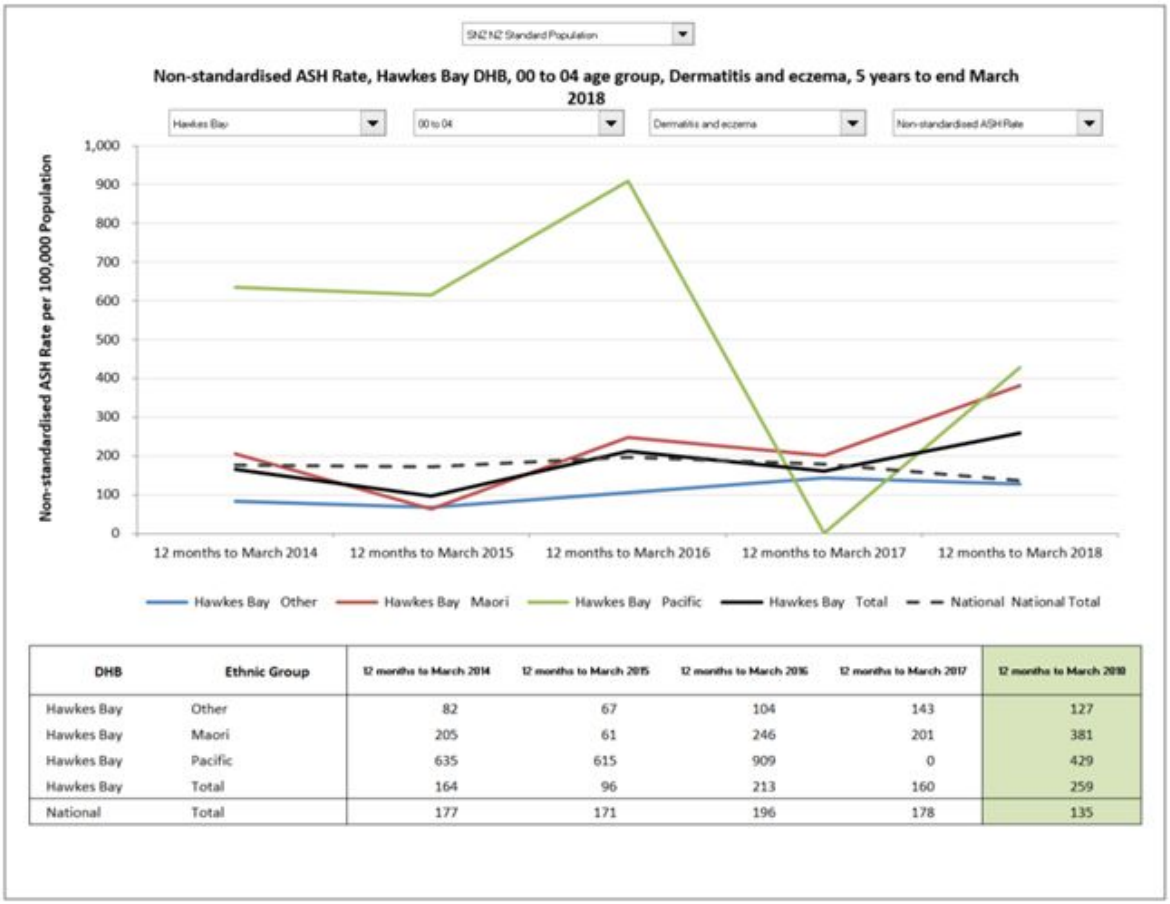
DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	181	202	122	143	236
Hawkes Bay	Maori	903	613	780	523	601
Hawkes Bay	Pacific	2,698	1,538	1,364	2,647	1,286
Hawkes Bay	Total	622	453	478	462	464
National	Total	496	456	491	470	498

Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	11	12	7	8	13
Hawkes Bay	Maori	44	30	38	26	30
Hawkes Bay	Pacific	17	10	9	18	9
Hawkes Bay	Total	72	52	54	52	52
National	Total	-	-	-	-	-

Data Analysis: **(Peter)**
Hawke's Bay ASH rate for Cellulitis (464) is below the National Rate (498). The total number of cases has stayed the same compared to the previous period however Pacific have seen cases reduce by 50% from 18 cases to nine.

Dermatitis and Eczema



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	82	67	104	143	127
Hawkes Bay	Maori	205	61	246	201	381
Hawkes Bay	Pacific	635	615	909	0	429
Hawkes Bay	Total	164	96	213	160	259
National	Total	177	171	196	178	135

Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	5	4	6	8	7
Hawkes Bay	Maori	10	3	12	10	19
Hawkes Bay	Pacific	4	4	6	0	3
Hawkes Bay	Total	19	11	24	18	29
National	Total	-	-	-	-	-

Data Analysis

Hawke's Bay ASH rate for Dermatitis and Eczema (259) is above the national rate (135) with the total number of cases for HB in the 12 month period to March 2018 being 29. The rate for Māori (281) is 3 times higher than Other (127) with the number of cases for Māori going from 10 to 19.

Programme Analysis

Skin Programme: *Linda St George, Nurse Educator Child Health Team*

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, and reduce stigma and discrimination for tamariki with skin problems.

During 2017-2018, key activities have included:

- Public Health Nurses and School Based Māori health provider nurses continue to utilise Skin Standing Orders which enable them to supply treatment for impetigo, boils, cellulitis, head lice and scabies
- ECE provider information is still needing to be included on the first contact form to identify if and where children attend. Currently, demographic information is not accurately captured to support targeted service delivery. The programme leader has sought support for this to happen from the Portfolio Manager, Integration
- There has been significant development of appropriate skin resources for ECE staff and whānau involving robust consultation. These resources include flip charts and talk cards and posters in Te Reo Māori and Samoan. This is in response to a survey in 2017 of ECE centres that found there is a demand among staff and whānau for more appropriate information and resources to be translated.
- Professional training for ECE centres, Te Kohanga Reo, and Pacific Language Nests kaimahi took place at a health promotion event in August 2017. A further Before School Health Hui for this audience is being planned for later in 2018 where the Skin Programme and resources will be promoted further.
- Designated Public Health Nurse skin roles for ECE centres, Te Kohanga Reo, and Pacific Language Nests have strengthened relationships and supported service delivery of the skin programme with these centres.

Going forward in 2018

- We have requested support from the newly-appointed Ministry of Health (MoH) Registrar to be responsible for an audit and analysis of the ASH rates of skin admissions to hospital, allowing the skin programme to progress further towards effectively closing equity gaps.

RECOMMENDATIONS: 0-4 yrs

	Key Recommendation	**Implementation lead**	**Champion(s)**	**Time Frame**
1.	Introduction of a field on the first contact form identifying ECE provider and school attended. This will enable a targeted approach to ensure the reduction in presentations for this ASH rate.	Marie Beattie - Portfolio Manager Helen August - Nurse Practitioner Intern	Phillip Moore Paediatrician	Dec 2018
2.	Recommend MoH registrar be engaged to audit and analyse 0-4 admissions to hospital for skin conditions to assist in addressing prevailing equity issues.	Marie Beattie - Portfolio Manager	Nicolas Jones - Medical Officer of Health	March 2019

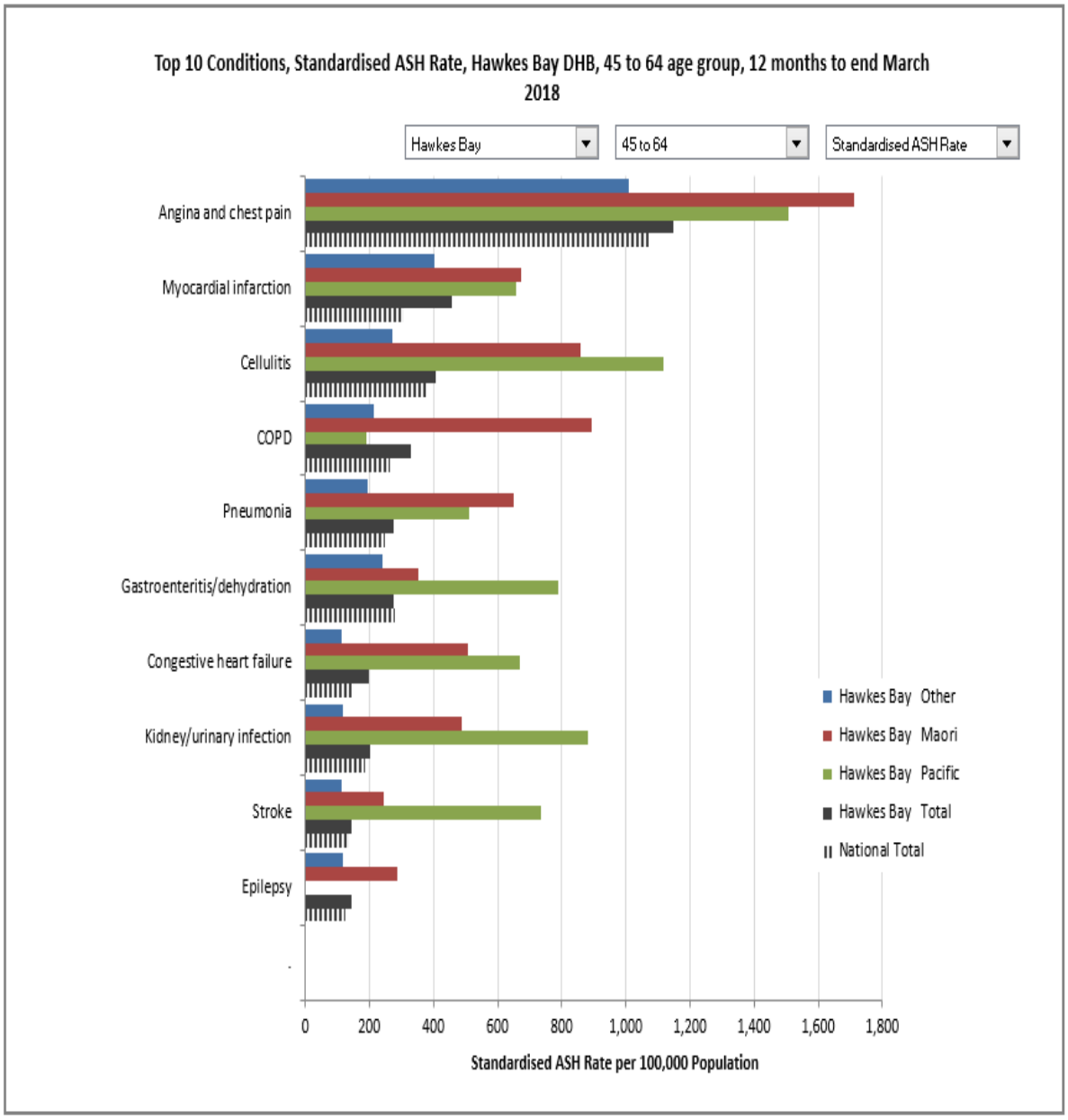
2. HAWKE'S BAY DISTRIBUTION AND TRENDS

45-64 YEAR 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.[5]

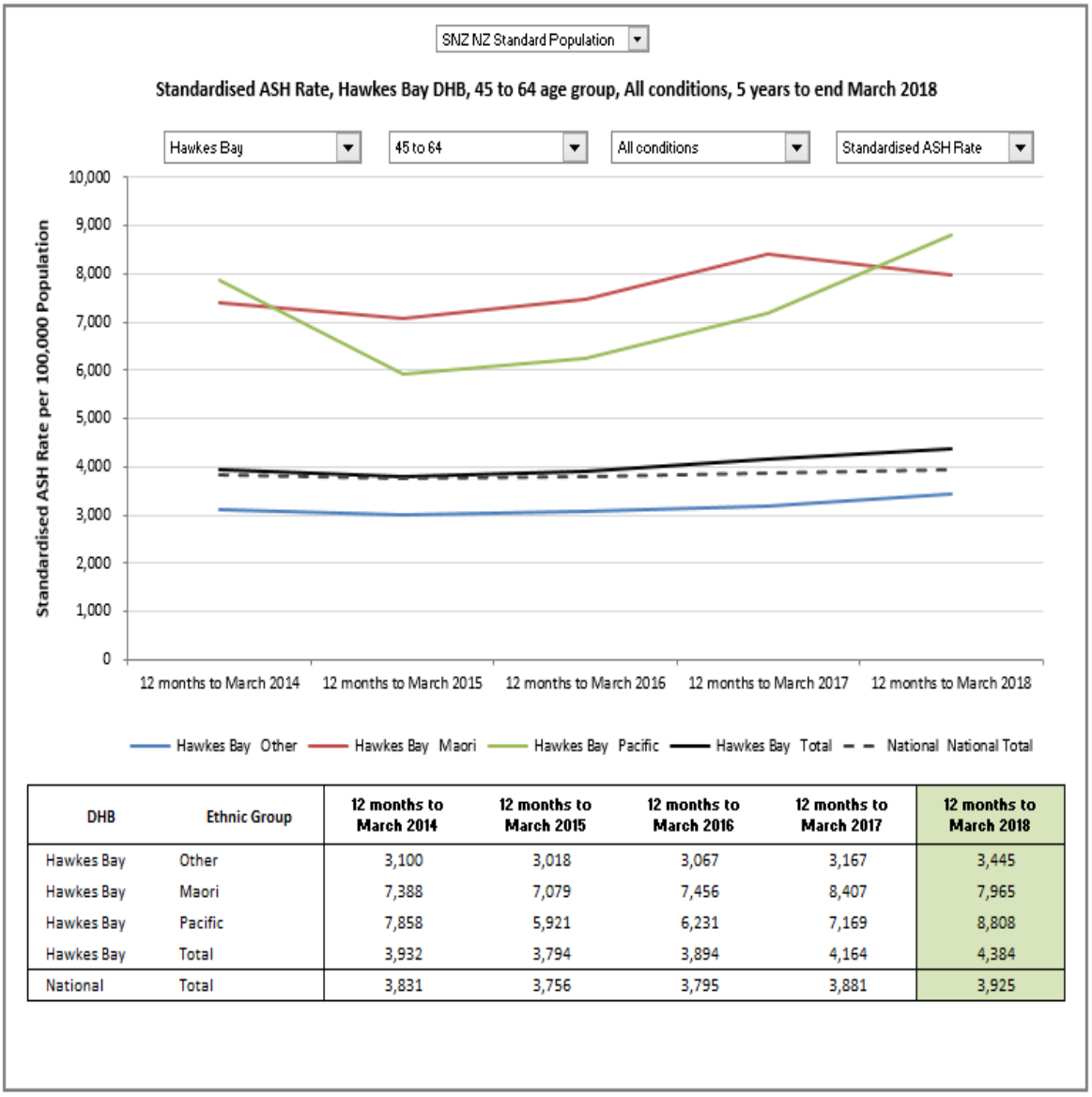
The focus of this report is on progress against reducing: Cardiac; Respiratory and Cellulitis related admissions; the highest contributors to Hawke's Bays top 10 ASH conditions. (See graph 1.0 below)

Graph 1.0 - Top 10 Conditions – HBDHB 12 months to end March 2018



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

Over time the HBDHB rates for **ALL Conditions** over 5 years has not significantly altered.



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	3,100	3,018	3,067	3,167	3,445
Hawkes Bay	Maori	7,388	7,079	7,456	8,407	7,965
Hawkes Bay	Pacific	7,858	5,921	6,231	7,169	8,808
Hawkes Bay	Total	3,932	3,794	3,894	4,164	4,384
National	Total	3,831	3,756	3,795	3,881	3,925

Data Analysis
The Māori rate has dropped from 8,407 to 7,965 but is still over twice the rate of Other.

The Hawke's Bay ASH rate for **All Conditions/Total Population** has increased by 5% from the previous period and is currently above the national rate.

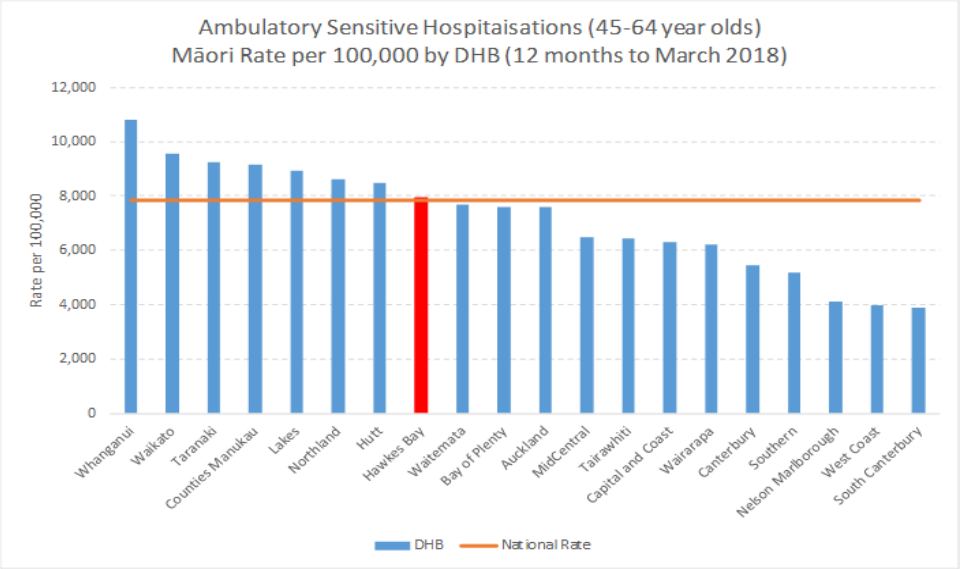
This chart and data is comparing the Māori rate with the Overall National rate, the charts on the next page are comparing the Hawke's Bay Māori rate to the Māori rates of the Other DHB's.

HOW WE COMPARE TO OTHER DHBS

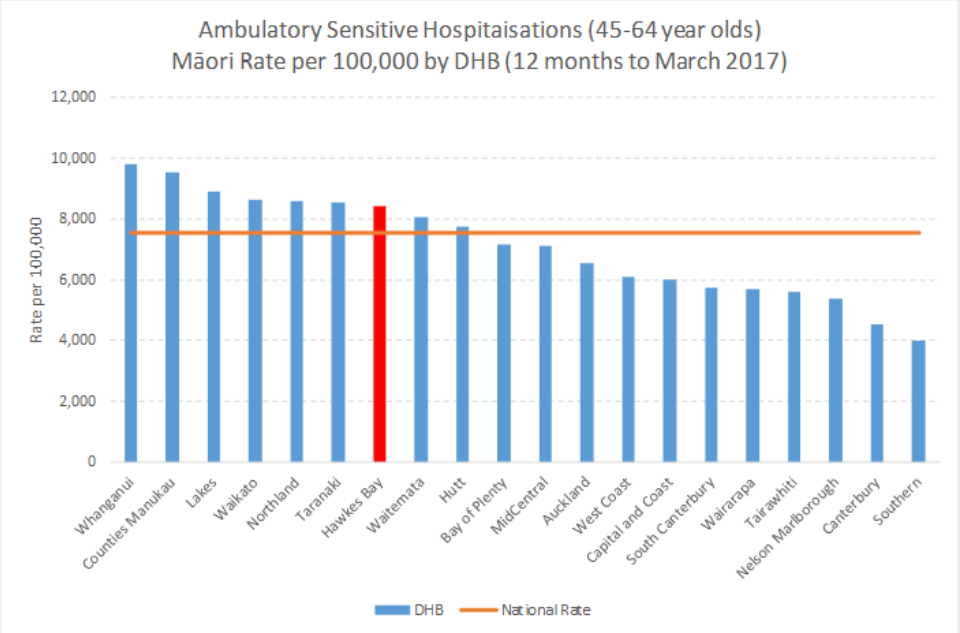
The Māori ranking of HBDHB has improved from seventh highest to eighth highest compared to the other DHB Māori Rates.

The Hawke's Bay Māori rate has reduced from 8,407 (111% of the National Māori Rate), to 7,964 (101% of the National Māori Rate).

Hawke's Bay Māori ASH rates 45-64 age group 12 months to March 2018 – Benchmark against DHBs



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

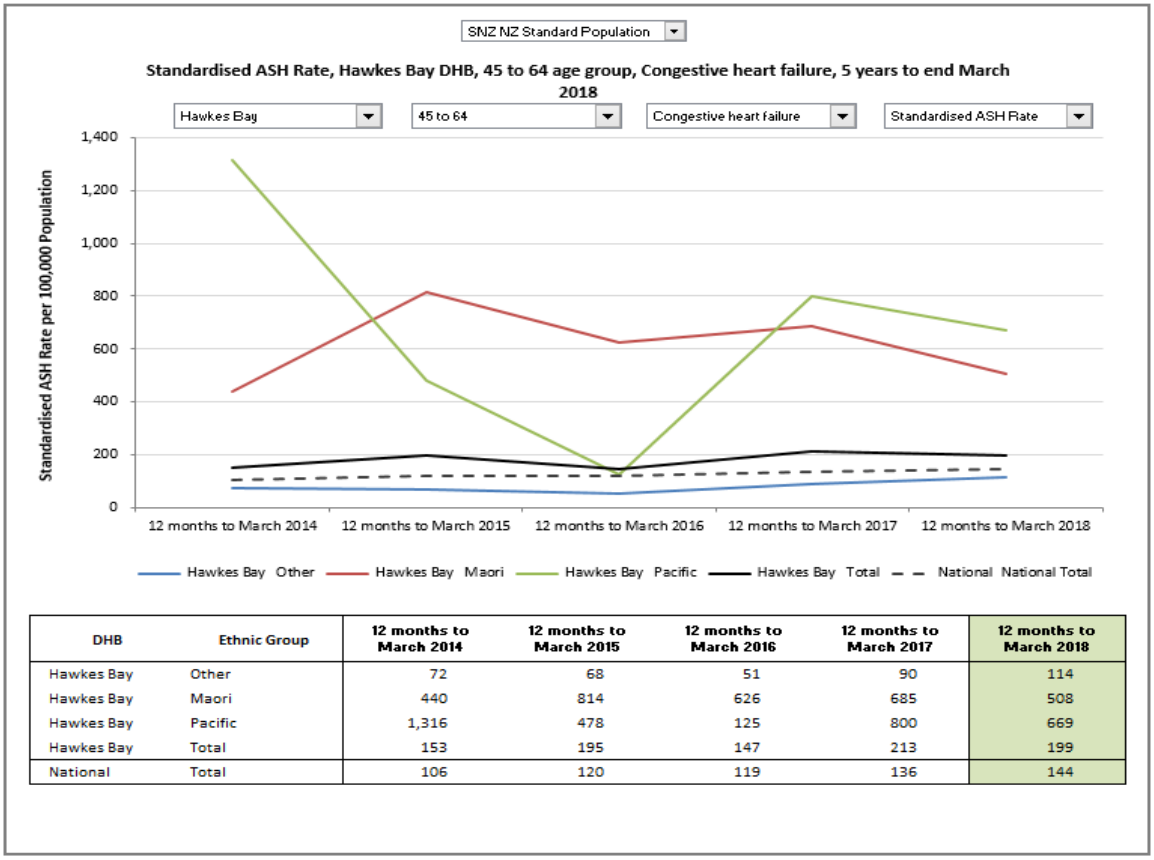


Cardiac and Respiratory Conditions, and Cellutis are the main focus areas for ASH 40-65yrs
The following graphs provide detail on the conditions that have been targeted as part of the 2017-19 SLM Improvement Plan (SLMIP). Each graph is followed by analysis by the Business Intelligence team.

A full narrative of activities aligned to the actions listed against the Te Ara Whakawaiora plan for ASH 45-65 is provided in the subsequent section - **Activity to Address 45-64 ASH Rates**.

The ASH 45-64 Cardiac Conditions are: Congestive Heart Failure; Hypertensive Disease,; Angina and Chest Pain and Myocardial infarction.

Congestive Heart Failure (CHF)



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	72	68	51	90	114
Hawkes Bay	Maori	440	814	626	685	508
Hawkes Bay	Pacific	1,316	478	125	800	669
Hawkes Bay	Total	153	195	147	213	199
National	Total	106	120	119	136	144

Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	26	24	19	33	43
Hawkes Bay	Maori	31	58	46	53	39
Hawkes Bay	Pacific	10	4	1	8	8
Hawkes Bay	Total	67	86	66	94	90
National	Total	-	-	-	-	-

Data Analysis

Hawke's Bay ASH rate for Congestive Heart Failure (199) is above the national rate (144). The rate for Māori (508) is four times higher than the rate for Other (114), Pacific is currently 669 which over four times the rate of Other.

Hypertensive Disease

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	16	17	26	28	36
Hawkes Bay	Maori	25	41	92	106	114
Hawkes Bay	Pacific	167		79	149	368
Hawkes Bay	Total	24	21	40	46	58
National	Total	28	34	36	38	39

Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	6	6	9	10	13
Hawkes Bay	Maori	2	3	7	8	9
Hawkes Bay	Pacific	2	0	1	2	4
Hawkes Bay	Total	10	9	17	20	26
National	Total	-	-	-	-	-

Data Analysis

The Hawke's Bay ASH rate for Hypertensive Disease (58) is above the rate for national (39). Other ethnicity rate is 36 compared with Māori (114) and Pacific (368). The number of cases for Pacific doubled from two to four over the 12 month period.

Angina and Chest Pain

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	1,033	955	927	1,064	1,008
Hawkes Bay	Maori	1,631	1,502	1,515	1,619	1,710
Hawkes Bay	Pacific	909	1,007	979	923	1,505
Hawkes Bay	Total	1,132	1,064	1,022	1,160	1,149
National	Total	1,120	1,080	1,078	1,122	1,069

Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	356	331	318	371	356
Hawkes Bay	Maori	120	115	113	124	135
Hawkes Bay	Pacific	8	9	10	11	17
Hawkes Bay	Total	484	455	441	506	508
National	Total	-	-	-	-	-

Myocardial Infarction rates

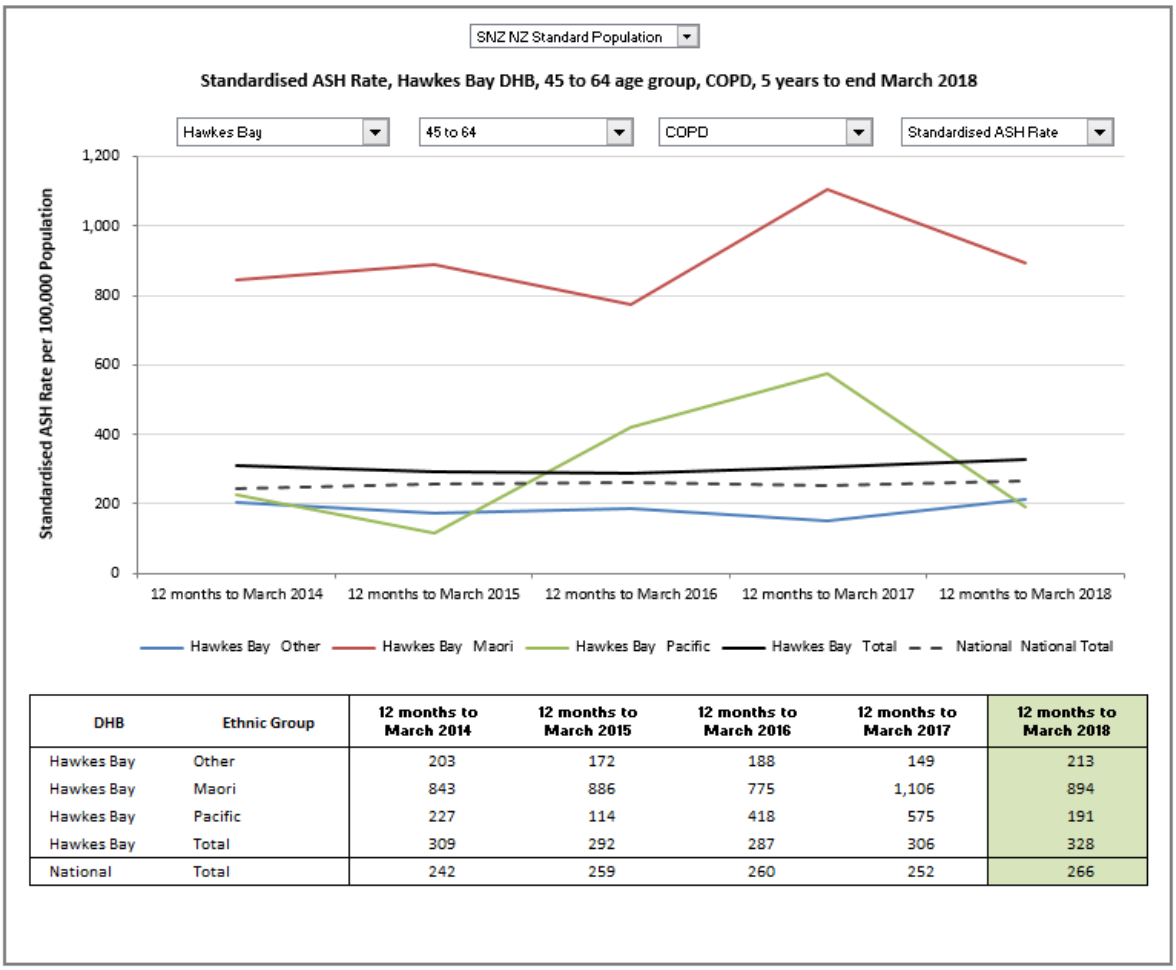
DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	145	142	156	132	149
Hawkes Bay	Maori	48	46	61	60	52
Hawkes Bay	Pacific	4	8	7	9	7
Hawkes Bay	Total	197	196	224	201	208
National	Total	-	-	-	-	-

Data Analysis

The Hawke's Bay ASH rate for Angina and Chest Pain (1,149) is the above the National Rate (1,069). The rate for Māori (1,710) and Pacific (1,505) have increased from the prior period with Māori being 1.7 times greater and Pacific 1.5 times greater that Other ethnicities. Overall Myocardial Infarction has remained the same as the previous 12 month period.

The ASH 45-64 Respiratory Conditions contributing to the ASH rate are: COPD, and Pneumonia.[6]

COPD



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	203	172	188	149	213
Hawkes Bay	Maori	843	886	775	1,106	894
Hawkes Bay	Pacific	227	114	418	575	191
Hawkes Bay	Total	309	292	287	306	328
National	Total	242	259	260	252	266

Events

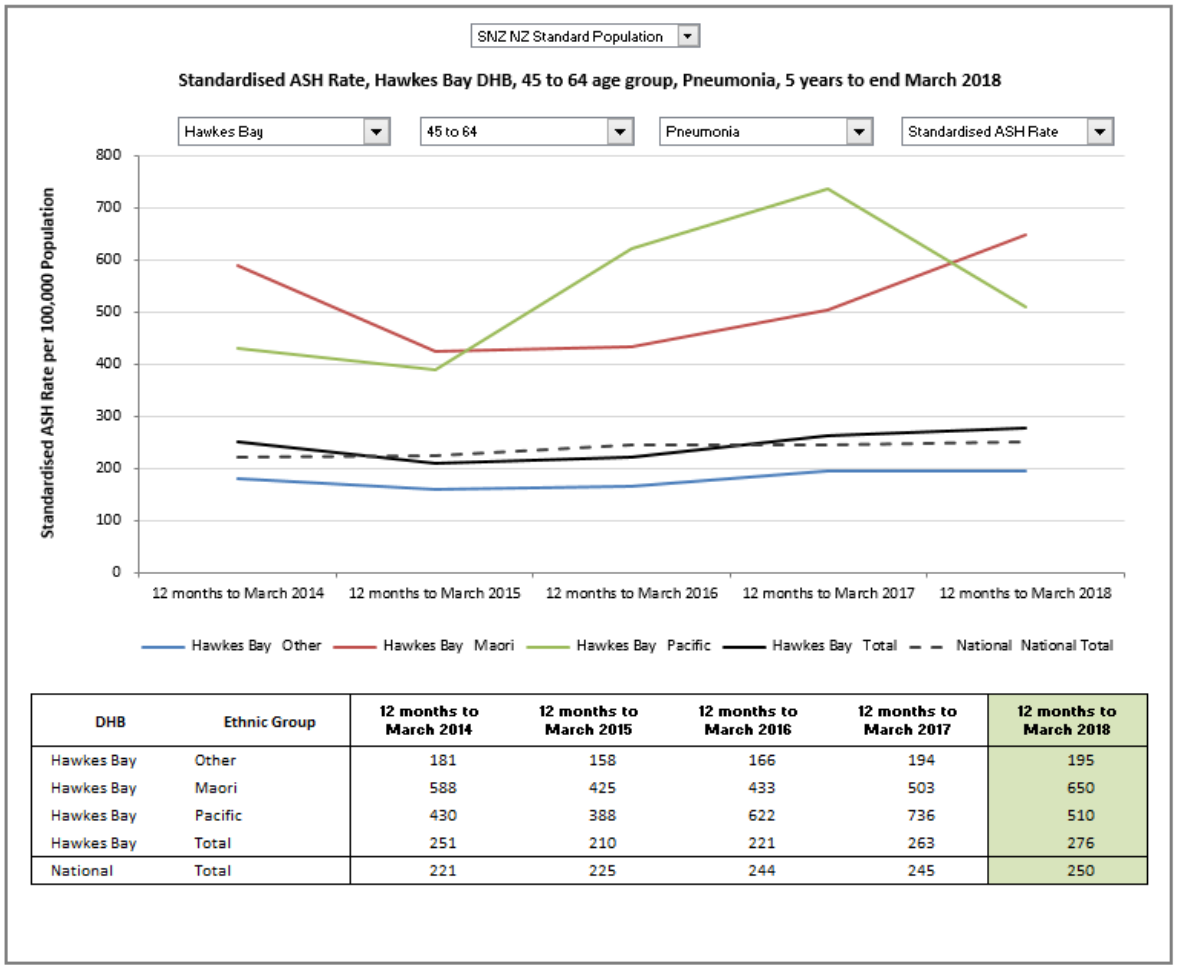
DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	72	63	68	53	77
Hawkes Bay	Maori	60	65	56	80	70
Hawkes Bay	Pacific	2	1	4	5	2
Hawkes Bay	Total	134	129	128	138	149
National	Total	-	-	-	-	-

Data Analysis

The Hawke's Bay ASH rate for COPD (328) is above the national rate (266) and has increase from the previous period from 306. The Moari rate (894) is four times greater than Other ethncities (213). Overall there were 11 more cases than preivous 12 month period.

[6] Asthma Rates per 1000 are low with event rates totally 42 per annum. This is considered too low numbers to be reporting against as the contribution to ASH is not statistically significant.

Pnuemonia



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	181	158	166	194	195
Hawkes Bay	Maori	588	425	433	503	650
Hawkes Bay	Pacific	430	388	622	736	510
Hawkes Bay	Total	251	210	221	263	276
National	Total	221	225	244	245	250

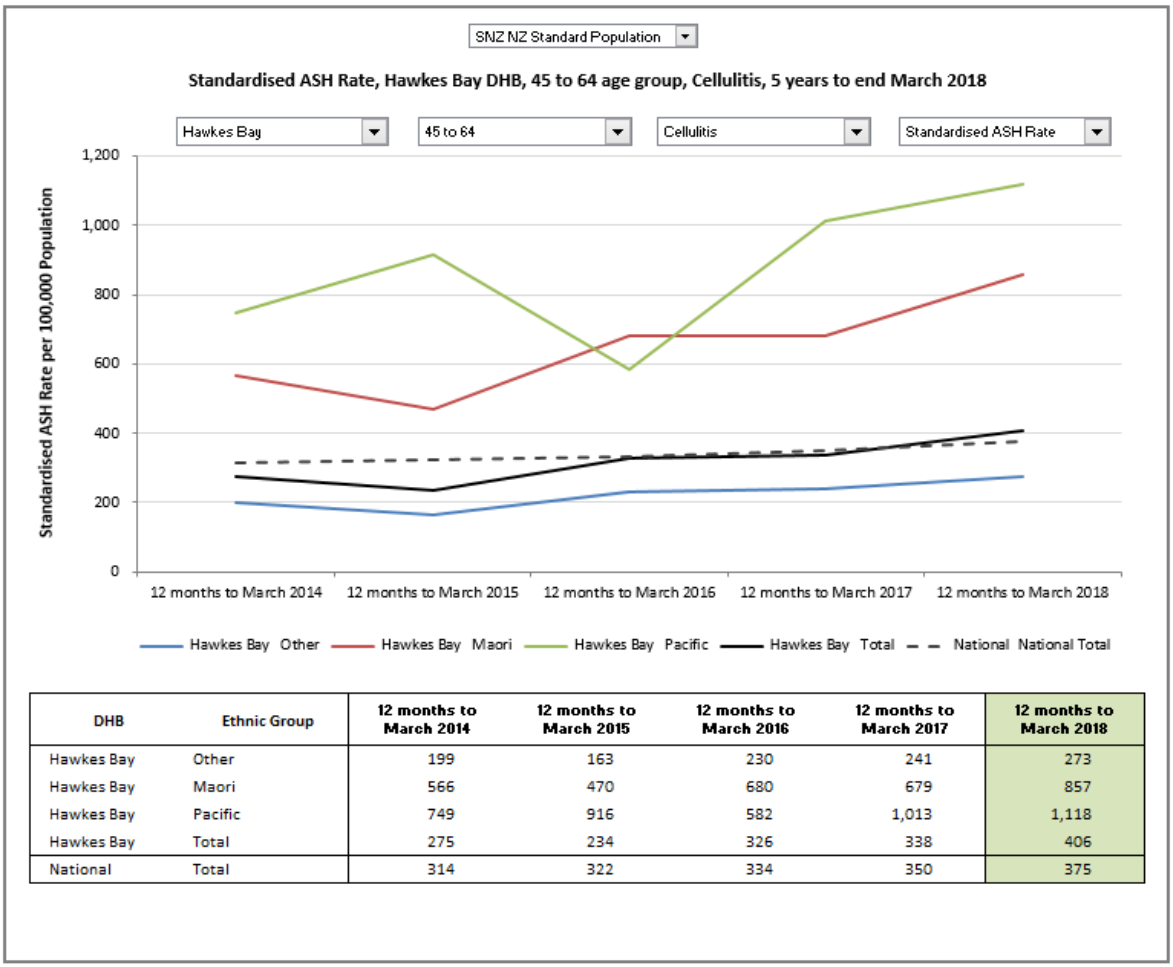
Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	64	55	58	70	70
Hawkes Bay	Maori	41	31	32	38	50
Hawkes Bay	Pacific	4	4	6	8	5
Hawkes Bay	Total	109	90	96	116	125
National	Total	-	-	-	-	-

Data Analysis

The Hawke's Bay ASH rate for Pnuemonia (276) is above the national rate (250). The Māori rate (650) is 3.3 times higher than the Other ethnicity and has increase from 503 in the preivous 12 month period.

The ASH 45-64 Cellulitis



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	199	163	230	241	273
Hawkes Bay	Maori	566	470	680	679	857
Hawkes Bay	Pacific	749	916	582	1,013	1,118
Hawkes Bay	Total	275	234	326	338	406
National	Total	314	322	334	350	375

Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	67	56	81	83	96
Hawkes Bay	Maori	42	35	52	53	68
Hawkes Bay	Pacific	7	9	7	10	13
Hawkes Bay	Total	116	100	140	146	177
National	Total	-	-	-	-	-

Data Analysis

The Hawke's Bay ASH rate for Cellulitis has gone from being below the national rate in the previous period to now sitting above the national rate. Māori (857) and Pacific (1,118) are 3.1 times and four times above the rate of the Other ethnicity (273).

ACTIVITY TO ADDRESS 45-64 ASH RATES

1. SLM 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 enrolment programme. Māori Base line 167. Māori Goal 350: Achieved: 91 Māori referrals (44 % of total referrals)

- The high needs enrolment programme is designed to address unmet need. Currently 97% of the population is enrolled in General Practice. Activities designed to engage the 3% of whānau who are not enrolled include:

    - ED identification of persons who register as 'GP unknown' with follow up by the PHO of the NHI listed and to either re-engage with their General Practice. Use of the high needs enrolment programme is offered and reinforced within ED for those without a GP

    - Encouraging whānau to enlist in the whānau wellness programme through the PHO, which provides free access to General Practice services and pharmacy over a 12 month (calendar year) period. This programme is made available to 250 whānau/families (not individuals) for the High Needs enrolled population. For the current 2018 cohort there are 525 individuals who have identified as Māori.

- In lieu of the range of programmes now in place to support high need enrolment, the ceiling that now seems to have been reached with this programme and the resources assigned to it, it is now time to consider the most effective use of resources to support enrolment for Māori.

- The reason why enrolment still needs to be a high focus is that without engagement with a primary health care home, all other early interventions and preventative approaches will struggle.

Increase number of referrals into the Hospital Discharge initiative
Base line was 300. Goal 500: Achieved 377 referrals

- The Criteria for referral to this programme has changed over time and in so doing has created lack of clarity for those referring from ED and in patient services. Steering Group discussions have been held on numerous occasions regarding the criteria and the need to continue to reinforce key messages about eligibility.

- The programme was reinforced during the period of industrial action and re clarification on eligibility criteria again provided. Continuing to reinforce the programme's focus on Māori and Pasifika, is a constant within management and steering group meetings.

- It is a valuable programme that requires greater publicity and visibility within hospital services. Greater efforts are in place to close the follow-up loop to ensure patients are followed-up and support to attend their post discharge appointment. A tracking mechanism to do this is underdevelopment.

- The Hospital discharge programme is managed through the CPO 7 programme. The full complement of initiatives included in the CPO programme is currently being reviewed. The Northland and Canterbury models for CPO are being used to scope the direction for the future HB model. The Northland model has a strong equity focus and the Canterbury model has proven results in reducing presentations to ED and ASH rates. The scoping paper for CPO is in its final draft and due to go to EMT in the first week of August.

[7] The Coordinated Primary Options Programme is being reviewed in its entirety currently, with the intention of extending its scope. Improving the Hospital Discharge component will form part of this review.

Rec*ruit into the position of Nurse Practitioner for heart failure with a Primary Care focus*

- Appointment has been made into this role. Work is underway to align the role closely with Primary Care and ensure there a close linkages with the PHO and General Practice teams.

- Close linkages are also being made with the Clinical Nurse Specialist (CNS) - Respiratory, and work that is being done through the Respiratory programme (see below).

Develop a programme to implement tracer auditing to inform Quality Improvement (QI) initiatives

- Tracer auditing has been utilised in demonstrating patient journeys, service involvement in care and highlighting areas across the sector for improvement. A selection of NHIs were traced and the findings used to demonstrate service utilisation and gaps in access to services. This proved extremely beneficial to clinical leads. The findings of which are being used to look at admission and readmission data, coordination of care and transition of care planning, both in and across inpatient and primary care settings. The lead who provided this support is no longer with the DHB, however there are members in the quality advisor team who are trained in tracer auditing. This has been flagged with the people and quality team as an area of work that provides great benefit to service design and planning.

- Basic IHI methodology training is the first step to being trained in tracer auditing methodology. This is being offered across the organisation and to external teams, e.g. community pharmacy.

2. *Collaborative Pathways*

- There are currently 75 Collaborative Pathways in place. Map of Medicine, the vendor for the pathways IT platform has now exited the market. The pathways continue to be available via an interim tool that the DHB has access to. This is a temporary measure while the new platform is put in place. An RFP is in play to identify a suitable vendor. The DHB is involved in that collective RFP for the Central Region.

- Pathways provide an integral part of care improvement and standards implementation. They are the platform on which CPO programme is based. The revision of the CPO programme, its focus on equity and the collection of evidence to demonstrate impact on ED presentations and admissions, and early and timely intervention in the provision of care, in the primary health care setting will be a priority within the revised CPO programme.

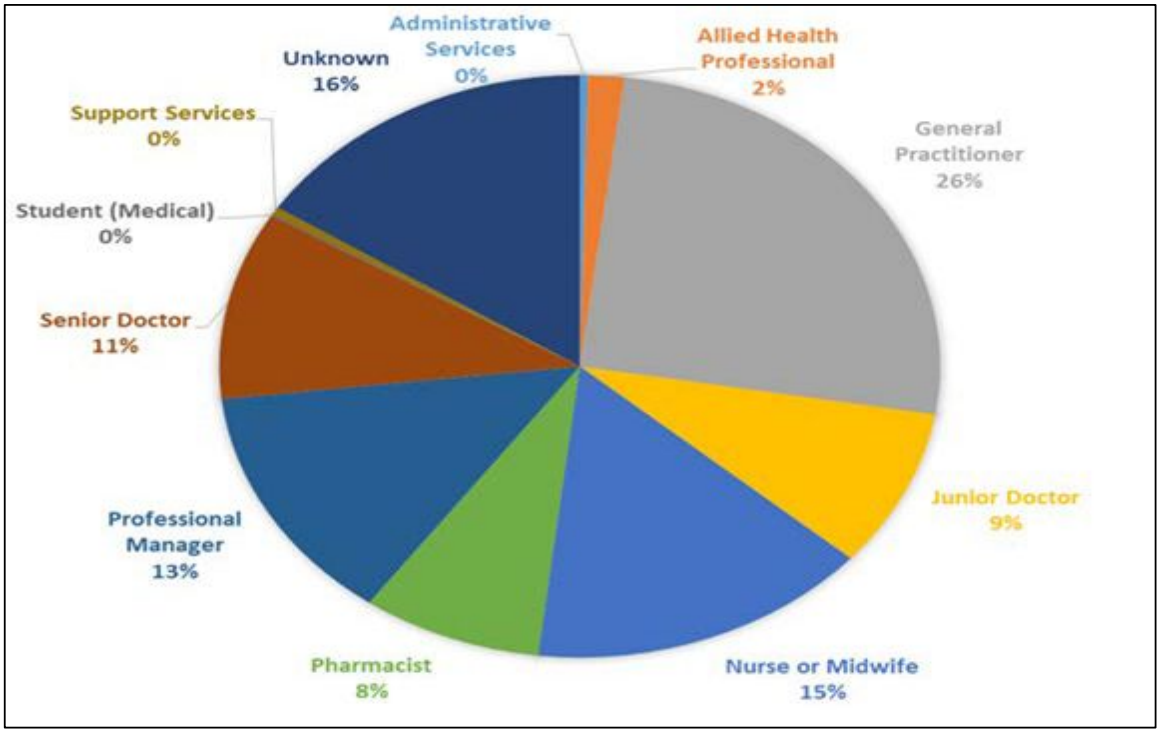
  "Collaborative clinical pathways are essential to the provision of an effective and efficient CPO pathway. Clinical pathways provide the mechanism for guiding adherence to best practice, the ability to inform clinical auditing and provide confidence in services that can be delivered through the CPO Programme.

  A priority for the DHB should be to develop systems and intelligence for a simple collection and interpretation of baseline CPO data both at the practice level but also at the ED and the hospital admission point. At present this data from ED/admissions is not coded under CPO conditions. The PHO data collection is based around claim data that is reliant on the GP filing a claim. There is very little, if any, patient journey data and this needs to be improved.

  The data needs to be able to show that the current CPO programme and the proposed expansion in the CPO programme reduces demand on ED, clinics and hospital admissions while improving the patient experience."

  Exerts from the draft: Scoping the expansion of the current Hawke's Bay DHB CPO Programme. Nicky Skerman 2018

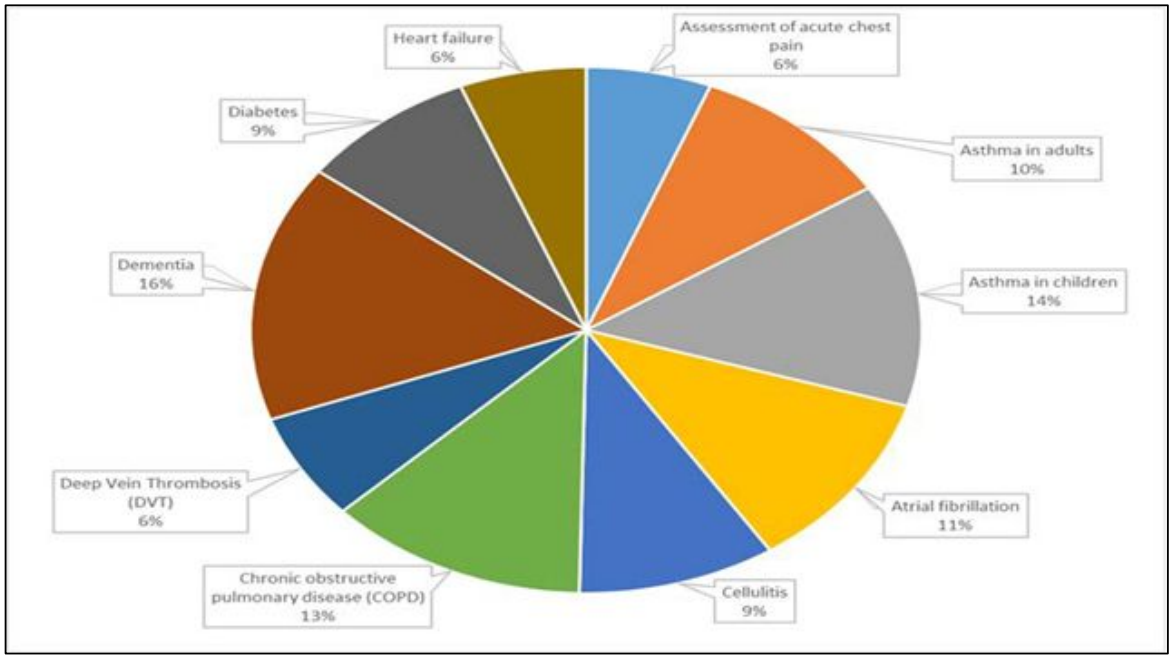
Figure 1.0 – Utilisation of pathways by service provider[8]



Pathways utilised that address the top five 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



[8] Not altered since previous report

3. Continuation of the Nurse Led Respiratory Programme: *Sue Ward - CNS Respiratory*

- The Respiratory programme continues to evolve, and education with all health care professionals cross sector continues to remain high priority. There is a MDT. The aim of this coordinated team is to ensure at every touch point for the patient this is a respiratory related contact being made with that whānau. The aim is to capitalise on every touch point available. The MDT includes: St John Ambulance; ED; Primary Care; Elderly Care; HHB; School Based Health Services; Public Health and Community Pharmacy.

- Lack of access to lung function results (due to primary care and secondary care not operating off a shared care record) means that evidence based treatment and management can sometimes be delayed for the patient. This is frequently commented on within clinical notes. The clinical portal development should address this gap.

- The health status review of 2017 for Central Hawke's Bay (CHB) highlighted high ASH COPD rates for CHB, with a 1.7 higher incident rate for Māori. This was tabled at the CHB Health Liaison Group Governance meeting and identified as an area of focus. A working group has been identified, led by the CNS Respiratory, CHB Health Centre Clinical Nurse Manager (CNM) and Clinical Nurse Lead of Te Taiwhenua o Heretaunga (TToH) CHB. It is recognised that this is a long-term programme using a collective impact multi-sector approach. The programme leads recognise the need to address the determinants of health, as well as coordinated clinical management. The Working Group is newly-formed and includes: healthy homes; nutrition; employment; pharmacy; Māori health providers; Council, education; and, primary care et.al. It is the aim of the Group to use existing resources to provide a connected and coordinated approach to prevention early intervention, and management. The programme will be focused on an outcome of respiratory well whānau/households across the age bands.

3. Implementation Plan for HBDHB LTCs Framework

- An operational working group was formed in February to advise on activities for the implementation of the LTCs framework. The Portfolio Manager leading this work resigned her position and the replacement was seconded into the role. Due to delays in recruitment to back fill this position, this work has only recently resumed.

- The focus for the implementation of the strategy will continue to be: Care Coordination; and, Transitions of Care. The service teams most directly involved in this work are Renal and Diabetes, Cardiac and Respiratory.

- The services are beginning to use recently obtained readmission data to examine the care coordination activities that will lead to reduced readmission rates. Focus will be on those with between two to four readmissions within a 12 month period. This work has only just commenced.

- A submission to Health Work Force NZ – Development Fund has been made by the DHB. This is directed at the development of a LTC workforce within the primary care workforce supported by clinical specialist support, using a multidisciplinary approach. If successful the grant will provide for four positions over a three year period. The model is based on a previous version submitted by the DHB for a health research grant that was unsuccessful. The model was adopted in Queensland, Australia and has been in place for the past 12 months.

Status of Quarter 2 - Recommendations (45-65 yrs)

	Key Recommendation	Implementation lead	Champion(s)	Time Frame	Status
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	DHB commitment to Interim tool for Clinical pathways confirmed. Jan 2019 new platform to be identified
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[9] 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	Not uniform part of service planning as yet Lead Portfolio manager recruitment delay has caused delays
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	Newly recruited Portfolio Manager to lead this work.
5.	Increase the weighting that is applied to health award applications in relation to equity.	Clinical Council	ED Equity and Health Improvement	July 2018	Being discussed: Increase weighting in each of the data sections or include in each category "Commitment to reducing Inequities"

Key Recommendation	Implementation lead	Champion(s)	Time Frame
Retain ASH 45-65 as contributory measure with activities to address within the SLM Improvement Plan	Medical Directorate Leads Portfolio Manager – Integration Innovation and Dev Mgr PHO	Exec. Director Primary Care	Quarterly
Present CPO scoping paper to committees and support a focus on addressing equity as the top line priority.	Emergency Department and Medical Directorate Leads Senior Commissioning Mgr. Innovation and Development Manager - PHO	Exec. Director Primary Care	December 2018
LTC Framework implementation plan to include formalised use of medical directorate clinical leads to influence activities directly relating to reducing ASH	Medical Directorate Leads Portfolio Manager – Integration Innovation and Dev Mgr PHO	Mark Peterson, CMO Primary	On confirmation into roles (Sept 2018)

[9] 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

The ASH rates for both 0-4 and 45-64 age groups give cause for some concern. While overall the equity gap in both age groups has not changed significantly there is now a trend towards a wider gap again having seen it close somewhat in the last few years.
This is within an environment where ASH rates overall nationally are increasing, especially in the younger age group.
It is disappointing to see both the increased rates of admission but more disappointing to see the Hawkes Bay DHB drop in "ranking" among other DHBs.
As detailed in the body of the report there are multiple interventions happening across the sector which ideally should be leading to lower rates of ASH and to a reduction in the disparity between Maori and the rest of the population.
The increased ASH rates overall reflect a health system under pressure. When under pressure it seems that the disparities become wider and we need to do more work to understand the drivers behind that change.

Dr Mark Peterson
Chief Medical Officer - Primary

RECOMMENDATION:

It is recommended that the Executive Management Team; Māori Relationship Board; Clinical Council; Consumer Council; and, HBDHB Board:

1. **Note** the content of the report
2. **Endorse** the actions being taken
3. **Support** recommendations made by EMT (31 July 2018)

   Provide quarterly updates against activities that;

   - contribute to the Te Ara Whakawaiora indicators
   - are reported against as part of the System Level Measures Improvement Plan
     - Keeping Children out of Hospital and Using Health Resources Effectively

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 Previous Meeting
18. Matters Arising – Review 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).