Māori Relationship Board Meeting

Date:	**Thursday, 12 May 2016**
Meeting:	**9.00am to 12.00pm**
Venue:	**Te Waiora Meeting Room, District Health Board Corporate Office, Cnr Omahu Road & McLeod Street, Hastings**

Board Members:

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

Apology: George Mackey

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

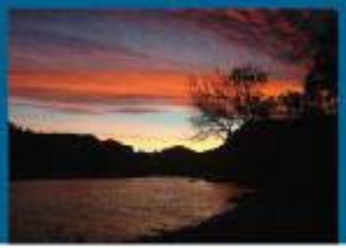
Our values

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 February Meeting	
6.	Minutes of the March Meeting	
7.	Matters Arising - Review of Actions	
8.	MRB Workplan 2016	
9.	MRB Chair's Report	
10.	General Manager Māori Health Report	
Item	**Section 2: Recommendation to Exclude the Public (from items 12-13)**	**9.20am**
11.	Under Clause 32, New Zealand Public Health & Disability Act 2000	

PUBLIC EXCLUDED

Item	Section 3: For Discussion / Decision	9.30am
12.	Minutes of the March Meeting	5-mins
13.	Prioritisation (Peter Kennedy)	30-mins

PUBLIC MEETING

Item	Section 4: For Endorsement	10.30am
14.	Best Start Healthy Eating Plan FINAL (Shari Tidswell)	20-mins
	Section 5: For Discussion	**10.50am**
15.	Customer Focussed Booking (Sharon Mason and Carleine Receveur)	20-mins
16.	Travel Plan Update VERBAL (Sharon Mason and Andrea Beattie)	20-mins
	Section 6: For Information Only (feedback via email)	**11.30am**
17.	Annual Māori Health Plan Quarter 3 (Jan-Mar 2016) Report	
18.	Te Ara Whakawaiora: Cardiovascular	
19.	Te Ara Whakawaiora Priorities & Reporting Schedule 2016-17	
20.	Youth Health Strategy DRAFT	
21.	Endoscopy Service Transition Update	
	Section 5: General Business	**11.40am**

Māori Relationship Board Interest Register - 30 March 2016

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict (if any)	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Declared
Ngahiwi Tomoana (Chair)	Active	Chair, Ngati Kahungunu Iwi Incorporated (NKII)	Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The HBDHB Chair	01.05.08
	Active	Brother of Waiariki Davis	Perceived Conflict of Interest. Non-Pecuniary interest. Waiariki Davis is employed by HBDHB and is the Health Records Manager.	Will not take part in any decisions in relation to Health Records management. All employment matters in relation to Waiariki Davis are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Uncle of Tiwai Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Tiwai Tomoana is employed by HBDHB and is a Kitchen Assistant in the Food and Nutrition Department at Hawke's Bay Hospital.	All employment matters in relation to Tiwai Tomoana are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Uncle of Iralee Tomoana	Iralee Tomoana is employed by HBDHB and works in the Radiology Department as a clerical assistant.	All employment matters in relation to Iralee Tomoana are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Brother of Numia Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital.	Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital.	The HBDHB Chair	01.05.08
Helen Francis	Active	Alzheimer's Napier previously a Committee member Patron and Lifetime Member	Alzheimer's Society holds a contract with the HBDHB to provide dementia specific daycare and community services.	Will not take part in any decisions or discussion in relation to HBDHB contract with Alzheimer's Society	The Chair	08.06.10 21.06.14
	Active	Employee of Hastings Health Centre	Actual Conflict of Interest. Pecuniary Interest.	Will not take part in any decisions or discussions in relation to Hastings Health Centre.	The Chair	18.02.09
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.11
	Active	HB Medical Research Foundation	Trustee	Declare this interest prior to any discussion in relation to the Foundation, and an appropirate mitigation action is decided on.	The Chair	20.08.14
Diana Kirton	Active	Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB.	Perceived Conflict of Interest. Non-Pecuniary interest.	Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO	The Chair	18.02.09
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on.	The Chair	16.01.14
	Active	Son, Chris Kirton, GP in Wairoa employed by HBDHB	Non-pecuniary interest: Will not take part in discussions around employment of GP's in Wairoa	All employment matters are the responsibility of the CEO.	The Chair	26.02.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
Denise Eaglesome	Active	Deputy Mayor of Wairoa District Council	Advocate as Deputy Mayor for Wairoa District, whereas HBDHB covers whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	28.02.11
	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussions in relation to the Trust.	The Chair	05.03.14
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	The Trust has a lifestyle Contract with HBDHB Awarded Green Prescription Contract	Will not take part in any discussions or decisions relating to the Contract.	The Chair	04.02.14 25.03.15
Tatiana Cowan-Greenir	Active	Husband, Parris Greening, Service Manager of Te Kupenga Hauora (TKH)	Contracted health provider of HBDHB	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.03.14
	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussions in relation to the Trust.	The Chair	19.03.14
Kerri Nuku	Active	Kaiwhakahaere of New Zealand Nurses Organisation	Nursing Professional / Industrial Advocate	Will not take part in any discussions relating to industrial issues	The Chair	19.03.14

Maori Relationship Board 12 May 2016 - Interest Register

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict (if any)	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Declared
	Active	Director of Hei Nursing	Actual Conflict of Interest. Pecuniary Interest.	Will not take part in any discussions relating to Hei Nursing	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	Maori Health Focused organisation	Will not take part in any discussions relating to the Trust	The Chair	19.03.14
	Active	Trustee of Te Timatanga Ararau Trust	The Trust has a lifestyle Contract with HBDHB	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.06.14
	Active	Employee of Te Puni Kokiri (TPK)	Working with DHB staff and other forums	No conflict	The Chair	19.03.14
Lynlee Aitcheson	Active	Chair, Maori Party Heretaunga Branch	Political role	Will not engage in political discussions or debate	The Chair	19.03.14
	Active	Chair of Te Whare Whanau Purotu Women's Refuge		No conflict	The Chair	22.12.15
Na Raihania	Active	Wife employed by Te Taiwhenua o Heretaunga	Manager of administration support services.	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.03.14
	Active	Member of Tairawhiti DHB Maori Relationship Board		No conflict	The Chair	19.03.14
	Active	Employeed as a Corrections Officer		No conflict	The Chair	19.03.14
Trish Giddens	Active	Trustee, HB Air Ambulance Trust	Management of funds in support of HB Air Ambulance Services	Will not take part in discussions or decisions relating to contracts with HB Air Ambulance Service.	The Chair	19.03.14
	Active	Manager, Taruna College		No conflict	The Chair	15.04.15
	Active	Assistant Director Governor, Rotary District 9930		No conflict	The Chair	15.04.15
	Active	Member of the Lotteries Board		No conflict	The Chair	15.04.15
Des Ratima	Active	Chair Takitumu Maori District Council	Maori Community Development Act 192	No conflict	The Chair	Dec 13
	Active	Chair Ahuriri District Heatlh Trust	Maori health post settlement equity group	Potential Conflict if contractural arrangements in place	The Chair	Dec 13
	Active	Chair Whakatu Kohanga Reo	Early Childhood	No conflict	The Chair	Dec 13
	Active	Chair Wanautahi Charitable Trust	Community Trust	No conflict	The Chair	Dec 13
	Active	Deputy Chair Maori Wardens NZ Maori Council	Maori Community issues	No conflict	The Chair	Dec 13
	Active	Chair of the kaupapa Maori Comittee	Maori Community Issues	No conflict	The Chair	Dec 13
Ana Apatu	Active	CEO of U-Turn Trust	Relationship	No conflict	The Chair	12.08.15
	Active	Chair of Directions	Relationship and contractual	Potential Conflict as this group has a DHB Contract	The Chair	12.08.15
	Active	Chair of Safer Hastings	Relationship	No conflict	The Chair	12.08.15
	Active	Member of Heart Foundation	Cardiac Stategic Advisory Group	No conflict	The Chair	12.08.15
	Active	Deputy Chair Health Promotion Forum	Relationship	No conflict	The Chair	12.08.15

MINUTES OF THE MĀORI RELATIONSHIP BOARD (MRB) MEETING HELD ON WEDNESDAY, 10 FEBRUARY 2016 IN TE WAIORA MEETING ROOM, DISTRICT HEALTH BOARD (DHB) ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS COMMENCING AT 9.00AM

Members:	Ngahiwi Tomoana (Chair) Heather Skipworth (Deputy Chair) Kerri Nuku Denise Eaglesome (video conference) Ana Apatu Tatiana Cowan-Greening (teleconference) Lynlee Aitcheson Trish Giddens Diana Kirton Helen Francis Des Ratima George Mackey Na Raihania
Apologies:	Kerri Nuku, leaving at 11.00am
In Attendance:	Kevin Atkinson (Chair HBDHB Board) Peter Dunkerley (HBDHB Board member) Kevin Snee (CEO HBDHB) Tim Evans (General Manager Finance, Informatics and Planning HBDHB) Chris McKenna (Chief Nursing Officer HBDHB) Matiu Eru (Pouahurea Māori Health Service HBDHB) Patrick LeGeyt (Programme Manager Māori Health Service HBDHB) Denal Meihana (Service Manager Māori Health Service HBDHB) Liz Stockley (CEO Health Hawke's Bay PHO/ General Manager Primary Care) Nicola Ehau (Head of Health Services Hawke's Bay PHO) Peter Kennedy (Finance Manager Chief Financials HBDHB) Mary Wills (Head of Strategic Services, Chief Financial HBDHB) Te Pare Meihana (Service Manager Wairoa Health Centre HBDHB) Jen Margaret (Quigley & Watts) Kate March (Quigley and Watts)
Minute Taker:	Lana Bartlett (MRB Administrator Māori Health Service HBDHB)

SECTION 1: AGENDA ITEMS

1. KARAKIA

Matiu Eru, Pouahurea opened the meeting with a karakia and mihimihi.

2. WHAKAWHĀNAUNGATANGA

The Chair welcomed everyone back and hoped everyone was well rested for a very busy year ahead.

3. APOLOGIES

K Nuku will be leaving at 11.00am, apology noted. Additional apologies had been received from Tracee Te Huia (General Manager Māori Health HBDHB) and Graeme Norton (Chair Consumer Council).

4. INTERESTS REGISTER

There were no conflict of interests declared regarding today's agenda items. Members were reminded to update any conflicts of interest with the Board Administrator.

5. MINUTES OF THE MEETING IN NOVEMBER

The minutes of the MRB meeting held 11 November 2015 were confirmed as a true and correct record pending the following amendments:

- Typo in the heading 'MINUTES OF THE MĀORI RELATIONSHIP BOARD ...'.
- Add Kate Coley (Director Quality Improvement Patient Safety) to the 'In Attendance' section. Kate presented the Consumer Story and provided a brief about the Quality Accounts.

- Add Anne Heast (Coach for the Executive Management Team) to the 'In Attendance' section.
- Page 10, bullet point two about Ngā Maia. K Nuku clarified they are actually Ngā Maia Māori Midwives Aotearoa, a national body that represents Māori birthing.
- Also on page 10, item 13 Health Literacy update regarding confusion in the Steering Group. The wording caused significant concern due to the language used. Should read "differing ideas". Reword **ACTION: MRB Administrator**.

Moved: D Ratima
Seconded: N Raihania
CARRIED

6. NOTES OF THE WORKSHOP

The notes of the workshop with the Māori Providers held 11 November 2015 were noted.

7. MINUTES OF THE PREVIOUS MEETING

The minutes of the MRB meeting held 11 December 2015 were confirmed as a true and correct record.

Moved: G Mackey
Seconded: L Aitcheson
CARRIED

N Raihania restated the feedback he emailed to members on 9 February 2016 about MRB discussing a smoother consultation process for papers and initiating the following policy "A requirement is for all consultation papers presented to MRB to have their HEAT and WOHIA assessment attached for MRBs consideration. The rationale is that a number of MRB questions relate to the above processes and if these are included then that will ensure a more timely response and quicker turn around. MRB would not consider papers without these attachments. All relevant managers should be advised of this process".

The Chair advised the action about Dr Fiona Cram training on all equity tools being held this month was the outcome of this discussion 11 December 2015.

8. MATTERS ARISING – REVIEW OF ACTONS

There were no matters arising.

REVIEW OF ACTIONS

11/12/15

2. Obesity and Alcohol & Other Drugs Strategies

Population Health is leading out and developing both strategies with the input of Māori Health and others. Mental Health were involved in the development of the Alcohol and Other Drugs (AOD) Strategy.

The Obesity Strategy has been modified. MRBs viewpoints about expanding to whānau instead of just targeting children have been considered. The outcome of earlier discussions about renaming or rebranding was unknown. MRB requested confirmation about the final draft being presented to MRB and added to the MRB workplan. **ACTION**

3. "Go Well" Travel Plan Issues

Board members were referred to Appendix 1 for responses to the issues raised by MRB at the December meeting.

4. Equity and Accountability Tool

There was a discussion about Dr Fiona Cram's training as follows:

- The expectation of the training is that it will start at a senior executive and clinical level then filter down to frontline managers and charge nurses so staff know what they are doing and what is expected.
- The tools will be useful to support the Treaty of Waitangi Responsiveness Framework and Cultural Assessments.
- A process of the Funding Management Group (FMG) is that all funding applications must undertake a HEAT assessment.
- A monitoring and auditing process is now in place to look at how the tool is being applied and if processes or programmes are achieving objectives.

- WOHIA tool is specifically designed to query policy change and looks at unintended consequences.
- Following the training by Dr Fiona Cram a process will be established by the funders to be embedded into Business as Usual (BAU). Utilisation will become part of the monitoring programme for equity.
- For MRB meetings, these tools would guide presenters to focus on identifying how proposals will reduce inequalities, benefit Māori and if they will achieve objectives.

Peter Kennedy (Finance Manager Chief Financials HBDHB) and Tim Evans (General Manager Finance, Informatics and Planning HBDHB) joined the meeting at 9.18am.

Tatiana Cowan-Greening joined the meeting at 919am via teleconference.

To get a better idea of what an application looks like once a HEAT assessment has been applied, it was asked that Dr Fiona Cram either attend the next meeting to give a demonstration or provide an example of an application. **ACTION**

9. MRB CHAIR'S REPORT

The amended Chair's report for the month of November 2015 was tabled and taken as read noting the correction to the 'Introduction' section, second sentence that reads "… the HBDHB Chair asked the General Manager Māori Health."

In addition, the list of MRB recommendations to the Board from June 2014 to June 2015 was also tabled as written in the Chair's Report. The Chair provided a brief explanation of the content of his report that generated lengthy discussions regarding the following matters:

Review of Māori Bachelor of Nursing Students

Initially, there were concerns about the failure of nursing graduates at EIT. There has been quite a bit of work happen with a tangible result of 40% intake of Māori nurses. The Head of Nursing EIT is now a member of the Tūruki Steering Group and the Chief Nursing Officer (CNO) meets consistently with the Head of Nursing EIT to resolve any identified issues.

MRBs concerns were clarified as follows:

- Nursing Entry to Practice (NEtP) and the quality of the programme, the lack of jobs available for graduates on completing the NEtP programme and whether students are made aware a job is not guaranteed even if they complete the programme. There is a concern DHB is giving out false hope.
- EIT retaining the funding of nursing students who do not complete the course. T Giddens advised that in her tertiary institution if students do not complete the training, funding is claimed back by the Tertiary Education Commission. Chris McKenna (CNO) offered to discuss MRBs concerns with EIT regarding the funding for students who do not complete the course and where it goes. **ACTION**

Chris McKenna (CNO) also advised that Health Workforce New Zealand (HWFNZ) contract allows for 14 NEtP graduates per year. Out of the central regional zone, HBDHB is the only DHB that fills the contract. HBDHB has a target to recruit 35-40% Māori. In addition, HBDHB are working closely with EIT to ensure transparency about expectations for Māori students. The national recruitment database ACE is an issue. When other DHBs do not recruit it makes the competition locally a lot more intense. But we are working on our recruitment process to recruit our own. In addition, keeping Kerri Nuku and Thomas Harding (Head of Nursing EIT) informed. So there is a lot of effort being put into resolving these issues.

K Nuku agreed stating part of her role as the Kaiwhakahaere of the New Zealand Nurses Organisation (NZNO) is looking at the nursing flow and workforce both nationally and internationally. MRB has been influential putting pressure on the DHB to look at what how our ageing population is managed as well as increasing the Māori workforce, primarily Māori nursing. A report in December from the CNO demonstrated that Hawke's Bay has always been punching above its weight in comparison to other DHBs and takes on a high number of new graduates in comparison to the much larger DHBs. The CNO and GM Māori Health are working on the infrastructure issues around supporting students through EIT by developing a mentoring programme within Tūruki. There are a number of initiatives available now that weren't available two years ago. We are responding to the needs of our community however there is always room for improvement. In terms of where we are ranked nationally, we should be proud of our achievements. Patrick LeGeyt (Programme Manager Māori Health Service HBDHB) added there is also a lot of activity happening in the DHB to move to a culturally competent health system. We are on the cusp of moving towards a whānau patient centred delivery system.

The Chair stated that these issues with the Bachelor of Nursing for Māori is a perfect example of where MRB has intervened and lobbied for change. This was a difficult case with complex barriers that was not confined solely to one sector. But MRB pushed repeatedly and now we are starting to see some fruition.

Due to a sense of despair that MRB were not making a difference and viewed themselves as a rubber stamping committee, Tracee Te Huia (GM Māori Health) was asked to trace MRBs recommendations to demonstrate progress and outcomes. MRBs concerns were more around the inadequate time allocated to discuss agenda items, measure recommendations and the lack of information has at times impacted on MRBs ability to add value and make informed decisions. Discussing the work plan for 2016 today, will assist MRB to better manage these issues.

List of Achievements and Recommendations to the Board
N Raihania recapped the feedback he emailed to members on 9 February 2016 about the list of achievements be the basis for an MRB – Ngāti Kahungunu Iwi Incorporated (NKII) Annual Hui. The Annual NKII Board meeting is on the 16 March 2016. It would be valuable to present both reports, List of Achievements and Recommendations, to the Board to demonstrate the achievements and our aims for 2016. The Chair invited the DHB to provide a presentation of the list **ACTION**

Tobacco Control Plan
The statement about smoking being a result of people needing their own space came from the International One Love Anti Violence symposium at EIT last year where it was demonstrated that smoking was a symptom of a whole lot of pressures put on namely indigenous women, Māori women in our case. The only 'free space' women could find for themselves was during smoking. The only freedom and space they owned. This was about equity and equality for Māori women so they don't need to use their space this way. The addiction is bad enough but the depression and suppression was even more of a point for examination. This is not restricted to smoking but also eating and obesity.

Living Wage in Hawke's Bay
If the DHB is going to adopt and support all DHB staff being on the living wage this would send a strong positive statement as well as significant movement across other DHBs. Kevin Atkinson (Chair HBDHB Board) advised there are a number of aspects about employment that need to be reviewed. This issue needs to be dealt with at a national level before changes can be made regionally. The DHB Chairs could then drive MRBs recommendations through the national and regional channels for approval.

A key principle of MRBs is reducing inequalities. Moving DHBs to the living wage would improve equity and reduce poverty. K Nuku stated she felt this was a watershed moment demonstrating that we are truly buying into our statement. L Aitcheson added having all staff on a living wage is really achievable considering the ratio of those below the living wage is 265 hospital based staff. An ethnicity breakdown of those staff below the living wage was requested **ACTION.** A funding bid has been developed by Tracee Te Huia (GM Māori Health) for the 2016/17 process.

Mary Wills (Head of Strategic Services) joined the meeting at 9.35pm followed by Kevin Snee (CEO HBDHB) at 9.43pm

Denise Eaglesome left the meeting at 9.48am due to technical difficulties.

8. GENERAL MANAGER (GM) MĀORI HEALTH REPORT

The report from the GM Māori Health for November 2015 was taken as read. In the absence of the GM Māori Health, Patrick LeGeyt (Programme Manager Māori Health Service HBDHB) provided the following commentary:

Annual Māori Health Plan 2016-17, Whānau Ora
N Raihania referred to his feedback emailed to members on 9 February 2016 about his suggestion for MRB to develop a Whānau Ora statement and description for the DHB. Due to confusion and lack of understanding about the direction in the area of Whānau Ora it was considered that by having a DHB Whānau Ora Statement it will enhance the business of the health sector and will provide clearer direction for all, particularly in a Kahungunu context.

Child Obesity
D Ratima raised his concerns about the statement on page 41 regarding obese children being referred to a health professional. The answers are with the whānau who should be included as part of the solution. Also, that Kōhanga Reo should be included in this discussion. Furthermore, that funding for the development of an

evidence based child obesity programme will be coming from the disinvestment of Kahungunu Hīkoi Whenua (KHW). It seems that every time there is an initiative, KHW is the target.

Patrick LeGeyt (Programme Manager Māori Health Service HBDHB) explained the focus of KHW is nutrition and physical activity. We are re-orientating some of the KHW funding as well as other health promotion resources and potentially putting the funding into another program that is still within the KHW Kaupapa to be more effective with the resources and more focused with the health needs of the population. D Ratima commented this explanation would have been helpful if it was included in the report.

The end goal is fewer obese people in our population. Kevin Snee (CEO HBDHB) commented that the workshop in March will assist in us setting goals and how we will achieve these. Reviewing funding of programs is an ongoing exercise. Evidence is good but it's not the be all and end all because evidence it is about something that has been proven in the past and not the future. We should consider evidence based medicine and practice with what we know and believe to work in our communities. This is why KHW was established. This is where Population Health meets Māori community expectations.

D Ratima requested it be noted that Kōhanga Reo should *not* be excluded from the obesity strategy and that it seems whenever there is a new initiative needing funding KHW is the target. MRB fought hard to retain KHW and the associate of KHW. We need to ensure the new programme that we are re-investing funds to provides added value than the current programme. This is a conversation that should have been had.

K Nuku commented the report did not clearly demonstrate the urgent need in Hawke's Bay to address obesity. These reports are not a research report but more so, generic reports. Local data about obesity had been presented to MRB previously through the Equity Report. Kerri requested that better clarity be given around data provided.

Nicola Ehau (Head of Health Services Hawke's Bay PHO) confirmed that this particular discussion about referral numbers is proposed to be an IPIF target this year and responsible for gathering the baseline of children who have been identified as needing support for their families. It would be helpful if MRB provide feedback to leverage discussions about how to manage this for next year and contract negotiations with the Ministry of Health and a body called PSAAP.

Māori Oral Health Project

Concern was raised about the work being done to determine the numbers requiring follow-up for improved appointment scheduling. Patrick LeGeyt (Programme Manager Māori Health Service HBDHB) advised we have clear data going back numerous years about DNAs by ethnicity, by age, about appointments. We have requested from Business Intelligence this data by NHI, by actual individuals. Then we know what volumes we are working with and if we have the resources to improve the situation. We should have data by NHI individuals together with volumes across Hawke's Bay shortly. The Māori Oral Health Project is a classic example of a HEAT assessment conducted over an old health business case. There were clear recommendations from the community about attendance and community engagement. A copy of the summary of these recommendations and a progress report of where these are at was requested **ACTION**

Tūruki Māori Workforce Development

N Raihania received a copy of the Tūruki Annual Report and acknowledged how well the report was put together and presented, and the information provided was expansive. The report has provided clarity about the relationship between Programme Incubator and Tūruki. Na would like to thank whoever was responsible for a well written report and Shane Whitley for sending out the report.

SECTION 2: PRESENTATION

11. NEW INVESTMENT PORCESS

Peter Kennedy (Head of Finance) and Tim Evans (GM Planning, Informatics and Finance) was in attendance to talk to the prioritisation process the DHB runs around new investment.

In December the DHB received the 2016-17 funding envelope which was about $8.5 million. Services then identified costs that are driving unavoidable cost pressures impacting on new investment. The result is a gap between the unavoidable costs and the new income. For 2015-16, the gap was $7 million and it is anticipated that it will be at least the same amount for 2016-17. Once it has been determined how much appetite we have for savings and new investment available for the DHB we run a prioritisation process using the Triple Aim Scoring Tool that produces a mechanically scored investment list. That is the purpose of this presentation is how we determine what stays above the line (can do) and under the line (what we physically cannot do). Clinical Councils mandate about resource allocation and making the determinations will receive the full list and score it using the Triple Aim Scoring Tool to form their view on where the cut off line is. Clinical Council then

makes recommendation to the Board, and that recommendation comes through MRB for feedback. It was made clear that whatever is moved above the line, will move something else under the line.

The challenge is MRBs meeting on 11 May is the same day as Clinical Councils meeting. MRB decided to move the meeting to 12 May to provide the opportunity to advice on the Councils recommendations before going to the Board. **ACTION MRB Administrator.**

Peter Kennedy (Head of Finance) advised the full list will go to EMT, then Clinical Council and then MRB before going to the Board. All feedback and recommendations will be presented to the Board.

There was a discussion about MRBs representation on the Clinical Council. Discussion points included:

- There are no Māori representatives per se at present.
- Although Clinical Councils Terms of Reference is clear about equity and matters pertaining to Māori, having principles about health equity does not necessarily mean we are looking from that lens. MRBs conversations about the HEAT and WOHIA tools were that they are only as good as the person applying the tools.
- Some health professions state clinical competencies are given more weight than cultural competencies and yet the two competencies are equally part of a whole picture. You cannot be competent if you don't have the two competencies of clinical and cultural.
- There is a role for MRB to have representation on Clinical Council. It would make more sense for a member endorsed from this group sitting on the Clinical Council that would feed between two groups.
- Chris McKenna (Chief Nursing Officer) has had conversations with Mark Peterson (Chief Medical Officer), Tracee Te Huia (GM Māori Health HBDHB) and also Kevin Snee (CEO HBDHB) about this matter. All thought it a good idea that MRB have representation on the Clinical Council in the same mandate as Graeme Norton (Chair Consumer Council). Graeme is an observer, can participate in conversation which informs Clinical Council but cannot participate in decision making.
- The Chair had an issue about MRB dropping out of governance because Clinical Council is executive management. Representation onto this group is putting one of our members at an operational level. MRB are operational to a certain extent with membership on Tūruki. The role of MRB prior to going to the board is clearly a governance role and will remain.

A discussion will be held with relevant stakeholders about MRB representation on Clinical Council and the Chair of Clinical Council will present the outcome to MRB at the 9 March meeting **ACTION**

D Ratima commented that MRB should have been included earlier in the budget allocation process instead of when recommendations are made and MRB are asking for input earlier in the process. In terms of representation, as the MRB we identify who we want on the Council based on our own criteria.

SECTION 3: PERFORMANCE MONITORING – DISCUSSION PAPERS

12. TE ARA WHAKAWAIORA: ACCESS AMBULATORY SENSITIVE HOSPITALISATIONS

Mary Wills (Head of Strategic Services) was in attendance to speak to the paper on behalf of Mark Peterson (Chief Medical Officer).

Progress has been made with the under 4 year olds whereby the gap of inequity has closed. The DHB has a focus and an investment programme. Congestive heart failure is a concern where the disparities are getting worse rather than better. Recommendations to address the concerns was tabled.

The following matters were discussed:

- Page 47 and 51 targets read the same. Page 51 is a mistake. Page 47 statement is correct. The Ministry of Health changed the targets and they were not intending the DHB report on these targets. But the DHB will be continue to report on these targets and do some work with Health Hawke's Bay to achieve the targets.
- D Ratima asked for an explanation of the acronym ASH that is not in the glossary.
- Note that graphs are end on year, asked would it be more helpful using the Trendly data that rolls out every six weeks and using shorter timeframes? Some of the measures are quarterly or annually. Increasing the frequency may not alter the results. Mary to seek advice from Mark Peterson if it will be more effective or make an impact to report more frequently.
- Page 56, the paragraph about Kōhanga Reo has been truncated.

- It was asked how it has been developing the clinical pathways given that a lot of the emphasis when working with Māori is about including the cultural components or cultural advisors to support developing the pathways. There have been challenges developing clinical pathways. The focus has been getting specialists and GPs talking together to agree to consistent pathways. There is further work required to involve consumer feedback and look at what happens once the pathways are in place. Next development will be to change and develop services.
- It was asked about what is the plan to progress Nurse-Led Clinics. Nicola Ehau (Head of Health Services Hawke's Bay PHO) stated this is not about starting up Nurse-Led Clinics and explained this programme is a joint project delivered by a CNS employed by DHB and general practice teams. There are no standalone clinics in the sector. There are some Nurse-Led Clinics functioning in General Practice. There are some clinics who are not connected to a GP and these are exceptions. We are currently working with GPs to extend their reach.
- There is opportunity for Nurse-Led clinics to be run at marae and connected into the pathway of care through to primary rather than being isolated.
- Page 47 the graphs demonstrate nationally the rates have stayed the same however in HB the rates are going down. The gap between Māori and Non-Māori is reducing. Hawke's Bay is lower nationally and this is quite a significant achievement. This is positive.

As there was no further feedback the Chair moved that the contents of the report be noted.

Liz Stockley (CEO Health Hawke's Bay PHO/ General Manager Primary Care) joined the meeting at 10.25am.

SECTION 4: PERFORMANCE MONITORING – DISCUSSION PAPERS

13. HEALTH LITERACY

Jen Margaret and Kate Marsh from Quigley and Watts were in attendance to discuss the Health Literacy Strategy Review. Quigley and Watts is a Wellington based company commissioned to develop a health literacy framework for the DHB. MRB provided extensive feedback and a final draft of the report will be complete mid-March.

Any further comments need to be emailed to jen@quigleyandwatts.co.nz by Friday, 12 February 2016.

14. HEALTH AND SOCIAL CARE NETWORKS

RECOMMENDATION

That MRB:

1. Endorsed the content of this Programme Brief pending consideration for MRBs feedback and input the strategic direction.

Kevin Snee (CEO HBDHB) and Liz Stockley (CEO Health Hawke's Bay PHO/ General Manager Primary Care) were in attendance to speak to the paper. There is relevance with the number of issues discussed today that related to the Health and Social Care Networks and how we organise our resources in localities more effectively to better deliver services. The programme was discussed at the HB Health Leadership Forum where general support about the intentions was agreed. The paper presented should be viewed as an evolution process. What Kevin and Liz were looking for from MRB were their views on the paper. Is it the right thing to do?

Wairoa and CHB were obvious geographical areas. Wairoa is making progress at bringing organisations together and CHB who haven't made the same progress but are still bringing organisations together. Wairoa and CHB are small populations and ideally you want larger populations. What is important about these localities is they are primarily geographical. It is marrying up the resources in a sensible way by the population geographically. It's about finding an accommodation which works and the efficient aggregation of the resources and best use of clinical staff that bring those resources together in an effective way.

The following discussions took place:

- The programme is in line with what MRB have been talking about for the last 10 years. Finally we have a design and from a Chairs perspective it's about time
- Be mindful of the smaller geographical areas and look at how we can meet the needs of these smaller populations. Perhaps merging smaller populations for example Camberley and Flaxmere.
- Look at harnessing volunteers to ensure sustainability to look after our population therefore include how we manage volunteers, non-for profit charitable agencies and organisations into the programme

- The proposal has a lack of Māori concepts. It is difficult to see Pae Ora, Whānau Ora or tikanga based approaches to medicine. There needs to be more push for our Māori values and concepts in the design phase. For the Māori of the HBDHB patient population, it is critical for these Māori ideals to come through the programme. Liz Stockley (CEO Health Hawke's Bay PHO/ General Manager Primary Care) advised the Māori ideals will come through the design of the model of care that will be co-designed with the communities allowing each of those communities to support a design that suits them.
- Articulating how the model will reduce inequity and improve health profiles is not clearly described in the document and should be added as a guide or principle. There were issues with the language used within the report and perhaps it could have been a little more descriptive. It was suggested that perhaps it is worthwhile having a template for the front page of each paper that asks how the paper addresses inequality, efficiency and quality.
- Te Pare Meihana (Manager Waiora Health Centre) described the programme as having two processes; first phase is getting the concept over the line in terms of the DHB and its system. The real challenge is when communities get together and agree that they want to do things differently and then what framework does it need to apply to get the results that it needs. Wairoa, if given the green light are already planning what we might make of this opportunity. There are a number of applications that we would see at the forefront in terms of leading the development that includes a strong tikanga base.
- Being bold enough disinvesting in programmes that aren't effective. We may not have the evidence base but it feels right to disinvest to reinvest.
- Use of the Health Equity Assessment Tool (HEAT) and the Whānau Ora Health Impact Assessment (WOHIA) tool throughout the entire process including funding bids, what will be the impact of the decisions and how we are going to engage the community
- Look at how we manage the inconsistencies and unintended consequences. Are we creating poverty zones and if so what incentives are in place to prevent this. For example, we might set things up in Wairoa but because of the population we don't get either enough resource or qualified staff.
- Exploring other opportunities like the 'Pop Up' type models of approaches where you have a group of expertise in one place for a day or two instead of 24-hour services.
- The principle is good but the detail needs a 'Māoriness' strand interwoven throughout from the start to finish. Therefore we need to get the first principle right so this is carried throughout. While it is important to have a statement it is more important for people to understand the meaning of the statement and how it can be achieved
- The major premise of this programme is the devolution out to communities which is fantastic. But the difficulty is that communities are defined by size so already disadvantages Māori communities because they don't have a population of 30,000. We merge the smaller population's further disempowering communities. The criteria should be based on the community's readiness to participate as opposed to its population to be considered as the mechanism for devolving or engaging communities. There are a number of small Māori communities that are going to be affected.
- The report is not about only engaging communities at 30,000 and above. It's about how to bring services together to focus on smaller groups to provide better services to the smaller populations is the focus. A view has been formed that it should be primarily geographically and Kevin Snee recognises that D Ratima disagreed with this criteria and will re-look at the geographical criteria.
- This will be hugely beneficial to the community because of the efficiencies and quality of service delivery as a result of those services being more focused. If this is put in place, it is up to us as MRB members to ensure it happens to the advantage of our people so they have equity.

15. WĀNANGA MRB WORKPLAN 2016-17

Last part of the meeting was to look at MRBs priorities for this year and the annual workplan.

Patrick LeGeyt (Programme Manager Māori Health Service HBDHB) listed the key considerations of MRB. There has been good discussion today and the feedback received has been more about discussion, less agenda items, more prioritisation but also taking into consideration our functioning roles of MRB to review the performance of the DHB against Māori health indicators, input into service design and projects and to ensure MRB priorities are making traction.

D Ratima has been consistent about Obesity as a priority and adding this to MRBs workplan. Des raised the need for a strategy around bariatric surgery. After much discussion MRB decided its emphasis has to be on prevention and younger people.

MRB requested the following as part of the workplan development:

- Increase from eight meetings to 10 per year not including the Hawke's Bay Health Leadership Forums. The reason being currently two of the 10 meetings are reserved for Hawke's Bay Health Leadership Forums and with MRBs busy schedule we cannot afford to lose two meetings
- Reduce agenda items to no more than six items
- Remove the Monthly Consumer Story as an agenda item
- Prioritise agenda items with topics pertaining to Māori health requiring in-depth discussion to be placed first on the agenda to allow sufficient time for discussion
- Increase discussion times per item to allow sufficient time for good input and avoid rushing through topics impertinent to Māori health
- Use time efficiently and remain within the allocated timeframe
- A reasonable sized workplan that is not too big
- Have a set amount of key strategies with a plan of how these will be addressed
- Restrict the number of goals
- Email feedback about papers to provoke thinking and discussion prior to the meeting
- Look at the possibility of presentations being presented to all of the committees at the one time
- Develop a feedback tool for presentations so that there is an outcome
- Consider doing something for the organisation in terms of developing a Whānau Ora Statement that is more of a vision statement for policies to hang off.

MRB members were asked to state their Māori health priorities. These were as follows:

- Addictions/Smoking especially for Māori women, Alcohol and Other Drugs
- Fluoride
- Obesity
- On top of the Māori health priorities to have an internal focus goal within the sector and an external goal (outside of the organisation). Plus an aspirational goal to keep us pushing forward and pushing the boundaries of innovation to do things differently. Whatever the MRBs priorities are, what would be our internal focus for that priority?
- DNAs
- Transport
- Maternal health - ante natal attendances for Māori, smoking and drinking during pregnancy, oral health, breastfeeding - best start to life is very important, empowering young Māori women and having community champions to motivate them for a better life, and teenage pregnancy
- Mental Health
- Physical activity and nutrition
- Employment and education

Patrick Le Geyt (Programme Manager Māori Health HBDHB) will collate an empirical list of the most quoted priorities and email them to MRB to adapt as priorities by email. **ACTION**

Further discussions included:

- It would be useful to access information on health priority costings. MRB could monitor where funds are being spent, the outcome of programmes and if the programmes are being run efficiently. Furthermore, provide the ability to view savings made through the programmes and by the strategies we have implemented. Perhaps quarter by quarter reports. Kevin Snee (CEO HBDHB) explained where each priority has clear funded programmes it is quite simple. However there are a number of contributing programmes to each priority that are not as easily defined for example child obesity. Obviously, MRB would have to state the reasons for wanting to receive the reports.
- Possibility of the space between Cashmore and Māori Health to be used as parking. The Travel Plan is currently working on reducing the parking issues.
- MRB should be thinking about prioritising for next year. Most of the priorities are about what happened in the last 3-6 months. How much emphasis do we get in a years' time.
- It was agreed that fruit would be provided throughout the meeting leading up to lunch as the break was too long between start and finish times for the meeting. MRB will set an example by only having fruit at morning tea and no muffins and scones at all. **ACTION**

Helen Francis excused herself from the meeting at 12.20pm.

SECTION 4: GENERAL BUSINESS

There were not matters for general business.

The MRB meeting was closed by a Karakia by Matiu Eru at 12.30pm.

Signed: _____

Chair

Date: _____

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

MINUTES OF THE MĀORI RELATIONSHIP BOARD (MRB) MEETING HELD ON WEDNESDAY, 17 MARCH 2016 IN TE WAIORA MEETING ROOM, DISTRICT HEALTH BOARD (DHB) ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS COMMENCING AT 9.00AM

Members:	Ngahiwi Tomoana (Chair) Heather Skipworth (Deputy Chair) Kerri Nuku Denise Eaglesome (video conference) Ana Apatu Tatiana Cowan-Greening (video conference) Lynlee Aitcheson Trish Giddens Diana Kirton Helen Francis Des Ratima George Mackey Na Raihania
Apologies:	Ngahiwi Tomoana (Chair) Trish Giddens Diana Kirton Helen Francis Des Ratima
Absent:	Lynlee Aitcheson Tatiana Cowan-Greening
In Attendance:	Graeme Norton (Chair Consumer Council HBDHB) Tim Evans (General Manager Finance, Informatics and Planning HBDHB) Chris McKenna (Chief Nursing Officer HBDHB) Matiu Eru (Pouahurea Māori Health Service HBDHB) Patrick LeGeyt (Programme Manager Māori Health Service HBDHB) Denal Meihana (Service Manager Māori Health Service HBDHB) Caroline McElnay (Director Population Health/ Health Equity Champion) Shari Tidswell (Team Leader/ Population Health Advisor HBDHB) Nicky Skerman (Population Health Strategist Woman, Child and Youth HBDHB) Kim Williams Population Health Advisor HBDHB) Tracey Ashworth (Population Health Advisor HBDHB) Katie Kennedy ((Portfolio Advisor Women, Child and Youth HBDHB) Carina Burgess (Head of Planning HBDHB)
Minute Taker:	Lana Bartlett (MRB Administrator Māori Health Service HBDHB)

SECTION 1: AGENDA ITEMS

1. KARAKIA

Matiu Eru, Pouahurea Māori Health HBDHB opened the meeting with a karakia and mihimihi.

2. WHAKAWHANAUNGATANGA

Heather Skipworth, Acting MRB Chair welcomed everyone to the meeting.

3. APOLOGIES

Apologies were received from N Tomoana, T Giddens, D Kirton, H Francis and D Ratima. K Nuku reported L Aitcheson will be arriving late.

4. INTERESTS REGISTER

There were no conflict of interests declared regarding today's agenda items. Members were reminded to update any conflicts of interest with the Board Administrator.

A Apatu reported her role as the Chair of Directions keeps dropping off. Notify Board Administrator **ACTION**

5. MINUTES OF THE PREVIOUS MEETING

There was no quorum therefore confirmation of the minutes from the last MRB meeting held 10 February 2016 could not occur.

6. MATTERS ARISING – REVIEW OF ACTONS

The following matters were raised:

Attendance

Correction, A Apatu was in attendance at the last meeting.

Health and Social Care Networks

Refer to the first bullet point on page 13. N Raihania requested it be noted that he strongly disagreed with the pretence that Māori ideals will come through the co-design discussion of smaller communities. The reality is that those discussions will favour the majority and reduce the opportunity for a Māori world view concept. If MRB agrees with that statement we may well have, in N Raihania's estimation perpetuated inequity into the networking model.

REVIEW OF ACTIONS

10/02/16

3. Funding for Māori Bachelor of Nursing Students

MRB acknowledged there has been a lot of progress made with the Māori Bachelor of Nursing Students. However, drop-off rates and student debt has been an ongoing concern. Chris McKenna (Nursing Officer) raised these concerns with Susan Jacobs (Dean Faculty EIT). It was clarified that students can apply for a partial or full refund pending on situation, as per the Academic Statute and Regulations below:

a) If a student withdraws before or during the first two weeks of a programme, he/she receives a full refund.

b) If a student withdraws after that period in the course, (whether failing or passing at that point), and has experienced exceptional circumstances, e.g. serious Whānau illness requiring the student's time, death in the family, complex issues such as child custody legal action etc., the student may apply for a partial or full refund.

c) If a student is unsuccessful in a course or a number of courses which may mean the student cannot continue in the programme, and there are no exceptional circumstances, normally there is no refund of fees.

Key point is there are options available for students who withdraw to apply for a refund especially if the circumstances are exceptional.

It was suggested that MRB meet with Adele White, CEO Ngāti Kahungunu Iwi Inc. (NKII) to discuss the following:

- Establish who has replaced Jenny Smith, former Director Te Ara Toiara: Health & Wellbeing NKII, who was a member of the tri-partite partnership formed between NZNO, EIT and HBDHB.
- Revisit the original action about obtaining Māori nursing drop-off rates for EIT and Te Tairawhiti and also request the story behind the statistics to help address the issues
- Extending the conversation to raise MRBs concerns about students who withdraw from the course for exceptional circumstances incurring a $30,000 debt. Furthermore, the possibility of the debt being returned to the funder, either partially or fully, so the student does not incur a debt. The refund could be credited to the student to use for future education.
- Develop high level priorities and objectives for MRB

It will be important to be clear about what information MRB require. The Chair requested that N Raihania and K Nuku to clearly articulate what MRB would like reported. Also, that G Mackey assist H Skipworth to draft-up the letter for NKII. K Nuku and N Raihania will attend the meeting with NKII along with H Skipworth.

Shari Tidswell (Team Leader/ Population Health Advisor), Tracy Ashworth (Population Health Advisor), Caroline McElnay (Director Population Health/ Health Equity Champion) and Kim Williams (Population Health Advisor) joined the meeting at 9.22am.

There was a lengthy discussion about the sentence "Whānau patient centred delivery system" on page 8 of the minutes. N Raihania emailed his concerns on 17 March 2016 about the language and its interpretation

that is confusing and unclear, especially as we refer specifically to a Whānau centred health system. The discussion ended with a caution of the language because there is a lot of jargon being used.

5. Living Wage

Reducing poverty is a key intention of the Living Wage Proposal that has been to the DHB Board and was discussed at length. The Living Wage Proposal will be prioritised against other district needs through the new investment process going through Clinical Council.

9. MRB Representation on Clinical Council

The meeting to discuss this is yet to be held. There is overall support for an MRB representative on Clinical Council. MRBs membership would include providing advice and guidance to Clinical Council, however MRB would not have decision-making rights.

Carina Burgess (Head of Planning) joined the meeting at 9.55am.

7. MRB CHAIR'S REPORT

The Chair's report for the month of March 2016 was taken as read. The following discussions took place:

Health and Social Care Networks

Concern that the model does not strongly include inequity therefore MRB requested this be added to the model. 'Nga mea Māori' (for Māori) is not defined anywhere within the model. The wording of the Chairs report needed to be stronger when advising that while MRB supported the recommendation, support was *in consideration* of the advice provided by MRB.

8. GENERAL MANAGER (GM) MĀORI HEALTH REPORT

The GM Māori Health report for March 2016 was taken as read. Tracee Te Huia (GM Māori Health HBDHB) provided the following commentary:

Whānau Ora Outcomes Framework, Page 21

The Whānau Ora Framework was email to MRB 4 March 2016. The GM Māori Health is seeking MRBs guidance and advice.

National Māori Provider Review by the Ministry of Health

Key point is the Māori Providers meet expected coverage of 90% of their contracts. Out of 22 Māori Providers, only five are not performing and these Providers are being managed by their respective DHBs. The full report is due out in May 2016.

Te Matatini – Ngāti Kahungunu 2017

The following feedback was emailed by N Raihania on 17 March 2016:

Possibility for every person entering Te Matatini to pass under or through a health station in the form of a tunnel or gateway to Kahungunu vitality? This station could showcase Māori health in a positive light and describe what it means to be healthy in Kahungunu. This thinking is about capitalising on a readymade audience.

9. MRB DRAFT WORKPLAN 2016-17

The workplans are draft therefore subject to change. The following discussions took place:

- The workplans demonstrate how heavy the agendas are. Especially the month of April, therefore MRB request a special meeting for this month.
- N Raihania stated MRB should increase to 11 meetings per year including strategic meetings. Leadership Forums should be optional. He said we should develop principles like looking at health for the population, and morbidity rates to build into the plan going forward and what each paper and presentation is doing to reduce inequity.
- Tracee Te Huia (GM Māori Health) explained the importance of the Leadership Forum meetings and for MRB to attend, as the vision to reduce inequity are developed at these meetings. This was agreed.
- N Raihania stated, for the next MRB, the first session should focus on roles and responsibilities followed by the setting of MRB principles.

- Reset as an MRB with NKII to develop MRB values, high level principles and objectives. Continue with what we are currently doing and hold another strategic planning hui. Perhaps including this discussion at the meeting with NKII.

The following feedback was received from N Raihainia via email 17 March 2016:

See more strategy meetings in the workplan. MRB needs the opportunity to establish its major strategy in terms of the bigger issues and then get the various teams to work on an Annual Plan or Statement of Intent that better reflects what MRB sees as the overarching issues. If MRB could establish a set of defined principles and specific outcomes then this would be what we would see as pertinent in any papers coming to MRB. N Raihania recommended the following:

1. MRB meet 11 times year in accordance with the cabinet fees framework
2. The health sector leadership meetings are not part of the 11 meetings
3. MRB meet specifically to identify its strategy in regard principles and outcomes for the year.

The Acting Chair, Heather Skipworth requested that any further feedback about the meetings be emailed to MRB Administrator **ACTION**

As a governance group, K Nuku was embarrassed at the quality of information MRB is provided. An equity lens needs to be applied to the reports because the reports we receive do not tell us how inequity is being addressed. It would also be helpful to get the structure to our presenters so presentations are more focused to stop us from going around in circles. Māori Health will set the principles of equity and develop a format for presentations of information coming to MRB.

SECTION 2: PRESENTATIONS

10. TE MATATINI – NGĀTI KAHUNGUNU 2017 PRESENTATION

With the meeting date change, presenters Te Rangi Huata and Ruth Wong were not available today. Therefore, the presentation has been rescheduled to April or March pending on the number of agenda items.

11. OBESITY PREVENTION STRATEGY

RECOMMENDATION

That MRB:

Discuss and make recommendations for the implementation of the Obesity Prevention Strategy (the Strategy), including processes for ongoing engagement for these communities.

Shari Tidswell (Team Leader/ Population Health Advisor) was in attendance to present the Obesity Prevention Strategy.

The following discussions occurred and MRB provided the following feedback about the implementation of the strategy including processes for ongoing engagement for these communities:

- Children don't have a voice so we need to target the youth to provide better understanding of foods and how certain foods impact on health and wellbeing. The strategy is a starting point but there is a need to have teenage youth involved whom are our future parents and leaders.
- Engage with the Māori Women's Welfare League.
- Investigate the cultural aspect because part of 'Manaaki' (a Māori custom) is to give and on the marae this is to provide a nice Kai (food). In the past Kai has mostly been bad. However, there has been a big shift in marae where fat is being removed and there has been an increase in salads. There is also another side to 'Manaaki' which is the removal of 'Tapu' which needs to be taken into consideration. It is up to the leaders of each marae to educate their people.
- Providing information about the effects of fatty fried food is vital.
- Obesity is an international priority but there is no reference to the severity locally which would have been useful to see the local information. Along with what is the geographical spread and are we improving or not. This could provide a more targeted approach and strategic alignment. It would also be valuable to see where we align with other DHB initiatives, what they are doing and how we measure. Also, identify what are the risks and unintended consequences.
- This is not just a DHB issue and needs a community wide approach. NKII should be included.

- The issue is that sugary and takeaway foods are more affordable. So obesity ties into the living wage discussion. Because of the addictive nature of obesity a lot can be learnt from the Smokefree Strategy.

SECTION 3: STRATEGIC/ SERVICE DEVELOPMENT

12. DRAFT ANNUAL PLAN AND STATEMENT OF INTENT

RECOMMENDATION

That MRB note:

The process, timeline and DRAFT contents for the HBDHB Annual Plan 2016/17 and provide any feedback to Carina Burgess.

Nicky Skerman (Population Health Strategist Woman, Child and Youth) joined the meeting at 10.45am.

Carina Burgess (Head of Planning) was in attendance to present the Draft Annual Plan, Statement of Intent and Māori Health Plan. Carina highlighted the Statement of Intent is included in the Annual Plan and there aren't any major changes. The draft is due 31 March 2016 to the Ministry of Health. In relation to the priorities, the biggest difference is improving Oral Health.

Patrick LeGeyt (Programme Manager Māori Health HBDHB) spoke about the Local Priorities and highlighted the following:

- The Ministry of Health recommend no more than three priorities. We have four priorities with two carried over from the last set of priorities. Obesity is not only a local indicator but is now a national indicator. Alcohol and Other Drugs (AOD) now have some measures.
- There is work needed with the data to ensure it is broken down by ethnicity.
- Access to Services at the 3-week and 8-week target haven't been doing well as a DHB therefore the Ministry of Health have requested to see some improvement.
- Services will be expected to do a Quality Project to review what we are doing and the referral processes. To be included into the plan.
- The Whānau Ora Forum developed five indicators for inclusion into this year's plan.
- Carries Free is a better measure for Oral Health rather than enrolment which is more relevant to measure the Access indicator.

Katie Kennedy (Portfolio Advisor Women, Child and Youth) joined the meeting at 10.47am.

MRB noted the process, timeline and draft contents of the HBDHB Annual Plan 2016/17 and provided the following feedback:

- Need to be cautious of the wording being used and the message communicated. The perception received today was that the DHBs primary aim is to achieve targets and not to reduce inequity.
- In terms of Whānau Ora and the impacts on children, where does this appear in the Annual Plan? It is easy to monitor and report how many women have had a smear but how do we capture and measure the social impacts? There is no strategic alignment with the Annual Plan priorities.
- Because of the social impacts of poverty such as obesity etc. add 100% staff on the living wage to the Māori Workforce indicator.

13. YOUTH HEALTH STRATEGY 2016-19 CONSULTATION

RECOMMENDATION

That MRB:

Discuss and make recommendations in the development and writing of the Youth Health Strategy.

Nicky Skerman (Population Health Strategist Woman, Child and Youth) was in attendance to present the Strategy.

MRB provided the following feedback regarding the development and writing of the Youth Health Strategy:

- Integrate the Suicide Strategy and what it means for youth to be healthy.

- In reference to the coloured hand-out of the slide 'Our Young People – Youth Consultation March 2016', the language of the young people demonstrates who they are. So their exact words should be used and not be changed.
- Most Iwi have their own youth plans and this should be taken into consideration. Best way to connect with these groups is to link with NKII. There are over 100 whānau on the 'Whānau Wellness Programme' that could be engaged.
- Set-up a governance group across the sector and including youth, and then expand. Services will be focused on healthy young people and to be driven by the governance group so that it aligns with the Obesity Strategy for a more targeted approach. The approach is key and will result in a positive outcome. Involve Māori Health Services and the findings of the DNA Project
- Looking at the 'Our Young People – Youth Consultation March 2016' diagram, Healthy Young Person is 'Mauri Ora', Healthy Whānau is 'Whānau Ora', Healthy Community is 'Waiora'.

14. DAVANTI INFORMATION SYSTEM REVIEW PRESENTATION

Lisa Ternent (Senior HR Advisor) joined the meeting at 11.40pm.

Tim Evans (GM Planning, Informatics and Finance) was in attendance to present the Davanti IS Review. The following matters were discussed:

- We do not benchmark with the other DHBs.
- Clinicians are involved at a governance level. Clinicians and patients are the main focus as they are the high users. We are heading towards patients accessing their own health information.
- Today's presentation was more about how departments function not about the Information System. To ensure better access and accurate data entry, and integrating the entire system.
- If we get this right, we can move to the Canterbury DHB system where providers have approved access to their system.

Largely, the MRB were supportive of the proposal management action in response to the Davanti Report on the grounds that this system will impact on the reduction of inequity and be part of this process. MRB requested the DHB consider future information systems for the Māori Providers and how they connect to the health system. Also, that the composition of the governance group comprise of a clinician who is a nurse off the floor because of his/her connection with working on the frontline; plus a member of the Māori Health team. Tim Evans (GM Planning, Informatics and Finance) will return to discuss setting up the governance group with MRB.

SECTION 4: FOR INFORMATION ONLY

15. ANNUAL MĀORI HEALTH PLAN QUARTER 2 DASHBOARD

The Quarter 2 Dashboard was taken as read. There was no further feedback received.

16. TE ARA WHAKAWAIORA: BREASTFEEDING REPORT

The Te Ara Whakawaiora: Breastfeeding Report was taken as read. There was no further feedback received other than to say this programme is vital to ensuring we monitor poor performance of the AMHP indicators.

SECTION 5: GENERAL BUSINESS

The following items were discussed for general business:

Health Impact Assessment Example

MRB received an HIA example via email 3 March 2016 for their perusal from Dr Fiona Cram.

Whānau Ora Notes from the March Workshop

The notes from the workshop were emailed to MRB 16 March 2016.

Resignation from Alliance Team

N Raihania's resignation was received via email 18 March 2016 that included his recommendations as follows:

1. That MRB accept the resignation of Na Raihania as the MRB representative on the Alliance Team
2. That the GM Māori Health (or designate) become the MRB representative on the Alliance Team.

3. That the Alliance Secretary (Ken Foote) be notified of the replacement.

MRB were in full support of the resignation by N Raihania. A formal acceptance of resignation email or letter will be required. **ACTION**

Co-Design Workshop being held on 29 April 2016

Invitation to MRB by Kate Coley to attend a workshop with Ko Awatea. Co-design is a way of working at a service level to bring the recipients of the service and the service together to work effectively, enabling culture of consumer engagement and interrelated projects. MRB representation to this workshop would be beneficial to the organisation.

Opening of new Birthing Unit 'Waioha'

Matiu Eru (Pouahurea Māori Health HBDHB) invited MRB to the opening scheduled at 6.00am on 4 April 2016.

As there were no further items for General Business the Chair closed the meeting and moved into Public Excluded.

Signed: _____

Acting Chair

Date: _____

MĀORI RELATIONSHIP BOARD
Matters Arising – Review of Actions

March Board Meeting

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at April 2016
17/03/16	**1. Update Interest Register** Inform Board Administrator that A Apatu role as Chair of Directions has dropped off.	MRB Admin	Apr 2016	**Complete**
	2. MRB Meetings Any further feedback about the meetings be emailed to MRB Administrator.	MRB Members	Apr 2016	**Complete** No further feedback received.
	3. Resignation from Alliance Team A formal acceptance of resignation email or letter is required.	MRB Acting Chair	Apr 2016	
	4. Māori Health Service Change of Proposal Send out the Change Proposal to MRB for their consideration once the document is made public.	MRB Admin	Apr 2016	**Complete** Emailed to MRB 31/04/16

December Special Board Meeting

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at April 2016
11/12/15	**1. Obesity and Alcohol & Drugs Strategy** Population Health, Consumer Council and MRB asked that the plan be further developed so that it is an effective strategy.	DPH/ HE		Best Start Healthy Eating Plan on the agenda for endorsement by MRB today.

November Board Meeting & Workshop with Māori Providers Meeting

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at April 2016
11/11/15	**1. Quality Accounts Communication Plan** Circulate Communication Plan of how to share the Quality Accounts with the community to MRB through MRB Adminstrator.	QIPS	Dec 2015	**Complete** Update was included in the GM Māori Health Report in March 2016. Next publication of Quality Accounts due in September 2016.

MĀORI RELATIONSHIP BOARD
DRAFT WORK PLAN 2016

as at 5 May 2016

NOTE: This is a living document that is continually edited, therefore is subject to change.

Meeting Dates 2016	Papers and Topics	Lead(s)
12 May	Investment/ Disinvestment Prioritisation Best Start Healthy Eating Plan FINAL Health Equity Update Youth Health Strategy 2016-19 DRAFT Endoscopy Service Transition/ Unit Development Update Travel Plan Quarterly Update VERBAL PRESENTATION Customer Focussed Booking Te Ara Whakawaiora Priorities and Reporting Schedule 2016-2017 **Monitoring – for information - no presenters:** Annual Māori Health Plan Q3 Jan-Mar 2016 Te Ara Whakawaiora: Cardiovascular	Tim Evans Caroline McElnay Caroline McElnay Caroline McElnay Sharon Mason Sharon Mason Sharon Mason Patrick LeGeyt
17 May	**HB Health Sector Leadership Meeting** – 8.30-3pm Waipatu Marae, Karamu Road North, Hastings	
8 Jun	Orthopedic Review closure of Phase 1 Health Equity Update Youth Health Strategy 2016-19 FINAL Suicide Prevention Plan Update Health and Social Care Networks Update Food Services Internal Review FINAL Integrated Shared Patient Care Record IS Review Update Annual Plan and Statement of Intent FINAL Active Whānau Programme Free Primary Care for 13 – 18 year olds Wairoa Health Needs Assessment Report **Monitoring – for information - no presenters:** Te Ara Whakawaiora: *Oral Health* (national and local indicator)	Andrew Phillips Caroline McElnay Caroline McElnay Caroline McElnay Liz Stockley Sharon Mason Tim Evans Tim Evans Tim Evans Patrick LeGeyt Patrick LeGeyt Patrick LeGeyt
13 July	Alcohol DISCUSSION Transform and Sustain Refresh Developing a Person Whānau Centered Culture DRAFT HB Integrated Palliative Care DRAFT DISCUSSION Programme Incubator 3-Monthly Student Uptake July Report WORKSHOP with Māori Providers	Caroline McElnay Tim Evans Kate Coley Tim Evans John McKeefry
10 Aug	Quality Accounts DRAFT Travel Plan update - verbal **Monitoring – for information - no presenters:** Annual Māori Health Plan Q4 Apr-Jun 2016 Te Ara Whakawaiora: *Culturally Competent Workforce* (local indicator) **tbc** Te Ara Whakawaiora: *Diabetes* (national indicator) **tbc**	Kate Coley Sharon Mason
7 Sept	**HB Health Sector Leadership Meeting** – venue and time TBA	

14 Sept	Orthopedic Review Phase 2 DRAFT Family Violence Strategy Effectiveness FOR NOTING Alcohol DRAFT Developing a Person Whānau Centered Culture FINAL Quality Accounts FINAL Health and Social Care Networks Update IS Review/Restructure Update Quarterly Update **Monitoring – for information - no presenters:** Te Ara Whakawaiora: *Obesity* (local indicator) **tbc**	Andrew Phillips Caroline McElnay Caroline McElnay Kate Coley Kate Coley Liz Stockley Tim Evans
12 Oct	Alcohol DRAFT Programme Incubator 3-Monthly Student Uptake Oct Report	Caroline McElnay John McKeefry
9 Nov	Tobacco - Annual Update FOR NOTING Travel Plan Quarterly Update VERBAL PRESENTATION **Monitoring – for information - no presenters:** Annual Māori Health Plan Q1 Jul-Sept 2016 Te Ara Whakawaiora: *Smoking* (national indicator) Te Ara Whakawaiora: *Cancer Screening Services* (national indicator) **tbc** **WORKSHOP** with Māori Providers	Caroline McElnay Sharon Mason
DEC	**No Meeting in December** The following papers will be emailed to MRB: HBDHB Workforce Plan – DISCUSSION DOCUMENT Health and Social Care Networks Update IS Review/Restructure Update Quarterly Update	 John McKeefry Liz Stockley Tim Evans

HAWKE'S BAY District Health Board Whakawāteatia	**Chair's Report**
	For the attention of: **Māori Relationship Board**
Document Owner:	Ngahiwi Tomoana, Chairman
Month:	May 2016
Consideration:	For Information

Recommendation

That MRB

Note the content of this report.

PURPOSE

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

INTRODUCTION

For this month I provide an update on the Board's response to my report about the MRB Special Meeting in April and Clinical Council's decision regarding MRB representation. This month's report also provides a brief overview of the feedback from Consumer and Clinical Council's about the Best Start Healthy Eating draft strategy, and the CEO's report on our performance for February and March. In addition, I provide a very brief outline on the Values and Behaviours presentation and the government's intention regarding Fluoridation. Key dates for the District Health Board (DHB) Elections has also been included in this month's report.

MRB Chair's Report – MRB Special Meeting

The Board acknowledged the action points from the report and agreed that better communications were a priority throughout the DHB, especially the positives. The Board supported the application of the HEAT tool to presentations and papers. Furthermore, the Board supported the use of the Customer Story as a catalyst for change, and was seen as a tool to identify unconscious bias against whānau by whānau stories being told and responded to.

MRB Representation on Clinical Council

Clinical Council approved MRB representation on their Board as an observer, the same capacity as the Chair Consumer Council. That is committee participation exclusive of voting rights.

Best Start Healthy Eating (Draft)

Clinical Council endorsed the direction of the strategy. Feedback included programme design inclusive of the community; improving 'food literacy' and providing education for health provider's up-skilling those providers to give better advice, as well as aligning strategies with the World Health Organisation (WHO) recommendations and six domains. Clinical Council also queried the name of the strategy asking should the name be 'Healthy Lifestyle'.

Consumer Council's view of the strategy was the strategy has good community engagement in the design, however the challenge will be to ensure the actions are owned in the community.

Performance Indicators

Shorter Stays in the Emergency Department (ED) improved in February with further improvement seen in March. There has been steady progress with Quarter 3 reaching 94 percent, up from both Quarter 2 of 93 percent and Quarter 1 of 92 percent. In the first two weeks of April there was an increase to 95 percent.

In February, too many patients were waiting longer than they should for elective surgery. But as anticipated for March, targets for waiting times were achieved with activity remaining above plan. In particular, individual specialities were closer to plan than previous years. Also, there has been significant improvement in the amount of orthopaedic elective surgeries in relation to major joints.

In February, Immunisation showed improvement as expected, and continued to improve in March. Immunisation is now above target.

There has been a decline in the last four months in Faster Cancer Treatment. The Medical and Surgical Directorate Leadership teams are focusing on key areas to improve performance. Such as, ensuring Consultants priories referral, identifying patients with a high suspicion of cancer and the need to be seen within two weeks; exploring options to bring the diagnostics services in-house instead of the current situation where an external contract providing the service; and resolving problems with accessing CT and reporting turnaround periods.

The financial result for February was favourable and with only four months of the financial year to go the CEO feels we are in a strong position. However, the focus on developing a sustainable position for next year remains constant. We are one of only six who are meeting financial targets plus delivering the largest surplus as a percentage of budget.

Values and Behaviours

John McKeefry (GM Human Resources) provided a presentation to the Board describing each Value and the methodology to fully embed our Values. Basically, we have to 'walk the talk' from front line staff to EMT, Board and across the sector in every engagement with consumers and between staff.

HBDHB Board Elections 2016

Triennial elections are coming up later this year for local government including the DHB. Key dates relating to the elections include:

13 July	First Public Notice of Election
15 July	Nominations Open / Roll Open for Inspection
12 August	Nominations Close / Electoral Roll Closes
19 August	Public Notice of Candidates
16 September	Delivery of Voting Documents
8 October	Election Day / Voting Closes at Noon
13 October	Official Result Declaration
5 December	New Board comes into office

The Board were asked to consider and decide on a number of pre-election issues and resolutions.

Draft Central Region Regional Service Plan 2016-17

The draft Regional Service Plan was presented to the Board in March for comment prior to submissions to the Ministry of Health by the end of March. Co-design principles across regional work was a strong focus of the draft plan. In 2016-17, the attention across the region would be on improving health outcomes and reducing disparities for Māori. As well as working on the implementation of the five themes within the NZ Health Strategy through integration, regional collaboration and reducing silos.

Fluoridation

The Ministry of Health recently announced the government's intention to ask DHBs to be responsible for the decision around fluoridation.

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

10

Recommendation

That the Māori Relationship Board:

Note the content of this report.

PURPOSE

The purpose of this report is to update the Māori Relationship Board on implementation progress of the Māori Annual Plan objectives for March 2016.

INTRODUCTION

This month's report provides an update on the following topics:

- Appointment of new DNA Kaitakawaenga
- Heat Tool Equity Workshop
- Health Workforce New Zealand (HWNZ) Hauora Māori Scholarships Update 2015–16 by District Health Board (DHB)
- Programme Incubator Quarterly Report for March 2016
- Cultural Training Report as at 31 March 2016
- Nuka Training in Hawke's Bay
- Well Child Tamariki Ora (WCTO) Project
- Annual Māori Health Plan Quarter 3 Peformance Highlights

Appointment of New DNA Kaitakawaenga

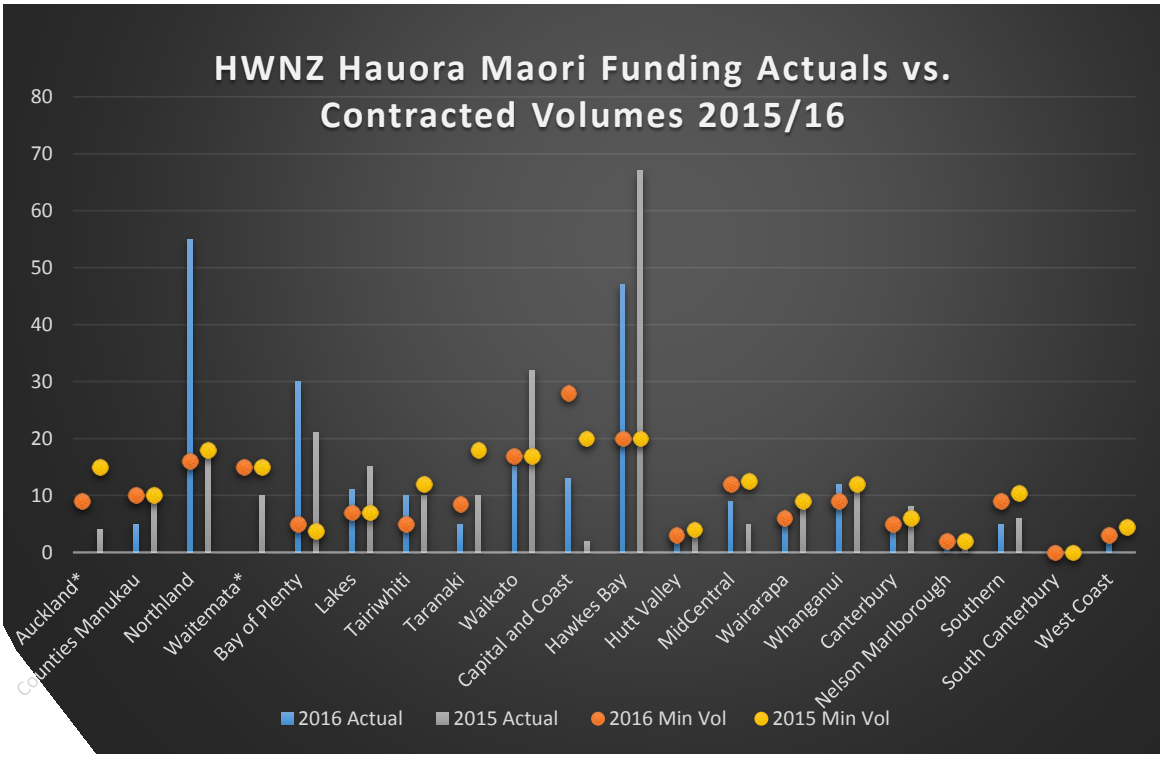
Twenty five applicants applied for the DNA Kaitakawaenga role. I would like to announce the appointment of Speedy White who joined the team 2 May 2016. Speedy was the former team leader of the Youth Services at the Taiwhenua o Heretaunga. Speedy is fluent in te reo, has strong connections with whānau of Kahungunu and is skilled in training and management.

HEAT Tool Equity Workshop

On 14 March 2016, the Māori Health Service (MHS) funded an Equity Assessment Tool Workshop with Dr Fiona Cram that was attended by Strategic Services Portfolio Managers; Population Health; Planning, Finance and Contracts staff. A follow-up workshop was held with the MHS, Strategic Services and Population Health Team leaders to complete a HEAT Tool assessment. Further development is required to bed down the HEAT Tool assessment into planning and procurement process for the Funding Management Group (FMG). A process for formalising the HEAT Tool in our operations across both funder and provider service of DHB is underway, led by Dr Caroline McElnay. Once completed the process will be taken through the Executive Management Team (EMT) to MRB for sign-off due in June.

HWNZ Hauora Māori Scholarships Update 2015–16 by DHB

The graph below shows the number of students from each DHB that were funded through HWNZ Hauora Māori scholarships for 2015 and 2016. The circles represent the minimum contracted volumes for each DHB for that year. Hawke's Bay (HB) consistently performs at a high level and have provided learnings to present other DHBs to support better use of the fund.



Programme Incubator Quarterly Report for March 2016

The table below demonstrates the number of student registrations received for Programme Incubator up to March for the 2016 school year. Human Resources is still waiting for information from some schools. The schools with low percentages, such as Havelock North High School and St Johns College have been engaged with so that we can better understand the reason for low percentage of Māori engaged in the programme.

School	Students registered	Māori Students registered	% Māori registered
Flaxmere College	4	4	100%
Hastings Boys High School	7	2	29%
Hastings Girls High School	25	13	52%
Havelock North High School	25	2	8%
Hukarere Girls College	5	5	100%
Karamu High School	48	15	31%
Lindisfarne College	11	2	18%
Napier Girls High School	27	5	19%
Sacred Heart College	21	4	19%
St Johns College	13	1	8%
Taradale High School	26	5	19%
Wairoa College	14	11	79%
Woodford House	14	4	29%
TOTAL TO DATE (04/04/16)	**241**	**73**	**31%**

Cultural Training Report as at 31 March 2016

Below are the figures of staff who have completed Treaty of Waitangi online and Engaging Effectively with Māori training as of the 31 March 2016.

DHB:

	Total Employees	Engaging effectively with Maori	Treaty of Waitangi
Frequency		**3 yearly**	**Once**
CEO Office	4	75.0%	0.0%
Chief Nursing Officer	13	76.9%	30.8%
CMO Hospital	1	100.0%	0.0%
Company Secretary	9	66.7%	33.3%
Health Services	2620	51.1%	38.7%
Human Resources	30	70.0%	80.0%
Maori Health	21	100.0%	85.7%
Planning Informatics & Finance	138	62.3%	69.6%
Population Health	54	94.4%	61.1%
Primary Care	1	0.0%	0.0%
Quality Improvement & Patient Safety	16	87.5%	81.3%
DHB Total	**2907**	**53.4%**	**41.5%**

Health Services:

	Total Employees	Engaging effectively with Maori	Treaty of Waitangi
Frequency		**3 yearly**	**Once**
Acute & Medical Services	824	43.1%	34.8%
COO Office	4	25.0%	50.0%
Director of Allied Health	1	100.0%	0.0%
Facilities & Operational Support	346	50.9%	30.9%
Health Service	1	100.0%	0.0%
Laboratory	78	15.4%	11.5%
Older Persons & Mental Health	402	62.2%	46.8%
Oral Rural & Community	303	71.6%	63.7%
Surgical	421	38.7%	30.6%
Women Children & Youth	240	68.3%	41.7%
Health Services Total	**2620**	**51.1%**	**38.7%**

Managers are working with their teams to ensure staff are enrolled onto the courses before the end of June which is when the current contract expires. Endorsement of the programme content and facilitation has been provided by senior doctors of this organisation who recently attended. These are:

Dr Richard Luke – “Even the most cynical among us found the course useful and informative. Great definition of cultural sensitivity and extremely articulate facilitator”.

Dr Malcolm Arnold – “I agree. It was informative and fun! Do it!!”

Dr Phil Moore – “I have done this course. I found it a refreshing change from “similar” courses in the past with an excellent facilitator. I came away with some new insights and made some positive changes to my practice. It is well worthwhile”.

Dr John Gommans - “Cultural competence and genuine partnership with Māori are important aspects of achieving excellence in medical practice and the Medical Council requires us to demonstrate our commitment to this as part of obtaining and maintaining our APC”.

Dr Tim Frendin – "I am very happy to promote the "Engaging with Māori" as a very productive and worthwhile exercise!"

Dr Russell Wills – "Hone did a terrific job. He did come up against some resistance, which revealed some disturbing, pejorative attitudes towards Māori. Hone handled them well and effectively challenged some thinking".

Nuka Training in Hawke's Bay

Last year I reported back on my visit to Alaska looking at native services in health. One of the organisations we visited was South Central Foundation (SCF), an Alaskan Native Health System that manages services for 229 federally recognised tribes with 55 villages and a population of 65,000 people across 107,413 square miles. Their operating budget is $290 million funded through Federal and State government, private foundations and third party billing. SCF runs a 150 bed hospital and a Primary Care Centre, known as an example of whole system transformation, is also part of the Alaska Native Medical Centre. SCF also owns and manages another large primary care centre, two federally designated community health centres, a community mental health centre and two residential substance abuse treatment centres. SCFs customer-owned, relationship based Nuka System of Care also offers pharmacy, outpatient behavioural health, dental and optometry services, home health nursing, specialised substance abuse treatment, youth and elder services and family wellness warrior initiatives. It has received many awards including the Malcolm Baldrige National Quality Award.

SCF will be coming to HB the 22 and 23 November 2016 to provide the Nuka Training. The training is in alignment with our Transform and Sustain programme and the development of Health and Social Care Networks in Primary Care. It will be open to 100 key people working within the HB health system. Registrations will open in August so watch out for it.

Key result areas for SCF:

- 93% customer owner satisfaction
- 94% employee satisfaction
- All staff know and understand the mission and vision statement of the organisation
- The hub of the system is the family
- Same day primary care access to services
- Hires using the values of the organisation as their measure
- Overall metrics are visual and accessible by all staff
- Moved to a one patient record across the health and social system

Well Child Tamariki Ora Project

The Ministry of Health (MOH) funded the HBDHB to complete a quality improvement project for WCTO. The aim of the project focused on:

1. Increasing WCTO enrolment
2. Reducing the differences in WCTO enrolment between population groups in the DHB region.

The MHS has contracted a consultant to carry out a brief investigation into the reasons for successful and unsuccessful early transfer from Lead Maternity Carer (LMC) to WCTO Providers.

The WCTO project was presented at The Hawke's Bay (HB) Midwifery meeting by MHS and the Women Children and Youth Strategist to introduce the project and answer any questions. The final project report, including interview findings; data analysis and recommendations will be completed by June 2016.

Annual Māori Health Plan Quarter 3 Performance Highlights

Achievements

1. HBDHB continues to have the highest percentage in New Zealand for Cervical Screening for 25-69 year old Māori women (73.2%) and the lowest disparity gap between Māori and European (4% gap).
2. Immunisation rates for 8 month old Māori increased from 93.3% in Quarter 2 to 97.7% in Quarter 3 to be above the target of ≥ 95%.
3. Immunised rates for Māori 4 year olds remains above the expected target of ≥ 90% with 93.25 immunised in Quarter 3.
4. Quick Access to Angiograms for Māori exceeded the expected target of ≥70% with 80% in Quarter 3 up from 60% in Quarter 2.
5. The number of Māori enrolled in the Health Hawke's Bay PHO has reached the 97% target up from 96.75 in Quarter 2 to 97.8% in Quarter 3.

Areas of progress

1. Pre-school Oral Health Enrolments for Māori under 5 years of age increased from 65.3% in Quarter 2 to 74.1% in Quarter 3. There is still some work to do to reach the expected target of ≥90%.
2. Cultural Training for HBDHB staff has increased from 66% in Quarter 2 to 70.6% in Quarter 3. Medical staff increased 19% in Quarter 2 to 32.4% in Quarter 3.

Challenges

1. Māori under Mental Health Act Compulsory Treatment Orders has risen 16.7 from 196 per 100,000 population in Quarter 2 to 212.7 in Quarter 3. There remains a widening inequality between Māori and non-Māori of 113.1 per 100,000 population.
2. Immunisation rates for Māori under 2 year olds dropped slightly below the targets of ≥ 95% with 94.81% of all Māori 2 year olds immunized in Quarter 3.
3. Heart and Diabetes Checks remained relatively unchanged from 86.3% in Quarter 2 to 86% in Quarter 3 just under the expected target of ≥90%.
4. Breast Screening has remained unchanged from 68.4% in Quarter 2 to remain on 68.4% in Quarter 3.
5. Māori Workforce remained relatively static in Quarter 3 at 12.4%, an improvement of only 0.1% from Quarter 3, and is below the expected target of 14.3%.

GENERAL MANAGER MĀORI HEALTH
Tracee Te Huia

HAWKE'S BAY
District Health Board
Whakawāteatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

11

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

12. Minutes of Meeting 17 March 2016
- public excluded

13. Prioritisation
- public excluded

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).

HAWKE'S BAY District Health Board Whakawāteatia	**Best Start: Healthy Eating and Activity**
	For the attention of: **Maori Relationship Board (MRB), Clinical and Consumer Council**
Document Owner: Document Author(s):	Dr Caroline McElnay, Director Population Health Shari Tidswell, Team Leader/Health Promotion Advisor Kim Williams and Tracy Ashworth, Population Health Advisors
Reviewed by:	Executive Management Team
Month:	May 2016
Consideration:	For endorsement

14

RECOMMENDATION

That MRB and Consumer & Clinical Councils:

1. Note responses to committee feedback and requests.
2. Review and provide feedback on the Plan.
3. Endorse the Plan to go to the Board for final endorsement in May.

OVERVIEW

This Plan responds to the HBDHB's request for further detail on how we address childhood obesity and reduce inequities. A draft plan was presented to HB Clinical Council, HB Health Consumer Council and the Māori Relationship Board. Feedback has been incorporated into this Plan which will be presented to the Board for approval in May 2016.

BACKGROUND

The benefit of healthy eating and activity are far reaching including; positively impacting on oral health, mental health and injury prevention. It can also reduce risk of cancers and other disease later in life.

Currently, a third of our population are obese, with higher rates for Māori (48%) and Pacific (64%) populations. Obesity is the second highest risk to health for people in the Hawke's Bay. Rates have been increasing. Obesity leads to a range of disease including; heart disease, diabetes and cancer and these incur high, medium and long-term costs to individuals, whānau, communities, the health sector and wider social services.

Increasing rates of obesity are contributed to our lifestyle - we are consuming more calorie rich nutrient poor food which is easily available and cheap. The cause is simple, the solution is complex. Culture, economics, access, knowledge, family structure, working patterns, government policy and genetics all have a part to play in the choices we make in what and the amount we eat. We need strong leadership, community engagement and to support whānau with lifestyle changes to reverse the obesity trend.

What does the evidence show as effective?

A focus on early years gives the greatest opportunity to achieve healthy weights across the lifespan.

- Healthy weight gain for pregnant women – this supports healthy birth weights for babies
- Healthy first foods - early behaviours are influential on our long-term health, children who are breastfed maintain healthy weight over their lifetime. Toddlers who eat healthy develop healthy eating habits over their lifetime
- School based programmes which support healthy eating and activity - children who are physically active and eat a healthy diet continue to be active and less likely to be obese
- Children influence the whānau and community – e.g. the results of Waikato's Project Energise
- Environments which support healthy eating choices and activity – settings (schools, churches) where the healthy choice is easy are effective in changing behaviours

Early intervention needs to include, changing the 'obesogenic environment' to a healthy eating one through; leadership, role modelling, consistent messaging, supporting healthy eating settings i.e. schools, workplaces and events, and retailers, and making healthy choices easy. An equity approach targeting Pasifika, Māori and high deprivation communities will provide the greatest gains.

What did the stakeholder and community input say?

The input from these groups and people reinforced the evidence, with following themes. Focus needs to be wider than the individual and include whānau and the environmental influences. Equity issues need to be addressed. Community and whānau engagement in programme design and delivery is critical in achieving sustainable outcomes. Build on existing effective initiatives to gain the benefit of existing skill and community linkages. Finally, prevention and intervention activities need to be part of healthy lifestyle changes which support whānau to achieve their health goals and uses a whole of community approach.

HOW HAVE WE RESPONDED TO COMMITTEE FEEDBACK?

The HBDHB committees represent a diverse range of interests and have provided a wealth of insight and feedback in the development of this Plan. Below is a summary of feedback requesting changes and responses from the Plan writers.

Committee/s	Feedback	Response	Page reference
EMT	More detailed for activities	Added 'how' and 'when'	13-16
EMT	Include a sugar focus	Specified sugar reduction in Objective 1 & 2, stated the sugar focus in activities. Agree that a settings and whanau approach includes responding to the "sugar" evidence, so while not specifically stated sugar is part of food literacy, healthy eating policy, leading key messages and programme content.	Whole document
Clinical, EMT	Focus on physical activity	Clarified the need to address an identified gap for healthy eating.	3
Clinical, Consumer, EMT, MRB	Issues: engaging retailers, levels of food literacy, national programmes, impact of poverty	Leadership and flexibility are needed to respond to these. The Plan does allow for both.	Whole document
Clinical	WHO, Ending Childhood Obesity report, integration	Included the six recommendations and clarified the links to our local implementation. All six are covered in the Plan's activities.	5 & 6

Committee/s	Feedback	Response	Page reference
EMT, Clinical Consumer	Change the Plan title to reflect physical activity, acknowledge obesity	Community and MRB feedback was to not focus on obesity, in order to reflect a lifestyle approach. We have included "activity".	Cover
Consumer	Change image on cover page	Changed to children climbing.	Cover
Consumer	Coverage, limitations of the decile system, rural communities	The overarching value of addressing inequity will be applied to all activities.	3 & 12
Consumer	Clarifying the purpose of the Plan is delivering activities	Opening paragraph rewritten to state this.	3

We also note the endorsement of the focus on childhood, environmental approach, training for providers working with whānau (including health professionals), engagement with community in designing programmes, delivering via existing programmes/services, healthy lifestyle approach and HBDHB leadership. It was also noted that we need to be flexible enough to respond to a changing context (Health and Safety Act, new research and national programmes) and needs (rural communities and school decile system).

What are the planned objectives?

Objective	Description
1. Increase healthy eating environments, by increasing healthy eating choices and physical activity, and reducing sugar	Addressing the environment by increasing healthy food choices in settings that children engage with including; education, marae, events and communities. Advocating for changes in marketing, retail and councils. Also reducing access to sugar i.e. Water Only Schools, SSB Free Events and support whānua to make informed consumer choices.
2. Develop and deliver prevention programmes – via food literacy, maternal nutrition, sugar reduction, physical activity and implementing policy	Implementing programmes which support healthy eating and physical activity for pregnant women, support breastfeeding, encourage healthy first foods, support whānau with healthy lifestyle changes, reduce sugar intake and school programmes which reinforces healthy eating messages and engage whānau in existing programmes shown to prevent the health risks associated with weight gain by maintaining healthy weight.
3. Intervention – support people to have healthy weight	Screening programmes identifying weight issues early and address weight gain via education, increased food literacy and whānau programmes. Screening during pregnancy and under five confer the greatest benefits over a lifetime.
4. Provide leadership in healthy eating	A population-wide improvement in healthy eating requires a cross-sector approach - the HBDHB is ideally placed to provide leadership and support key stakeholders in promoting healthy food environments, prevention programmes and early intervention.

This Plan provides an evidenced-based approach to increasing healthy weights for children in Hawke's Bay and will be delivered with community partners in order to support whānau engagement. Finally, the HBDHB has a role in leadership and will need to advocate for changes nationally and locally to develop an environment which supports healthy lifestyle changes. The Plan is attached.

Best Start: Healthy Eating and Activity

A plan for improving healthy eating and active lives for children in Hawke's Bay

2016-2020

May 2016

Table of Contents

Executive Summary

Best Start: Healthy Eating Plan

The purpose of this Plan is to outline the Hawke's Bay District Health Board's activities which will achieve the goal - "improving healthy eating and active lives for Hawke's Bay children". It also summarises the sources which informed the Plan's development:

- reports, plans and strategies which inform the context for childhood obesity
- key evidence and input from key stakeholders, including communities

The activities fall into four objectives developed from the informing sources:

- Increasing healthy eating environments, by increasing healthy eating choices and physical activity opportunities and reduces sugar intake.
- Developing and delivering prevention programmes which include; food literacy, maternal nutrition, sugar reduction, implementing healthy policy and physical activity in early childhood and schools.
- Interventions which support children to have healthy weight.
- Providing leadership in Hawke's Bay for healthy eating.

These objectives have indicators which will help us measure progress toward our goal and this progress will be reported annually. The Plan is based on the principles of reducing inequity, engaging with whānau and Pasifika communities, health leadership and sustainable change.

How can we achieve healthy weight children in Hawke's Bay?

- Evidence supports a focus on early years to achieve the greatest opportunity for healthy weights across the lifespan
- Promoting healthy food environments, through leadership, role modelling, consistent messaging, supporting healthy eating settings i.e. workplaces and events, and working with retailers to make healthy choices the easy choice.
- We will make the greatest gains by having an equity approach targeting Pasifika, Māori and high deprivation communities.
- Stakeholder and community input noted that prevention and intervention activities need to be part of healthy lifestyle changes which support whānau to achieve their health goals and use a whole of community approach.
- We need a greater focus on healthy eating behaviour change while supporting existing physical activity initiatives. We noted a wide range of activity based programmes in Hawke's Bay and only a few healthy eating programmes, so the Plan's emphasis is on nutrition to address this gap.

This Plan outlines activities that will support whānau and communities to engage with programmes and interventions which support health weight.

What is the situation we aim to change?

Increase the number of health weight children

Over a third of our Hawke's Bay population is obese with higher rates for Māori (48%) and Pasifika (64%) populations. Obesity is the second leading risk to health in the Hawke's Bay. Rates have been increasing over the past decade.

Obesity leads to a range of diseases including heart disease, diabetes and cancer and these incur high medium- and long- term costs to individuals, whānau, communities, the health sector and wider social services. (Detailed data has been presented in the Equity Report[1]). We can change this trend by focusing on increasing the number of healthy weight children.

Create a healthy eating environment
Children are consuming more calorie rich, nutrient poor food which is easily available and cheap. While the cause may seem simple the systems we need to change to reduce obesity are complex: culture, economics, access, knowledge, family structure, working patterns, government policy and genetics all have a part to play in the choices we make in what and how much we eat and what we feed our children.

Make the healthy choice the easy choice
Unlike tobacco, where the message is simple, "don't start smoking or quit", food, exercise and healthy weight messages are dependent on a range of factors i.e. age, gender, type of activity. Therefore the key is to make changes to our wider community which means influencing our employers, retailers, food manufacturers, education sector, government departments, whānau and iwi, to provide environments which support healthy eating and activity in a daily lives.

What has been shown to work?

- Healthy weight gain in pregnancy supports healthy birth weights for babies.
- Introduction of appropriate 'first foods' develops healthy eating behaviours and supports life time healthy eating Healthy First Foods – breastfeeding supports healthy weights for both mother and baby. Toddlers who eat healthy food and appropriate portions develop healthy eating habits over their lifetime.
- School based programmes which support healthy eating and activity - school aged children who are physically active and eat a healthy diet continue to be active and maintain healthy weights.
- Children influencing the health behaviours of whānau and community - the best example in New Zealand are the outcomes of Waikato's Project Energise and safety belts usage.
- Making the healthy choice the easy choice is effective in changing behaviours. When children only have water to drink they drink water e.g. water only events and schools.
- Leveraging of the benefits of healthy eating and physical activity including positively impacting on oral health, mental health and injury prevention and reducing chronic diseases.

[1] HB DHB Equity Report. http://www.ourhealthhb.nz/assets/Strategy-Documents/13676-HealthEquity-Report-PRINTlr.pdf

Context

The greatest health benefit comes from prevention and early intervention so a focus on the childhood years provides the most re

International

The World Health Organisation's (WHO) "Ending Childhood Obesity Report (ECHO)[2]" calls for governments to take leadership and for all stakeholders to recognise their moral responsibility in acting on behalf of the child to reduce the risk of obesity by addressing the following comprehensive recommendations:

1. Promote the intake of healthy foods and reduce the intake of unhealthy foods and sugar-sweetened beverages by children and adolescents.
2. Promote physical activity and reduce sedentary behaviours in children and adolescents.
3. Preconception and pregnancy care to reduce the risk of childhood obesity.
4. Early childhood diet and physical activity guidance and support to develop healthy habits.
5. Promote health, nutrition and physical activity for school-age children by promoting healthy school environments.
6. Provide family-based lifestyle weight management services for children and adolescents.

National

Since the retraction of the Healthy Eating Healthy Action Strategy in 2009, there has been no overarching strategy for healthy weight available to support DHB planning. In 2015 the Ministry of Health released the "Childhood Obesity Plan[3]" which will be implemented at a local level via DHBs, schools, sports trusts and community organisations. The following six action areas align with the WHO ECHO report:

1. Increasing awareness and making healthy choices easier i.e. health star rating.
2. Supporting healthy weight gain in pregnancy and childhood.
3. Reducing the risk of progression to obesity in adulthood.
4. Slowing the progression of obesity related complications, such as diabetes and heart disease.
5. Maximizing the effectiveness and efficiency of obesity treatment.
6. Monitoring trends in obesity/complications and evaluating prevention intervention programmes.

Local

To support strategic coordination and alignment across these contexts, a Hawke's Bay Obesity Prevention Strategy (Appendix A) using a lifespan approach was adopted in 2015 and this Plan has been developed to respond to the childhood part of the lifespan approach. The Plan outlines the evidence, stakeholder and community views, alignment and framework used to achieve the goal of "improving healthy eating and activity for children in Hawke's Bay". It is supported by the following objectives which align closely with both the Ministry's Childhood Obesity Plan and the ECHO report's recommendations:

1. Increase healthy eating and physical activity environments.
2. Develop and deliver prevention programmes.
3. Intervention to support children to have healthy weight.
4. Provide leadership to enable healthy eating behavior.

Locally, we have organisations supporting healthy eating and active lifestyles. They include active transport plans which promote walking and cycling, and community-led healthy lifestyle programmes, such as, Iron Māori and Patu Aotearoa, and community gardens i.e. based in schools and marae.

[2] World Health Organization 2016 "Ending Childhood Obesity" http://www.who.int/end-childhood-obesity/en/

[3] Ministry of Health, New Zealand, "Childhood Obesity Plan" http://www.health.govt.nz/our-work/diseases-and-conditions/obesity/childhood-obesity-plan

The HBDHB supports a range of these initiatives via funding, resources and expertise. Healthy eating practices have also been implemented in workplaces such as; the HBDHB, schools with sugar free drinks policies and events promoting healthy food. These plans and activities help make the healthy choice easier, however Hawke's Bay rates of obesity are increasing. Further action is needed including; building on the effective programmes/activities currently delivered, extending the environmental influences, having a greater focus on nutrition, increasing the leadership supporting healthy eating and coordinating activity strategically.

Evidence

Obesity is an equity issue, with 25% of Pasifika and 19% of Māori children being obese at 4 years compared to 12% for other ethnicities, inequity starts early. (HB Data)

Current data

Obesity is the second leading risk factor affecting health in New Zealand (after tobacco-use). It is linked to a range of diseases with high health and non-health costs. One-third of New Zealand's population is obese compared to an average OECD obesity rate of 17%; in fact only three OECD countries rate higher (United States, Mexico and Hungary) and our closest neighbour Australia, has a 25% rate[4].

Obesity is unfairly distributed in New Zealand with rates for Māori children twice and Pasifika three times the total population rate, and children living in our most deprived areas are more likely to be obese than those living in our least deprived areas (one and a half times and three times respectively)[5]. This inequity profile is reflected in Hawke's Bay with 19% of Māori and 25% of Pasifika children aged 2–14 years obese compared to 12% for non-Māori[6]. B4 School Check data also shows total four year old obesity prevalence is 4.2%, while Māori rates are 6% and Pasifika nearly 14%, with 6% of four year olds living in quintile 5 areas obese compared to 1.8% for four year olds living in quintile 1 areas.

Obesity impacts

At a societal level there is also an impact for our health system, it has been estimated that medical costs attributed to excess weight and obesity in 2006, were NZ$686 million[7]. There are other costs including infrastructure costs required by organisations to adjust for obese clients and staff. The impact of obesity goes beyond poor health outcomes, reduced quality of life and reduced life expectancy. The New Zealand Institute of Economic Research report identified that obesity impacted on a wide range of areas including; lower wages, increased sick leave, lower school education achievement, poorer mental health and barriers to public infrastructure i.e. plane seat being too small[8]. These impacts affect whānau and the community economically and socially.

Addressing childhood obesity

Addressing childhood obesity is particularly important as overweight children are more likely to develop adult obesity that continues throughout their lifetime[9] because pre-conditions for obesity are set very early in life[10]. The familial influence is the biggest influence on dietary intake and level of physical activity for children, therefore any approach needs to be cognisant with whānau acceptance and involvement.

[4] OECD. (2013). "Overweight and obesity", in OECD Factbook 2013: Economic, Environmental and Social Statistics, OECD Publishing.

[5] Ministry of Health. (2015). *Tatau Kahukura: Maori Health Chart Book 2015*. (3rd edition). Wellington: Ministry of Health

[6] Ministry of Health. (2015). *Annual update of Key Results 2014/15: New Zealand Health Survey*. Wellington: Ministry of Health.

[7] La A, et al. (2012). Health care and lost productivity costs of overweight and obesity in New Zealand. Aut NZ J Public Health 2012;36(6):550-6.

[8] New Zealand of Economic Research, The Wider Economic and Social Cost of Obesity, January 2015

[9] Sundborn, G., Mwerriman, T.R., Thornley, S., Metcalf, P., Jackson, R. (2014). An 'End-Game' for sugar sweetened beverages? Pacific Health Dialog. Vol 20 (1).

[10] Morton, S.M.B., Maternal nutrition and fetal growth and development, in Developmental Origins of Health and Disease, P.D. Gluckman, Hanson, M.A., Editor. 2006, Cambridge University Press: Cambridge. P. 98-130.

Furthermore, education provides a logical setting for approaches to enable healthy eating and activity environments for children.

Children spend approximately a third of their waking hours during the school term in a structured school environment that has close links with whānau. Evidence shows that early intervention programmes delivered in this setting are particularly effective because behaviour change is reinforced across the wider school and home environment. The food environment has changed over time; access to fast foods and sugary drinks has increased, while the availability of fresh foods has decreased. Exposing children to food marketing on the journey to and from school, at school and during screen time impacts on whānau ability to make healthy food choices.

The food environment forms part of the largest and most significant impact on increases in obesity - the "obesogenic environment". This is the complex influences in the environment which influence our lifestyle and eating behavior. There is strong evidence to show that advertising high calorie low nutrition food to children increased consumption by children. Auckland University conducted a review of supermarkets in 2015 to assess their food content. 60% of food did not meet Ministry of Health Healthy Eating Guidelines[11] (low in sugar, salt and fat). If our main food source i.e. the supermarket, has mostly unhealthy food it is likely you will be eating unhealthy food.

Healthy public policy is one of society's most powerful mechanisms for environmental change. Parallels for obesity prevention efforts can be drawn to tobacco control. For example, limiting marketing on television, creating smokefree spaces and increasing taxes on tobacco products changed the environment, influenced people's decisions, and consequently smoking rates dropped. Sustained advocacy for similar interventions could provide the catalyst for change in the obesity epidemic[12].

There is evidence that brief interventions can support at least short-term improvements in behavioral change and body weight if they combine both physical activity and nutrition components, are delivered by appropriately trained practitioners, encourage self-monitoring, foster support networks, and are flexible enough to respond to individual circumstances[13].

The health sector needs to develop and deliver evidence based information and education campaigns to raise awareness of the health problems related to poor nutrition, overweight and obesity in a format that is appropriate for the groups and settings most vulnerable. This can only be achieved through appropriate and meaningful engagement with priority groups and settings to determine the current levels of health literacy and appropriate way to communicate key messages. Only a well–informed consumer is able to make rational decisions.

[11] Ministry of Health, "Healthy Eating Guidelines"
[12] http://www.hsph.harvard.edu/obesity-prevention-source/policy-and-environmental-change/
[13] Cavill N et al. Brief interventions for weight management. Oxford: National Obesity Observatory, 2011.

Stakeholder and Community Input

Engagement with community, whānau and settings children engage with is vital

To gain further local knowledge and engagement we sought input from stakeholders and community to help us understand the issues from their perspective and how they feel these issues can best be addressed. Overall this input aligned with the evidence and reinforced the need to continue to engage whānau in development and delivery, use consistent messages, build on existing effective programmes and support settings children engage in to provide healthy eating environments. We have noted that physical activity is supported in a wide range of ways including; schools, sports clubs, dance groups, community facilities and out of school programmes, but there needs to be more support for healthy eating. (Appendix B notes the source documents for the summaries below)

The **Maternal Nutrition programme** has ensured feedback and consultation occurs throughout development and delivery, providing an opportunity for participants to inform the programme's development. Key themes identified were:

- A supportive and trusting relationship between advisors (programme supports) and participants is a key facilitator of programme success. This relationship is about the needs and priorities of participants being listened to and embedded within a plan that will work for their lifestyle.
- Programme design needs to reflect a wellbeing approach by promoting a holistic view that is about participants investing in their own health and the things (food, exercise, etc.) that will benefit their wellbeing. This decentralises nutrition and exercise, and prioritises the women and their babies in a way that is well placed to ensure the sustainability of any changes women make.
- The majority of responses indicated significant flow-on effects to the whānau with respect to increased physical activity and healthy dietary changes.

Stocktake of healthy eating and activity initiatives offered to Hawke's Bay primary schools used consultation to provide an overview of healthy eating and activity initiatives offered and explored the views of stakeholders. Key themes identified were:

- Healthy eating and beverage policies must be better understood by their users and consistently implemented across settings.
- All food and beverages provided in schools must meet New Zealand Food Nutrition Guidelines.
- Access to sugary food and beverages and high fat, processed foods on the journey to/from school and within the environment undermines school healthy eating ethos.
- Food security is a contributing factor.
- Sustainable healthy eating behaviour change is transferrable across the wider school community and the home environment.
- Whānau should feel empowered to participate in programme development, activities and desired outcomes.
- A school-based physical activity programme that encourages whānau participation is needed for ***all*** children
- Programme components must have the capacity to be tailored to local needs.

Consumer Council input came from a workshop session with Council representatives in January 2016. This identified key enablers for change:

- Using belief structures, key groups/stakeholders including Government
- Strengthening connections
- Culturally appropriate modes

Initiatives, approaches and key messages identified:

- Wellbeing literacy, coordinated pathways
- Using points of influence i.e. pregnancy, parenting, education curriculum
- Promoting incidental exercise, hooks to engage
- Doing our best for our children, translate healthy into everyday life
- Work with whānau and make the healthy choice the easy choice

The overall view was to work at a range of levels from individuals to whānau, settings, communities and politically to create the greatest gains.

Māori Relationship Board Feedback

During 2015 support was given for the Strategy i.e." the strategy is a very comprehensive plan that exhibits a number of activities" and "supportive of the current strategy in term of its focus". There were further recommendations including; engaging whānau, HBDHB showing leadership, engaging with the community, speaking to the right people and work more closely with Māori. These have been picked up in the development of this Plan. Further feedback was sought to develop this Plan in March 2016 as noted below (meeting minutes March 2016).

- We need an equity lens on this strategy, how are we watching for any unintended consequences.
- The strategy is a starting point but there is a need to have teenage youth involved who are our future parents and leaders, nutrition advice to Māori homes and communities needs to be included.
- Investigate the cultural aspect of food because part of 'Manaaki' (a Māori custom) is to feed the people.
- It would have been useful to see the local information, the geographical spread and if we are improving or not. It would also be valuable to see where we align with other DHB initiatives, what they are doing and how do we measure against them.
- This is not just a DHB issue it is a community issue so we need to involve hapū and iwi.
- The issue is that sugary and takeaway foods are more affordable so obesity ties into the living wage discussion. Addiction ties into obesity.
- We need to stop siloing the issues that are bad; addiction, sexual health, oral health, obesity, smokefree, and suicide etc. It's about employing the whānau into good lifestyles. When we change the whānau environment we change the way they look at themselves and opt for good decisions as a by-product.

Overall the stakeholder and community input reinforced the evidence, with the following overarching themes:

- Focus needs to be wider than the individual and include whānau and the environmental influences.
- Equity issues need to be addressed.
- Community and whānau engagement in programme design and delivery is critical in achieving sustainable outcomes.
- Build on existing effective initiatives to gain the benefit of existing networks, skill and community linkages.

Alignment

Leadership is critical and all stakeholders needs to use their influence

Hawke's Bay DHB is well placed to lead healthy eating. To lead, we need to engage across a wide range of stakeholders including private sector, government bodies and community organisations to deliver the complex and multi-factorial solutions required for obesity reductions. Recognizing and acting on obesity is crucial – particularly in childhood so we can slow progression of a greater burden of disease.

To be responsive to whānau and our communities, healthy eating will be incorporated with wider healthy lifestyle programmes and be supported in an environment which makes the healthy choice the easy choice. The Plan works with providers who have existing whānau relationships, uses settings which influence wider community and whānau, and aligns with national resources, programmes and messages.

The Obesity Prevention Strategy (Appendix A) provides a lifespan approach to support coordination and alignment, for services, messages, initiatives and monitoring. The table below uses the Strategy's age groups and this Plan's key outcome areas to show where this coordination and alignment occurs for health services supporting child healthy weights.

Strategy Groups	Environment	Prevention	Intervention	Leadership
0-4 years	Advocacy to change marketing practices Policy support for ECEs-MoH Licensing Criteria	Resources to support breastfeeding, first foods – maternity services, Well Child/Tamariki Ora Early engagement with LMC and oral health services Messages- media community	Workforce development/screening tools/resources- midwives, Well Child/Tamariki Ora, and B4 School Check Clinical pathway- pediatric dietetic services	Breastfeeding Strategy National Obesity Plan Primary care- general practice and LMCs NCTD Well Child/Tamariki Ora health network Maori Health Plan TAW targets
5-12	Policy support for schools Advocacy-Health Promoting Schools programme	Consistent messaging –Health Promoting Schools, nutrition programmes, Fruit in School, PHNs, Water Only Schools	Supporting whānau based programmes- Sport HB, Iron Maori, community providers General practice Secondary services	MoE, principals, school boards National Obesity Plan
13-18	Policy support for schools- MoE	Food literacy workforce development- PHNs, teachers, community workers	School clinics General practice	HB Youth Health Strategy National Obesity Plan

Plan Framework

As outlined earlier, this Plan was informed by:

- Evidence, which clearly shows nutrition is the key in healthy weight, change needs to be lifestyle and must have a whānau and community approach and best outcomes are achieved when focusing on early intervention and early years.
- Stakeholder and consumer input supports the evidence with issues such as; food literacy, environmental and economic influences, whānau engagement and a cross-sector approach all being required to support lifestyle changes.
- Our local Strategy provides a structure to align the wide range of national and local activity needed for sustainable change.

Goal: Improving healthy eating and active lives for children in Hawke's Bay

Guiding Values

- Reducing health inequity in our Hawke's Bay communities, use an equity lens to review and deliver this Plan
- Improving Māori health outcomes
- Engaging the Pasifika communities
- Enable cross-sector leadership
- Approaches and activities support and engage whānau and communities
- A sustainable population health approach

As illustrated by the values, this Plan has a strong commitment to reducing the social and health inequities associated with poor nutrition and weight gain.

Objectives

Objective	Description
1. Increase healthy eating environments, by increasing healthy eating choices and physical activity, and reducing sugar	Addressing the environment by increasing healthy food choices in settings that children engage with including; education, marae, events and communities. Advocating for changes in marketing, retail and councils. Also reducing access to sugar i.e. Water Only Schools, SSB Free Events and support whānua to make informed consumer choices
2. Develop and deliver prevention programmes – via food literacy, maternal nutrition, sugar reduction, physical activity and policy	Implementing programmes which support healthy eating and physical activity for pregnant women, support breastfeeding, encourage healthy first foods, support whānau with healthy lifestyle changes, reduce sugar intake and school programmes which reinforces healthy eating messages and engage whānau in existing programmes shown to prevent the health risks associated with weight gain by maintaining healthy weight.
3. Intervention – support people to have healthy weight	Screening programmes identify weight issues early and address weight gain via education, increases food literacy and whānau programmes. Screening during pregnancy, and under five confer the greatest benefits over a lifetime.
4. Provide leadership in healthy eating	A population wide improvement in healthy eating requires a cross-sector approach, the HBDHB is ideally placed to provide leadership and support key stakeholders in promoting healthy food environments, prevention programmes and early intervention.

Objectives, Indicators and Actions

Objective 1: Increase healthy eating and activity environments

Indicator 1a: Increase the number of schools with healthy eating policies

Indicator 1b: Increase the number of settings including workplaces, churches and marae with healthy eating policy

What the data shows

There is limited data for the region, monitoring this objective will require the collection of baseline data for each indicator using the schools data in HealthScape and surveying other settings.

Activity to deliver objective one			
	What	**How**	**When**
Current activity	• Work with settings to increase healthy eating including education, schools, workplaces, events, Pasifika churches, marae • Support national messaging including sugar reduction i.e. Water Only • Advocate for changes in marketing and council planning	• Healthy eating policies which reduce sugar intake in 5 ECE centres, key community events increase healthy food choices, 4 Pasifika churches have a healthy eating approaches and guidelines for marae reviewed with Ngāti Kahungunu Iwi Incorporated • Communication plan implemented for national messages Submissions made • Supporting the implementation of programmes and plans i.e. i Way, Active Transport, Sport HB and Ngāti Kahungunu Iwi Incorporated plans	July 2017
New actions	• Support education settings to implement healthy eating and food literacy- early childhood, primary schools secondary schools, • Establishing a base measure for monitoring • Engage cross-sector groups to gain support and influence to increase healthy eating environments • Investigate food security for children and their whānau identifying issues	• 50% increase in schools with “water only” policy annually • Decile 9/10 communities have a whānau co-designed programme delivered in primary schools, - trialled 2016, 5 new schools annually • All schools surveyed for status in healthy eating/water only policies • Establish a group to influence changes in the environment across Hawke’s Bay • Partner with Auckland University to establish a baseline for the Hawke’s Bay food environment and monitor annually	Reported annually to 2020
Key partners	Ministry of Education, school boards, principals, school communities (including whānau), Ngāti Kahungunu Iwi Incorporated, employers, Councils, event organisers		

14.1

Objective 2: Develop and deliver prevention programmes

Indicator 2a: Rates of breastfeeding at 6 weeks increase

Indicator 2b: Number of healthy weight children at 4 years remain stable or improves

What the data shows

- Child fully or exclusively breastfeeding at 6 weeks rates as 68% for total population, 58% Māori and 74% Pasifka (December 2015 Ministry of Health)
- 76.5% of Hawke's Bay four year olds are healthy weight, 65.2% Māori and 66.9% Pasifika (2014 Before School Check data, Health Hawke's Bay)

Actions and Stakeholders			
	What	**How**	**When**
Current activity	• Implementing Maternal Nutrition Programme activities- breastfeeding support, healthy first foods • Supporting settings to implement healthy eating/sugar reduction programmes/policies • Supporting health promoting schools	• Breastfeeding support resources provided via Hauora • All Well Child/Tamariki Ora providers trained in Healthy First Foods • All schools, ECE, Well Child/Tamariki Ora Providers with health eating policies are provided with information resources and advice • Health Promoting Schools health promoters are up-skilled to implement healthy eating approaches	July 2017
Next actions	• Extend the Maternal Nutrition programme developing programmes in ECE and resources to support B4 School Check providers • Supporting healthy pregnancies, via education and activity opportunities • Support the development of whānau programme (building on existing successful programme) • Develop food literacy resources including sugar reduction messages -deliver via programme and settings • Support healthy eating programmes and approaches in schools	• Deliver training to LMCs, Well Child providers and B4 School Check nurses to increase skills to promote healthy eating- Healthy Conversation, Healthy First Foods, B4 School Check resources • Contract and support local provider/s to deliver the maternal healthy eating activity programme • Contract and support local provider/s to deliver whānau based programmes i.e. Active Families • Deliver key messages for whānau with 2–3 year olds • Develop food literacy resources for B4 School Check provider, promote Healthy First Food and heart foundation school resources • Support the co-designed programme for deprivation 9/10 communities	Reported annually until 2020
Key partners	Hauora providers, early childhood education providers, schools, principals, boards, Ministry of Education, workplaces, Ngāti Kahungunu Iwi Incorporated, Councils, LMCs, Maternity Services, Heart Foundation, Sport HB, Iron Maori, Patu Aotearoa		

Objective 3: Intervention to support children to have healthy weight

Indicator 3a: Increase referral to programmes which support healthy lifestyles and whānau engagement for 4 year olds with a BMI over 21

Indicator 3b: Increase food literacy training to targeted workforce including midwives, Well Child/Tamariki Ora, education workforces, social services and Before School Check practitioners.

What the data shows

- 55 Hawke's Bay children were identified with BMI over 21, of these, 47 were referred to interventions including Pre-school Active Families and the remaining 8 were given advice. Of the referrals 55% were Māori, 29% other and 19% Pasifika. (2015 B4 School Check Clinical Data- Health Hawke's Bay)
- 57 participants attended breastfeeding support training, 23 Well Child staff attended First Foods Trainer Workshops and 83 health professionals attended Gestational Diabetes updates (2015 HBDHB Maternal Nutrition Report to MoH)

Activities and Stakeholders			
	What	**How**	**When**
Current activity	• Screening including gestational diabetes, Well Child/Tamariki Ora and B4 School Checks • Whānau activity based programmes for under 5s • Paediatric dietetic referrals	• Monitor the screening and responding referrals • Fund Active Families under Five and monitor implementation. Investigate extending to further providers • Monitor referrals and outcomes	July 2017 Māori Health Targets - 6 monthly to the Board
New actions	• Support screening in maternal programme, Well Child/Tamariki Ora and B4 School Checks • Provide whānau based programmes to support lifestyle changes which support healthy weight i.e. Active Families • Support referrals to programmes via a range of pathways • Develop a clinical pathway from well child/primary care to secondary services • Support child health workforce, to deliver healthy conversations	• Support training for health professionals completing screening - maternal, Well Child/Tamariki Ora and B4 School Checks. • Contract community providers to take referrals for whānau with an overweight child (3-12 years) • Clinical pathway developed with key stakeholders- whānau, parents, children and health professionals • Healthy Conversation training delivered	Annually until 2020
Key partners	Well Child/Tamariki Ora, primary care, general practises, LMCs, Strategic Services, Oral Health Services, Paediatric Services, Maternity Services		

Objective 4: Provide leadership in healthy eating

Indicator 4a: Monitor the implementation of the HB DHB Healthy Eating policy

Indicator 4b: Engage support from key partners

What the data shows

Hawke's Bay District Health Board policy is compliant with MoH requirements December 2015. Obesity responses have been workshopped with cross-sector leaders and presented at the Intersectorial Forum in 2015.

Activities and Stakeholders			
	What	**How**	**When**
Current activity	• Share information, evidence and best practice and healthy weight data with key community partners • Show leadership by establish the HBDHB Healthy Eating Policy and implementing the Healthy @ Work workplan	• Regular updates provided via Maternal, Well Child/Tamariki Ora and B4 School Check forums. Regular meetings with community providers • Review and monitor the HBDHB Healthy Eating Policy and support the implementation of the Health @ Work workplan	July 2017
New actions	• Lead an equity focus by applying an equity lens to review this plan and delivered activity • Lead messaging and delivery to reduce sugar intake • Align HBDHB Healthy Eating Policy with national food and beverage guidelines • Develop a process for a cross-sector approach to support healthy eating environments • Influence key service delivery stakeholders to maintain best practise and consistent messaging • Continue engagement with community particularly key influencers for Māori and Pasifika i.e. marae and church leaders	• Equity assessment written and finding used to refine this plan to improve response to equity • Cross-sector activity includes a sugar reduction focus • Reviewed policy reflects the healthy eating guidelines • Framework/process implemented for cross-sector approach and inter-agency activity reported • Hauora, general practice, LMCs, contracted community providers provide national messages consistently to whānau, community and their workplace • Key activities Waitangi Day celebrations - policy/guidance document development Ngāti Kahungunu Iwi Incorporated and engagement with Pasifika church leaders	Ongoing until 2020
Key partners	Iwi leaders, Ngāti Kahungunu Iwi Incorporated staff, community leaders, governments department leaders, local authorities leaders, non-government organisations leader, private sector leaders, Pasifika community leaders, Ministry of Health, Ministry of Education		

Monitoring process

It is proposed that implementation of this Plan will be informally monitored via the Population Health Advisors Team and formally monitored via reporting on the HBDHB Annual Plan and to governance committees via key target measures and an annual report on activities.

There are also a number of aligned monitoring and reporting pathways for healthy weight:

- National targets including B4 School Check, breastfeeding rates (quarterly reporting)
- Population Health Core Plan six monthly and annual reporting
- Reporting on alignment with national guidelines for DHB Healthy Eating policy
- HBDHB Māori Health Target- healthy weights at 4 years
- Maternal Nutrition Programme outcomes framework (evaluations) reporting to MoH six monthly
- Schools Programme outcomes (evaluation), Population Health Plan
- Health Promoting Schools reporting framework

Data limitations:

- Data for over 5s is limited and not consistent
- Engaging with schools data is yet to be explored
- There is no baseline data for the healthy eating environment including food security
- There are time lags in data from the Ministry of Health i.e. breastfeeding data

Delivery mechanism

Annual plans detail the activities, outcome measures and who is responsible for activities being achieved. We deliver these activities with community partners i.e. Well Child/Tamariki Ora providers. Each of the activities is included in annual planning for HBDHB, particularly in the Population Health Service Annual Plan (Appendix C) where the:

- advocating for healthy eating environment and policy is part of the health promotion section
- develop and delivery of whānau based programmes is included in the maternal nutrition and health promotion sections
- support tools and workforce development for screening and referrals for interventions appear in the maternal nutrition section and health promotion sections
- information sharing and policy leadership is in the health promotion section
- consistent messaging and alignment national messages is in the health promotion sections
- developing a cross-sector model is in the health promotion section

While HBDHB have a leadership role, we need to partner with local government, schools, workplaces, community providers and Ngāti Kahungunu Iwi Incorporated to support healthy eating environments. As such, delivery detail will be outlined in these organisations plans and contracts.

Finally, timing of delivery is dependent on funding sources, as they become available new actions can be initiated. For example the HBDHB will negotiate with MoH in 2017 for funding associated with the National Childhood Obesity Plan, Population Health has secured another year of Maternal Nutrition funding from MoH and are completing a business case for EMT to funding a school aged programme.

Appendices

Appendix A: Obesity Prevention Strategy

Summary document previously presented to HBDHB Board.

Appendix B: Stakeholder Feedback

Full report are available on request for:

- Schools Stocktake Feedback
- Maternal Nutrition and Active Families Evaluation (client and stakeholder feedback)
- Minutes from Consumer Council workshop
- Maori Relationship Board meeting minutes (June 2015, September 2015 and March 2016)

Appendix C: Population Health Annual Plan

Available on request and has been presented to the HBDHB Board as part of the Annual Plan approval process.

HAWKE'S BAY District Health Board Whakawāteatia	**Customer Focused Booking Programme Update**
	For the attention of: **Maori Relationship Board (MRB), Clinical and Consumer Council**
Document Owners:	Sharon Mason, COO
Document Author:	Carleine Receveur
Reviewed by:	Health Services Leadership Team, Executive Management Team
Month:	May, 2016
Consideration:	For Information

RECOMMENDATION

That MRB and Consumer & Clinical Councils notes:

- The contents of this report
- That due to the complexity and depth of work involved in clinic scheduling, the Customer Focused Booking is shifting from a project to a programme. Under this umbrella programme a discreet project for Clinic Scheduling and Booking is being developed.

SUMMARY

The Customer Focused Booking project is making steady and sound progress towards a booking environment that is customer focused. High level achievements include the project identifying and supporting a Customer Focused Booking training programme for booking staff and the progression of UBook as an IS enabler for on line customer clinic booking.
Ensuring that the DHB has a stable platform for clinic scheduling and booking is a prerequisite for introducing the UBook system. However the project has found that there is a lack of operational processes and supporting business rules that enable certainty for booking in the clinic environment. The DHBs high level of rescheduling of patient appointments due to hospital driven reasons is an indicator of this issue. For the organisation to utilise the functionality of the UBook there needs to be clinic scheduling operational processes designed and implemented. Due to the complexity and depth of work involved in clinic scheduling, the Customer Focused Booking is shifting from a project to a programme. Under this umbrella programme a discreet project for Clinic Scheduling and Booking is being developed.

BACKGROUND

Since July 2012 there have been numerous attempts to introduce Customer (Patient) Focused Booking principles and system changes. The scope of work has included the clinic and booking environments of the elective specialties that sit within the Elective Services Patient Indicators (ESPI).

A customer focused approach is one in which places the customer at the heart of the booking process. The key elements of a customer focused booking system include:

1. DHB values and behaviours e.g. customers feel respected

2. Effective customer engagement for good health outcomes

3. Customer participation and input e.g. when arranging appointment times, so responsive to their needs

4. Ease of understanding and navigation e.g. customers know how and who to contact about their appointment

5. Support mechanisms for staff to enable them to deliver an exceptional customer experience are in place

6. IS systems that support the outcomes identified to occur

7. A mechanism to monitor the system and ensure continuous quality improvement.

A patient survey conducted in 2012 provided evidence that improvements in the booking system was required. Some of the high level findings included that 45% of the respondents had their appointment rescheduled, 20% indicated that they were not given enough notice of their appointment and 18% indicated that staff did not make an effort to make an appointment that suited.

Despite design workshops and processing mapping a consensus of the way forward was not agreed or implemented. In July 2015 the Chief Operating Officer (COO) requested that the project be re-activated and incorporate the findings and work from the DNA project.

In response to the COO's request a new project was formed and renamed as "Customer Focused Booking" to signal a focus on customer service based principles and that this was a new project with a different approach.

LAST UPDATE

The last project update was provided to the Consumer / Clinical Council and Board in September 2015. At this time a new project team was established with a new project sponsor, steering group, project manager, and project framework. As a result of recent horizon scanning the opportunity was taken to present Hutt Valley's District Health Board (HVDHB) UBook – a customer focused booking system developed by HVDHB. There was overwhelming support from both councils and board for HBDHB to adopt this system.

It was also signalled that the project included the outcomes / actions from the DNA project (which are inherently linked to achievement of this project's goal). There are natural links/synergies/ interdependencies that were evident from the outset, however the two projects had run in isolation of each other.

PROGRESS TO DATE

Since the last update in September 2015 the project has made good steady progress. The project work streams have evolved and matured as the intelligence gathering has occurred. The project has invested time in investigating current processes and understanding what the current status and issues are. This has been an important investment as there are significant areas requiring system improvement to support and sustain Customer Focused Booking principles. Due to the complexity and level of change required the Customer Focused Booking project has now moved into a programme of work with both a fully developed project and work streams under this umbrella.

The current work streams are described below with commentary on progress to date.

1. IS Solution

Since September 2015 IS staff continued to work closely with HVDHB. Dependency was on HVDHB to write up the necessary installation files so HBDHB could progress UBook as the IS option. There have been significant delays in receiving UBook installation files, however they were issued to HBDHB on the 16/3/2016. In the interim another potential IS solution was identified through the WEBPAS vendor, referred to as Ultragenda. This product has not yet been released in New Zealand. The IS staff conducted a review of Ultragenda including requirements and costs comparing the product with UBook. Cost alone (at half million yearly licencing fee) made this an unrealistic option for HBDHB.

2. Clinic Scheduling

A prerequisite for enabling customer focused booking is to have a stable clinic scheduling environment whereby clinic booking can be made in advance with high assurance that these clinics would not be changed. A recent investigation into clinic scheduling conducted as part of the project found that there was significant amount of rescheduling of clinics. The main reasons for this was dominated by the hospital environment (refer to appendix one)

The project released an internal report describing the findings of an investigation into current clinic scheduling processes from a booking administration perspective.

The high level findings included:

- Lack of business rules
- No methodology to calculate FSA to follow up clinics
- High level of rescheduling
- Clinic Templates not reflective of the work that is being done e.g. overbooking

From these finding it has become clear that there is a need to establish a platform of business rules and processes in the clinic environment to enable Customer Focused Booking. Due to the complexity of the issue Clinic Scheduling has now moved to a separate project under the Customer Focused Booking programme of work.

The purpose of this specific project is to design a platform of clinic scheduling business processes across the foundation components for the ESPI speciality clinics so that the DHB can optimise wait list management, deliver on agreed performance measures and support customer focused booking principles.

3. Customer Focused Booking Training

Customer service excellence in a health setting comes with a unique set of challenges and opportunities. Patients frequently suffer high level of stress, not only from illness or injury but also from the levels of customer service given.

The project recognised that to support our customers we need to support booking and administration staff – as a key group of people that interact with our customers, navigating the complexity of our health system. To do this the Customer Focused Booking project engaged the services of Business Training NZ who have developed a one day workshop referred to as “Putting the Patient First – Customer Service Strategies for Healthcare Professionals”.

Five workshops were conducted in early February with a total number of 49 staff participating. The workshop goals were to provide skills and techniques that are required to communicate in ways that will enhance patient satisfaction, the overall patient experience and the experience of

staff. The workshop facilitators have experience working with health professionals and administration staff in a number of different health settings across New Zealand.

A participant evaluation was conducted which indicated an overwhelming positive response to the course with all participants recommending this workshop to colleagues (see appendix two). The Administration management team have been keen to ensure the learnings from the course were built on and embedded in the way "we do our business". Initiatives such as visual resources and prompts to support customer focused booking and monthly "Director of First Impressions" are examples of how the team have used the training to support a customer focused booking approach as business as usual.

4. Text to Remind and Demographics

These two work streams are currently being supported by an Improvement Advisor from Quality Improvement and Patient Safety, who works in partnership with the business owner and project manager. The text to remind and demographics workstream were formed as a direct result of the observations that were being relayed back to the business from the DNA project. The initial focus of both work streams was to form a clear understanding of the issues with the current system and to recommend improvements. A fundamental issue for both work streams has been the lack of documented processes to ensure a standardised approach and shared understanding of the process, roles and responsibilities.

Next Steps

A key focus of activity will be on the installation of UBook into the HBDHB environment.

The provisional IS timeframe is provided below:

Activity	**Timeframe - 2016**
Download UBook files into test environment	March - May
Internal testing of UBook by bookers and administration staff	June - July
Further IT development (e.g. integration into Webpas)	Aug - Sept
Robust testing in the external environment	Sept - Oct
Further developments / testing / troubleshooting	Oct - Nov
Training, communications	Nov
Go Live (with speciality)	Dec

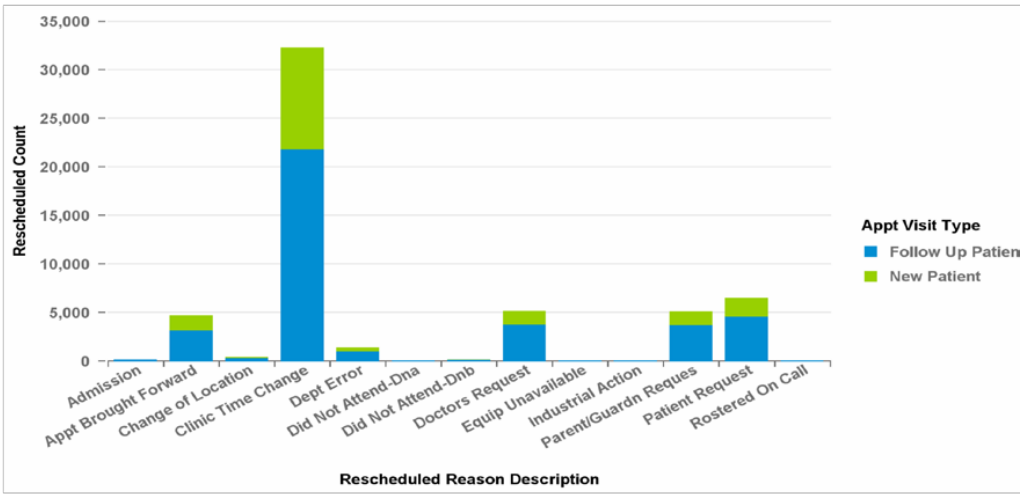
At time of the submission of this report it was anticipated that UBook would go live before the end of December 2016. One of the risks to achieving the go live date is gaining the necessary security clearance. The installation of UBook will be the first HBDHB experience of opening the DHBs IS patient information to the external environment. It is essential that robust testing, documentation and analysis are followed through to ensure the highest level of security is maintained, as this will set a precedence for future IS developments for HBDHB.

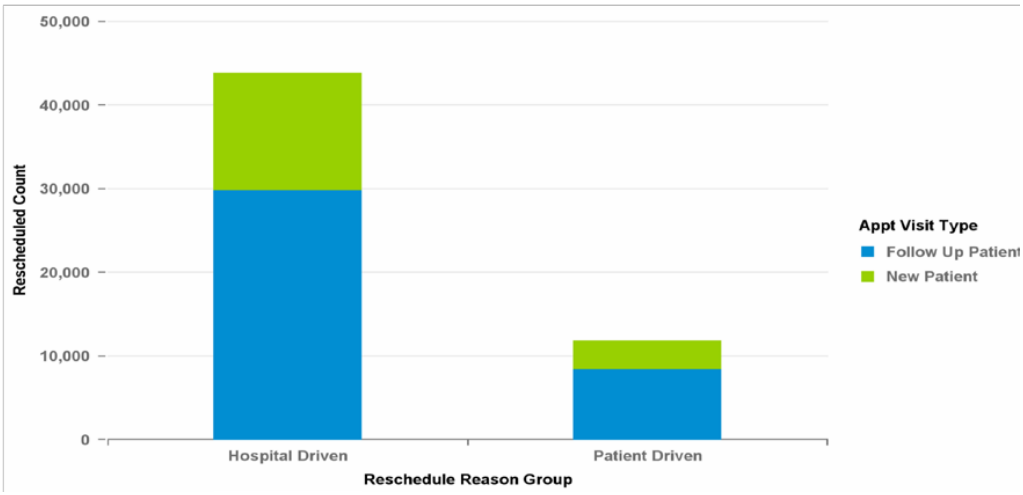
In parallel to the IS UBook work, the Clinic Scheduling project will commence with the aim of having a pilot speciality engaged and ready to be the first pilot for UBook outpatient booking in December.

Appendix One: Reschedule volumes by reason January 2013 – December 2015

Reason Group	Reason Description	Follow Up Patient	New Patient	TOTAL
Hospital Driven	Appt Brought Forward	3,113	1,535	4,648
	Change of Location	246	116	362
	Clinic Time Change	21,714	10,550	32,264
	Dept Error	901	444	1,345
	Doctors Request	3,711	1,374	5,085
	Equip Unavailable	7	9	16
	Industrial Action	23	12	35
	Rostered On Call	10	6	16
Hospital Driven	Total	29,725	14,046	43,771
Patient Driven	Admission	96	18	114
	Did Not Attend-Dna	17	17	34
	Did Not Attend-Dnb	64	27	91
	Parent/Guardn Reques	3,644	1,427	5,071
	Patient Request	4,511	1,949	6,460
Patient Driven	Total	8,332	3,438	11,770
TOTAL		38,057	17,484	55,541

Reason Grou
Hospital Drive
Patient Driver
TOTAL





Appendix Two: Customer Focused Booking Training – Participant Evaluation

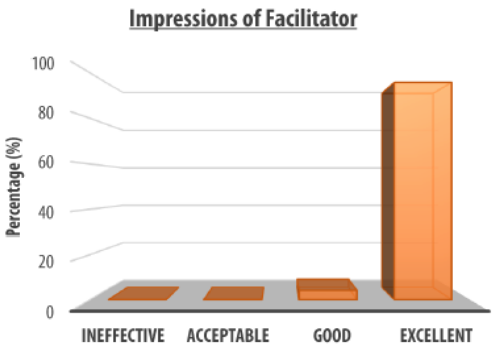
businesstraining NEW ZEALAND
MAXIMISING STAFF PERFORMANCE

Analysis of Participant Evaluations

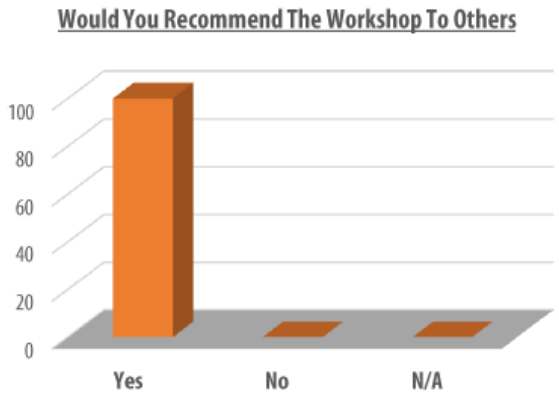
Programme	Customer Service Strategies for Health Professionals
Client	Hawkes Bay District Health Board
Date	2nd, 3rd, 4th, 5th & 9th February 2016
Facilitator	Gerry Hassan
No. of Evaluations	49

What did you think about the content of the workshop?	Nothing New	Useful	Very Useful	Excellent	Total Responses
No. of replies	0	2	22	25	49
Percentage	0	4	45	51	100

What was your impression of the facilitator?	Ineffective	Acceptable	Good	Excellent	Total Responses
No. of replies	0	0	2	46	48
Percentage	0	0	4	96	100



I would recommend that my colleagues go to this workshop	Yes	No	N/A	Total Responses
No. of replies	48	0	0	48
Percentage	100	0	0	100



15

HAWKE'S BAY
District Health Board
Whakawāteatia

16

MĀORI RELATIONSHIP BOARD

TRAVEL PLAN QUARTERLY UPDATE

Verbal Update by
Sharon Mason (Chief Operating Officer)
Andrea Beattie (Property and Service Contracts Manager)

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Māori Health Plan Q3 (Jan–Mar 2016) Full Report**
	For the attention of: **Executive Management Team and Māori Relationship Board**
Document Owners:	Tim Evans, General Manager Planning, Informatics and Finance Tracee Te Huia, General Manager Māori Health
Document Author(s):	Patrick Le Geyt, Programme Manager Māori Health Justin Nguma, Senior Health & Social Policy Advisor Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Not applicable
Month:	May 2016
Consideration:	For Monitoring

17

RECOMMENDATION

That EMT and the Māori Relationship Board:

Note the contents of this report.

CONTENTS OF THE REPORT

This is a report on:

- The Māori health indicators agreed as part of the development of 2015 /16 Annual Māori Health Plan.

A quick reference summary dashboard is included and shows our position as at the end of this quarter for all indicators. The dashboard uses traffic light methodology (as described in the key on page 4) to represent this.

As this report is for the period ending March 2016, some results may vary to those presented in other reports.

KEY FOR DETAILED REPORT AND DASHBOARD

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

Table of Contents

PERFORMANCE HIGHLIGHTS

Achievements

1. HBDHB continues to have the highest percentage in New Zealand for Cervical Screening for 25-69 year old Māori women (73.2%) and the lowest disparity gap between Māori and European (4% gap).
2. Immunisation rates for 8 month old Māori increased from 93.3% in Quarter 2 to 97.7% in Quarter 3 to be above the target of ≥ 95%.
3. Immunised rates for Māori 4 year olds remains above the expected target of ≥ 90% with 93.25 immunised in Quarter 3.
4. Quick access to Angiograms for Māori exceeded the expected target of ≥70% with 80% in Quarter 3 up from 60% in Quarter 2.
5. The number of Māori enrolled in the Health Hawke's Bay PHO has reached the 97% target up from 96.75 in Quarter 2 to 97.8% in Quarter 3.

Areas of progress

1. Pre-school oral health enrolments for Māori under 5 years of age increased from 65.3% in Quarter 2 to 74.1% in Quarter 3. There is still some work to do to reach the expected target of ≥90%.
2. Cultural Training for HBDHB staff has increased from 66% in Quarter 2 to 70.6% in Quarter 3. Medical staff increased 19% in Quarter 2 to 32.4% in Quarter 3.

Challenges

1. Māori under Mental Health Act compulsory treatment orders has risen 16.7 from 196 per 100,000 population in Quarter 2 to 212.7 in Quarter 3. There remains a widening inequality between Māori and non-Māori of 113.1 per 100,000 population.
2. Immunisation rates for Māori under 2 year olds dropped slightly below the targets of ≥ 95% with 94.81% of all Māori 2 year olds immunized in Quarter 3.
3. Heart and Diabetes Checks remained relatively unchanged from 86.3% in Quarter 2 to 86% in Quarter 3 just under the expected target of ≥90%.
4. Breast Screening has remained unchanged from 68.4% in Quarter 2 to remain on 68.4% in Quarter 3.
5. Māori Workforce remained relatively static in Quarter 3 at 12.4%, an improvement of only 0.1% from Quarter 3, and is below the expected target of 14.3%.

Please note:

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

ANNUAL MĀORI HEALTH PLAN, QUARTER 3 JANUARY - MARCH 2016 DASHBOARD REPORT

Access to Care
PHO Enrolment and ASH rates

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
PHO Enrolment	94.7%	96.7%	97.8%	96.7%	≥ 97%	346		↑
0-4 years (6m)	82.0%	82.0%	-	-	≤ -	-		↓
45-64 years (6m)	100.0%	98.0%	-	-	≤ -	-		↓

Child Health
Breastfeeding rates (3m)

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
QIF Data								
At 6 Weeks	68.0%	62.0%	-	-	≥ 75%	-		↑
At 3 months	54.0%	45.0%	-	-	≥ 60%	-		↑
At 6 months	59.0%	54.0%	-	-	≥ 65%	-		↑

Immunisation

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Immunisation (8 Months)	95.9%	92.6%	97.7%	93.2%	≥ 95%	7		↑
Immunisation (2 years)	95.0%	95.1%	94.8%	94.9%	≥ 95%	0		↑
Immunisation (4 years)	-	94.2%	93.2%	91.2%	≥ 90%	11		↑
65+ Influenza (3m)	68.0%	56.5%	-	-	≥ 75%	-		

Rheumatic Fever

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Hospitalisation rate (6m)	-	-	2.09	-	≤ 2.6	0		

Oral Health

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Pre-school enrolment rate	65.3%	65.3%	74.1%	99.8%	≥ 90%	-771		↑

SUDI

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Rate per 100,000	4.6	2.9	Update not available		≤ 0.5	-		

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

Time Series Key:
Target
Actual

Cardiovascular Disease

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Heart & diabetes checks	83.9%	86.3%	86.0%	90.8%	≥ 90%	-454		↑
Quick access to angiograms	66.7%	60.0%	80.0%	71.1%	≥ 70%	1		↑
Completion of registry data	12.5%	71.4%	100.0%	100.0%	≥ 95%	1		↑

Cancer

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Cervical screening (25-69 yrs)	73.8%	74.1%	73.2%	77.2%	≥ 80%	-604		↑
Breast screening (50-69 yrs)	67.2%	68.4%	68.4%	79.0%	≥ 70%	-54		↑

Smokefree

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Smokefree 2 weeks postnatal	58.0%	62.0%	53.0%	73.0%	≥ 86.0%	-		↑
Pregnant smokers Brief Advice to Quit	100.0%	95.2%	86.2%	88.6%	≥ 90.0%	-2		↑

Mental Health & Addictions

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Mental Health Act community treatment orders (per 100,000)	-	196	212.7	99.6	≤ 81.5	46		↓

Maori Workforce

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	2.7%	2.7%	2.9%	3.2%	≥ -			
Management & Administration	15.7%	16.5%	16.1%	-	≥ -			
Nursing	10.1%	10.6%	10.7%	-	≥ -			
Allied Health	11.9%	12.6%	12.4%	-	≥ -			
Support Staff	26.7%	28.2%	30.2%	-	≥ -			
Māori staff - HBDHB	11.6%	12.3%	12.4%	-	≥ 14.3%			↑

Cultural Responsiveness

Indicator	Baseline	Prior period result	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	9%	19%	32%	-	≥ -		
Management & Administration	43%	79%	82%	-	≥ -		
Nursing	41%	70%	75%	-	≥ -		
Allied Health	59%	77%	80%	-	≥ -		
Support Staff	12%	36%	39%	-	≥ -		
Māori staff - HBDHB	40%	65.5%	71%	-	≥ 100%			↑

Te Ara Whakawaiora Priorities

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Obesity (B4SC Healthy Weight for 4yrs)	-	26.0%	52%	56%	≥ 50%	-		↑
DNA's	16.2%	15.2%	18.20%	4.10%	≤ 7.50%	-135		↓
Oral Health (% Caries Free at 5yrs)	38.7%	38.7%	36.0%	70.1%	≥ 65%	-250		↑

Quarterly Performance and Progress Update

1. Access to Care

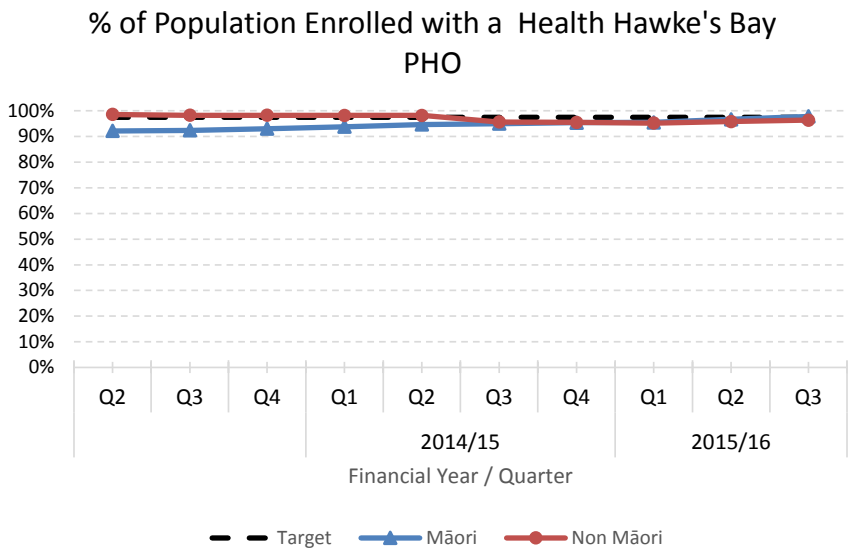
Outcome: Increase enrolment in the PHO

Key Performance Measures	Baseline[1]	Previous result[2]	Actual to Date[3]	Target 15-16	Trend direction
Māori	94.7%	96.7% (F)	97.8% (F)	≥97%	▲
Pacific	99.3%	87.5% (U)	89.4% (U)	≥97%	▲
Other	98.2%	96.2% (U)	96.7% (F)	≥97%	▲
Total	97.3%	96% (U)	96.7% (F)	≥97%	▲

Comment:

As at 31 March 2016 – 624 x consultations were provided to unenrolled patients who are either Māori Pacific or living in a Quintile 5 residential areas. 317 were GP consults and 307 were Nurse consults at a total cost of $21,205.50. 215 enrolments have been confirmed as identifying as Māori. It can take up to 20 weeks for a person to appear on the Health Hawke's Bay register. As at 31 March 2016 there is a total of 157 criteria to be confirmed.

Time series



1 October 2014 to December 2014

2 October to December 2015

3 January to March 2016

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
1.1	**Promote population enrolment at GP services**						
1.1.1	Promote at birth – automatic enrolment process	Quarterly		# of new born babies enrolled at birth– by ethnicity		On track	As at 31 March 2016 85% of new-born babies were enrolled with a general practice. There is no disaggregated data at the moment. 19 x New-borns where practice was nominated but not enrolled 26 x New-borns enrolled before current quarter and registration not confirmed. 32 x New-borns registered this quarter.
1.1.2	Work with Practices to update and re-enrol members whose membership is due to lapse	Quarterly	PHO Lead	# re-enrolled members at GP services		Behind schedule	As at 31 December 2015 1003 x patients last appointment/ enrolment date is greater than three years in the next funding quarter is noted. This provides practices with a three month window to invite patients to complete and sign a new enrolment form.
1.1.3	Re-connect ED attendees with primary care providers	Quarterly	PHO Lead	# of ED attendees reconnected to primary care providers by ethnicity		Behind schedule	No ED referrals to the High Needs Enrolment Programme Vouchers have been received from general practice for claiming.
1.2 Practices are supported to better engage with Māori accessing their services							
1.2.1	Support practices through quality improvement programme 'He Taura Tieke' to enhance effective responsiveness to their Māori population.	Quarterly	PHO Lead	# of self-assessment and annual quality improvement plans completed by participating Practices (18 in 15/16		On track	The eight practices identified in Q2 are progressing well with their Action Plan with the support of the contracted provider. Practice champions are fully engaged. One meeting held with practice champions this quarter. On track to complete Action Plan by 30 June 2016.

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
1.2.2	Implement health literacy training programme across the general practice	Quarterly	PHO Lead	# of general practice services covered by health literacy programme Evaluation report on the training and customer survey Six monthly reporting of PHO SIA contract Six monthly reporting of PHO Health Promotion plan	Customers' feedback on the impact of the training on service delivery	Behind schedule	There has been a delay outside of the control of HHB to upload the training modules onto Ko Awatea. This has now been completed and the testing will be completed end of April. A Launch of the programme will occur before the end of June.
1.2.3	Carry out a training of trainers programme on 'Stanford' Self-Management Programme with focus on protocol and processes which supports Māori cultural context	Quarterly	PHO Lead	# of Māori trained to be master trainers including participation from Māori NGO.	Māori are actively participating in the programme through Sport HB, Iron Māori, Hikoi koutou, Patu, Kahungunu Hikoi Whenua	**Complete**	Two Train the Trainer courses were completed during this quarter. The first training course was a mixture of main stream, Whāriki and Pacific Island facilitators. Nine people attended the course consisting of: • 5 Māori participants (3 to be used for the Whāriki programme) • 3 Pacific Island participants • 1 European participants The second training was a Diabetes Cross Training where courses would be delivered to participants who have diabetes. 14 people attended this training consisting of: • 9 Māori participants • 2 Pacific Island participants • 3 European participants Three diabetes courses will begin in the next quarter with these new facilitators.

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
							Seven long term conditions courses were held during this quarter. Five of these classes were delivered under the Māori arm (Whāriki) with more of an emphasis on tikanga Māori. From these seven classes: • 63 participants registered for the classes • 40 participants were Māori (64%) • 45 completed the course (71%) • 29 participants who completed the courses were Māori (73%) • 75% of participants from the Whāriki programme were Māori with 73% of completed participants being Māori.
1.2.4	Implement priority campaign actions to support Māori communities understanding of identified Health issues	Ongoing	PHO Lead	# of campaign sessions carried out among Māori communities	Programme Evaluation provide feedback on the community uptake of the programme and impact	On track	The strategic approach has been completed and a plan for implementation will be developed in Q4
1.2.5	Implement whānau Wellness through free GP services	Q2		Up to 250 whānau onto the Whānau Wellness Programme in the first quarter for free GP services	Evaluation of the programme provide feedback on the Whānau uptake of the programme and impact	On track	Whānau Self-Assessment Results – This information informs planning of Whānau quarterly sessions: Identified Oranga Kainga/Housing Concerns/Issues/Needs: • 43 families identified Cold/uninsulated homes • 24 families identified Curtains and Blankets

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
							• 19 families identified overcrowding concerns Oranga Wairua Concerns/ Issues/ Needs: • 57 families identified Stress as a concern • 23 families identified Mental Illness • 21 families identified overcoming addictions • 20 families identified connection with Te Ao Māori • 6 families identified overcoming gambling Oranga Tinana – Physical Health of Tamariki concerns/issues: • 45 families identified Asthma • 39 families identified Skin • 38 families identified Throat • 37 families identified Dental • 35 families identified Ear Infections • 31 families identified Weight • 26 families identified Nutrition • 14 families identified Smoking • 12 families identified Immunisation Oranga Tinana – Physical Health of Pakeke/Kaumatua (Adults): • 65 families identified Weight

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
							• 58 families identified Exercise/Physical Activity • 46 families identified Smoking • 42 families identified Blood Pressure • 41 families identified Dental Care • 37 families identified Nutrition • 31 families identified Diabetes • 31 families identified Heart Health Oranga Whānau – Family collective concerns: • 36 families identified Budgeting and Finance • 30 families identified Health Educations • 19 families identified Family and Personal safety • 19 families identified Advocacy • 12 families identified Early Childhood Education Based on the information provided by whānau above, the first quarterly session was named Preparing for Winter included guest speakers and presentations from: • HHB – Healthy Homes Insulation Programme • HBDHB – Rheumatic Fever Programme and how to keep a home warm and healthy video

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
							• HBDHB – Clinical Respiratory Nurse Sue Ward to discuss Asthma, Respiratory and prevention of Influenza • The NZ Red Cross Curtain Bank • HHB Flu Vaccination Promotion and Encouragement • Patu Up Participant shares his journey with Patu Up with before and after pictures • HHB Healthy Eating and Portion Control Education and Giveaways • HHB IPIF Screening Promotion • NZ Red Cross Community Resilience Programme/Preparing for a Disaster.

Outcome: Reduction in Ambulatory Sensitive Hospitalisation (ASH) rates in 0-4 year olds. There will be specific focus on ASH conditions with the highest inequity – dental decay, skin conditions (dermatitis & cellulitis), respiratory (e.g. Asthma) and ear, nose and throat infections.

Key Performance Measures	Baseline[4]	Previous result[5]	Actual to Date[6]	Target 15-16	Trend direction
Māori	-	82%	-	-	-
Other	-	66%	-	-	-
Total	-	73%	-	-	-

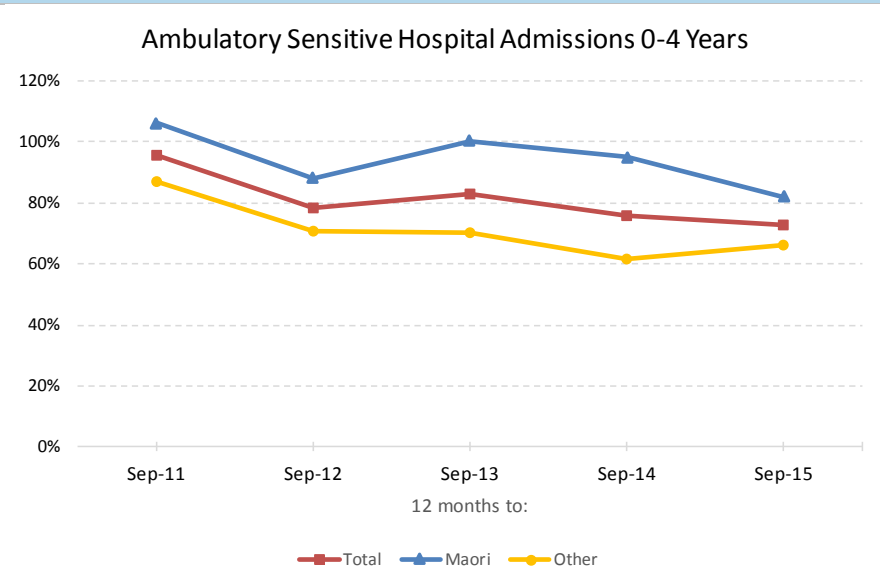
The Ambulatory Sensitive Hospitalisation rates for 0-4 age group are six months in arrears from MOH and will be updated in Quarter 4.

Nevertheless SH Rates to date are pleasing, a drop in the overall Māori ASH rates and a significant narrowing of the disparity gap can be seen. It is also notable that HB rates are among the lowest in the country.

Reductions in rates of admissions for Dental conditions, Respiratory infections (Upper and ENT), and gastroenteritis can be seen in the 12 months to the end of Sept 2015. The Top 5 ASH conditions for Māori in the 0-4 year age group are Asthma, Dental conditions, Respiratory Infections- Upper and ENT, Respiratory Infections – Lower, Gastroenteritis/Dehydration and Cellulitis (5th equal).

Multiple activities are working to reduce hospital admissions for these top 5 condition's including: Healthy Housing Programme; Oral health enrolment at birth (quadruple enrolment); identifying and highlighting referral pathways for Asthma; supporting GP practices to provide whānau with appropriate preventative measures for Asthma; Public Health visits in Hawke's Bay Kōhanga Reo; development of Te reo skin infection prevention and management resources and the wider impact of School Public Health programmes which identify and educate whānau around the identification and management of skin conditions.

Time series



Source: Ministry of Health

4 No baseline data available

5 12 months to September 2015

6 Next update available in Q4

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
1.3	**Carry out intervention initiatives focused on reducing ASH rates among 0-4 year olds**						
1.3.1	Develop a Kaupapa Māori resource for use in Kōhanga Reo for promotion of skin health	Q4	Katie	# of Kaupapa Māori resource materials developed and distributed	Resource materials developed in partnership with Te Kōhanga Reo Regional Office	On track	Printing and distribution underway
1.3.2	Provide healthy homes assessments and improvements to enhance healthy living conditions	Ongoing	Liz	# of eligible housing intervention plans referred and signed off by families		On track	Crowding review - 70 families state positive reduction in structural and / or functional crowding post interventions
1.3.3	Develop appropriate action plans for improving housing conditions for all eligible children in Hawke's Bay	Ongoing	Liz		Action plans in place	On track	40 housing plans developed in partnership with Whānau this quarter.
1.3.4	Increase enrolment of children with Community Oral Health Service		Shari/ Kelly	Number of children enrolled with Community Oral health services by age and ethnicity		On track	No narrative report received.
1.3.5	Establish and maintain data base to inform health progress on families	Ongoing	Liz	# of readmission cases for children who have had housing intervention plans completed	Feedback on the levels of family satisfaction with the referral process	On track	All Whānau health intervention data held in ECA. Referrals closed on completion of interventions and review of crowding.

Outcome: Reduction in ASH rates in 45-64 year olds. There will be specific focus on ASH conditions with the highest inequity – heart disease, skin infections, respiratory infections and diabetes

Key Performance Measures	Baseline[7]	Previous result[8]	Actual to Date[9]	Target 15-16	Trend direction
Māori	-	172%	-	-	-
Other	-	82%	-	-	-
Total	-	98%	-	-	-

Comments:

The Ambulatory Sensitive Hospitalisation rates for 45-64 years age group are six months in arrears from MOH and will be updated in Quarter 4.

It is important to differentiate between COPD and **Asthma** due to differing diagnostic groupings and for this reason an Asthma pathway has been developed, collegial with both primary and secondary respiratory and paediatric services. CNs from the respective services are socialising pathways within their defined age groupings. Asthma pathways have been socialised to general practice through x2 CME sessions.

The COPD pathway has been gaining traction as a vehicle for prevention of admissions - well supported by CNS and PHO respiratory pilot.

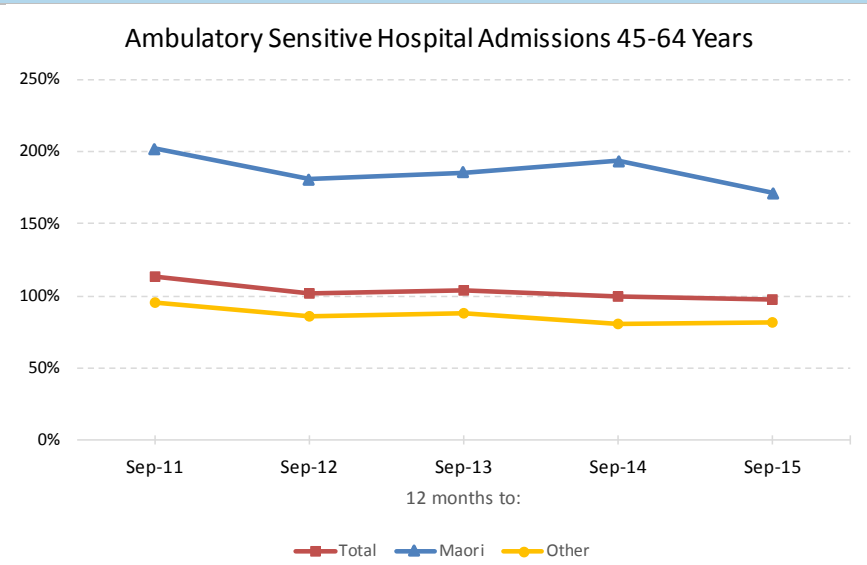
CHF - widespread consultation has occurred - awaiting clinical lead sign off for publish next month.

Cellulitis - scope - adult only: It is in the final stages of development.

Chest pain: Has been published but not socialised. Planning is underway for a cardiac evening, organised by cardiac services, to socialise.

Cardiac and CHF pathways are aiming for mid-June completion.

Time series



Source: Ministry of Health

Planned Activities and Progress

7 No baseline data available

8 12 months to September 2015

9 Next update available in Q4

ID	Actions/Activity	Date	Lead	Quantitative Measures	Qualitative Measures	Progress	Progress Comments
1.4	**Carry out intervention initiatives focused on reducing ASH rates among 45-64 year olds**						
1.4.1	Promote Heart and Diabetes Checks through PHO	Ongoing	PHO Lead – Victoria Speers	# of Heart and Diabetes Checks	IPIF and Te Ara Whakawaiora reporting	On track	The Ministry of Health has taken over the reporting for CVDRA's. Reporting up to 31 March 2016 is not expected until the 4th week of May 2016. As at 31 December 201 90% of Health Hawke's Bay's eligible population has received a CVDRA in the past 5 years. The coverage rate for Māori was 86%. Health Hawke's Bay is focused on achieving equity for our Māori and Pacific enrolled population. Currently six general practices are engaged with our CVDRA Rebel Sports Promotion where general practice are funded $20 per eligible Māori and Pacific patients so they can receive a free CVDRA and then the patient is rewarded with $20 Rebel Sports Gift Card.
1.4.2	Carry out practice audits through PHOs for pre-diabetics (HbA1c 40 to 49) for each member Practice	Ongoing	PHO Lead – Trish Freer	28 audits completed # of pre-diabetics (HbA1c 40 to 49)		On track	27 of the 28 practices have completed a DCIP. The data to enable analysis for the pre diabetes has not previously been available. Analysis of practice data is utilised and included in DCIP practice plans (early intervention advocacy)
1.4.3	Increase GP referrals to available publicly funded community services supporting self-management	Ongoing	PHO Lead – Trish Freer	# of GP referrals made		On track	HHB continue to work with GPs and encouraging them refer to the program however no data has been made available specifically relating to GP referral rates. Stanford is a tool however to support knowledge of funded services within localised communities.

1.4.4	Carry out 6 monthly survey of practices to identify referral trends and service availability	Ongoing	PHO Lead – Victoria Speer	56 surveys completed Survey report		**Complete**	Being developed (no change since last report)
1.4.5	Monitor recently published Chronic Obstructive Pulmonary Disease (COPD) pathway to confirm equitable access	Ongoing	PHO Lead – Victoria Speer	Monitoring report on recently published Chronic Obstructive Pulmonary Disease (COPD)		On track	HHB do not currently have the capability to monitor respiratory conditions – specifically COPD but looking to amend Dr Info audit to support this for 26 practices
1.4.6	Continue funding of Coordinated Primary Options (CPO) programme	Ongoing	HBDHB		Levels of acute hospitalization and ASH from cellulitis, DVT COPD exacerbation; pneumonia; sub-acute community support reflected through Te Ara Whakawaiora reporting	On track	This was not confirmed for HHB leadership whilst it was considered for the previous year it was agreed that the information being collated by the DHB and the information generated by the CPO programme were measuring different things.

2. Child Health						
Outcome: Breastfeeding of pepi improved						
Key Performance Measures	Baseline [10]	Previous result	Actual to Date	Target 15-16	Trend direction	
Infants are exclusively or fully breastfed at 6 weeks						
Māori	-	62% (U)[11]	-	≥75%	-	**Comments** The Breastfeeding rates data is produced six monthly and therefore will be updated in Quarter 4. The combined Breastfeeding, Smoking and SUDI resource for parents, based on the Mama Aroha Breastfeeding Cards is now in draft form and consumer testing is now underway. A cross sector Hawke's Bay breastfeeding Plan is now in development. Combined Breastfeeding data for both Tamariki ora and Plunket is now available through the MOH Quality improvement Framework for the first time, this will provide more accurate breastfeeding data for Hawke's Bay, to guide targeted Breastfeeding activity development.
Pacific	-	57% (U)	-	≥75%	-	
Total	-	66% (U)	-	≥75%	-	
Infants are exclusively or fully breastfed at 3 months of age						
Māori	-	45% (U)[12]	-	≥60%	-	
Pacific	-	47%% (U)	-	≥60%	-	
Total	-	55% (U)	-	≥60%	-	
Infants are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)						
Māori	-	54% (U)[13]	-	≥65%	-	
Pacific	-	59% (U)	-	≥65%	-	
Total	-	66% (F)	-	≥65%	-	

10 No baseline data available

11 6 months to December 2014

12 6 months to June 2015

13 6 months to June 2015

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
2.1	**Carry out activities to promote breastfeeding**						
2.1.1	Form multi agency working group to coordinate development of Breastfeeding action plan	Q 3	Katie Kennedy		Breastfeeding action plan developed	Behind schedule	Working group formed, planning stakeholder and community consultation process for quarter 4
2.1.2	Continue with WCTO Quality improvement project	Q1	Katie Kennedy	Breastfeeding resource PDSA completed	Appropriate sector wide participants	**Complete**	Breastfeeding PDSA completed
2.1.3	Facilitate inter-sectorial Breastfeeding Governance group	Ongoing	Katie Kennedy	# inter-sectoral Breastfeeding Governance group meeting held this quarter A community breastfeeding resource in place KPI results card updated and distributed quarterly	An inter-sectoral Breastfeeding Governance group consisting of the right and appropriate representatives	On track	1 Breastfeeding governance group meeting this Quarter. Development of breastfeeding/ Sudi/Smoke free resource for Whānau in draft stage. KPI Card being further developed by DHB business intelligence team to better reflect trends in breastfeeding rates/ and improve timeliness
2.1.4	Facilitate Hawke's Bay Breastfeeding multi agency Group meetings	Q1-4	Katie Kennedy	# of group meetings held	Multi- agency attendance at meetings	On track	2 meetings held this quarter and attended by relevant Health Professionals
2.1.5	Complete consultation with women not accessing established antenatal and postnatal breastfeeding support services (Māori, under 20, quintile 5) to inform targeted service design and implementation	Q3	Katie Kennedy	A consultation report on women not accessing established antenatal and postnatal breastfeeding support services		Behind schedule	One meeting carried out and further meetings planned for Q4
2.1.6	Promote breastfeeding through pregnancy and parenting education	Ongoing	Jules Arthur	# of breastfeeding sessions in pregnancy and parenting classes held each year # of Māori women and whānau attending breastfeeding classes	Consumer feedback from each set of classes reviewed Development of consumer feedback from those not attending	On track	Monthly Breastfeeding specific classes run by a Lactation Consultant. 2 Sessions held in this time period and will continue on a monthly basis. Good attendance for this.

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
							Drop –in pregnancy and parenting education sessions have commenced in March 2016 in Te Kakano antenatal class. All sessions will be facilitated by Lactation Consultant and midwife. Ongoing consumer feedback through Maternity Facebook page and Survey Monkey. First Maternity Consumer Forum held at Plunket Hub in March 2016 as part of Maternity Quality and Safety program. Facilitated by Maternity Consumer Representatives. Attended by Breastfeeding advisor and other members of Maternity Team. Good feedback obtained around ways to serve our consumers better including around breastfeeding and access to help when required. Next Consumer Forum currently being planned

3. Increasing Immunisation

Outcome: 95% 8 month olds completing primary course of immunisation

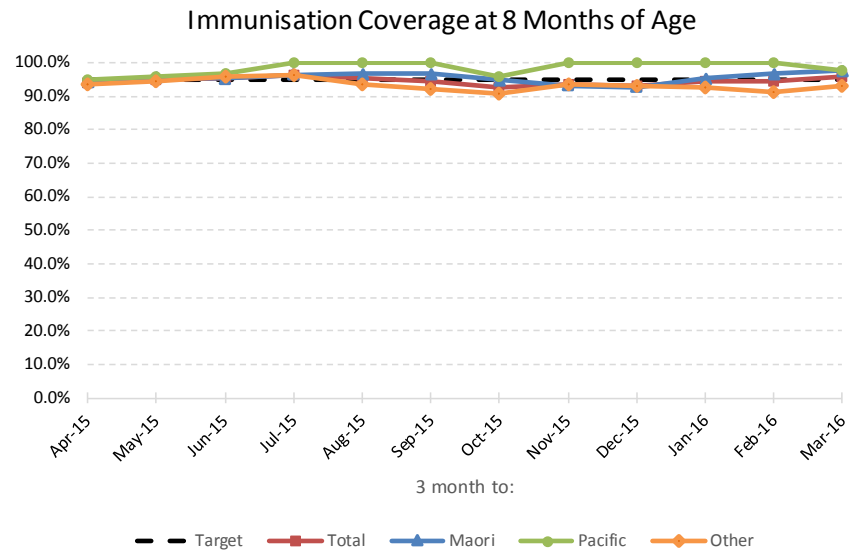
Key Performance Measures	Baseline [14]	Previous result[15]	Actual to Date[16]	Target 15-16	Trend direction
Māori	95.9%	92.6% (U)	97.7% (F)	≥95%	▲
Pacific	100.0%	100% (F)	97.6% (F)	≥95%	▼
Other	95.7%	93.3% (U)	93.2% (U)	≥95%	▼
Total	96.0%	93.3% (U)	95.8% (F)	≥95%	▲

Comments:

The Ministry of Health have taken over the reporting for Childhood Immunisations. Reporting up to 31 March 2016 is not expected until the 4th week of May 2016. As at 31 December 2016 Health Hawke's Bay had a 95% coverage rate for 8 month Immunisations. Māori coverage rates were also 95%. The 2 year old immunisation coverage rate was 94% for total population and 95% for Māori.

Target achieved for the quarter ending 31 March 2016.

Time series



Source: National Immunisation Register, Ministry of Health

Outcome: 95% of two year olds are up to date with immunisations

14 October to December 2014

15 October to December 2015

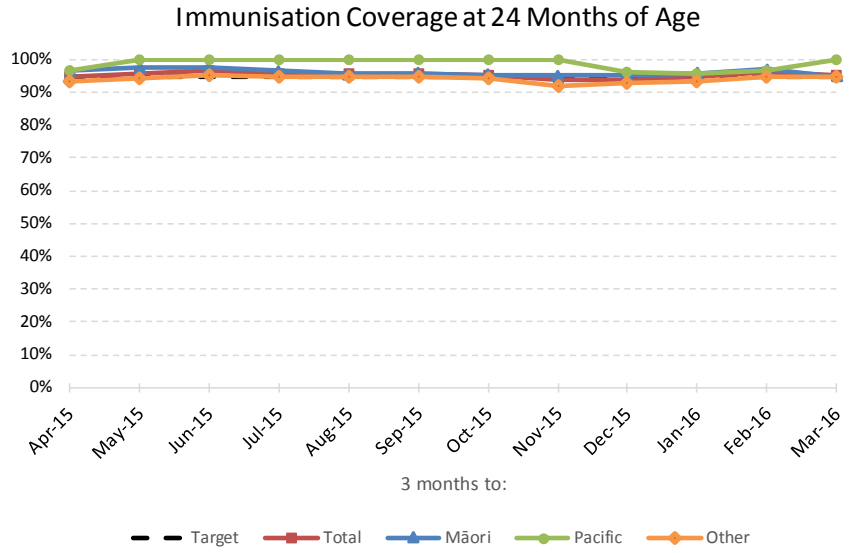
16 January to March 2016

Key Performance Measures	Baseline [17]	Previous result[18]	Actual to Date[19]	Target 15-16	Trend direction
Māori	95.0%	95.1% (F)	94.8% (F)	≥95%	▼
Pacific	95.0%	96.2% (F)	100% (F)	≥95%	▲
Other	91.8%	92.9% (U)	94.9% (F)	≥95%	▲
Total	94.4%	93.9% (U)	95.1% (F)	≥95%	▲

Comments:

Target achieved for total population. One further child would have achieved the threshold of 95% for Māori.

Time series



Source: National Immunisation Register, Ministry of Health

17

17 October to December 2014

18 October to December 2015

19 January to March 2016

Outcome: Working toward 95% of four year olds being up to date with immunisations

Key Performance Measures	Baseline [20]	Previous result[21]	Actual to Date[22]	Target 15-16	Trend direction
Māori	-	94.2% (F)	93.2% (F)	≥90%	▼
Pacific	-	96.4% (F)	92.6% (F)	≥90%	▼
Other	-	91.1% (F)	91.2% (F)	≥90%	▲
Total	90.6%	92.7% (F)	92.2% (F)	≥90%	▼

Comments:

Target achieved.

Time series

As this is a new indicator there is not enough data to produce a time series chart.

95	Health Hawkes Bay PHO-587862	94.88	95.53	✓ -0.53
95	Maori	95.42	95.07	✓ -0.07
95	Pacific	95.24	100.00	✓ -5.00
95	Other-Quintile 5	90.00	94.29	✗ 0.71
95	Asian-Quintile 5	100.00	100.00	✓ -5.00
95	National	93.20	93.83	✗ 1.17

Source: Health Hawke's Bay IPIF Data Information

Planned Activities and Progress

ID	Actions/Activity	Date	Lead	Quantitative Measures	Qualitative Measures	Progress	Progress Comments
3.1	**Maintain immunisation coverage of 8 month infants and 2 year old children at 95% or above and working toward 95% of four year old children being up to date with immunisations ensuring equity of coverage between different ethnic populations**						
3.1.1	Facilitate HBDHB Immunisation Steering Group meetings	ongoing	HBDHB	# quarterly steering group meetings held	Datamart reports on immunisation showing numbers, rates, geographical coverage, equity, etc. distributed to key stakeholders	On track	1 meeting held

20 October to December 2014

21 October to December 2015

22 January to March 2016

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
3.1.2	Coordinate Inter-agency activities to promote Immunisation Week	Q4	HBDHB	Inter-agency activities to promote Immunisation Week held Narrative report on activities to promote Immunisation Week		N/A	
3.1.3	Carry out Practice Patient Management System (PMS) audit to identify children who have not received immunisations; due and overdue	Ongoing	PHO Lead	# of children who have not received immunisations; due and overdue.		On track	No change from Q2.
3.1.4	Recall children who have not received immunisations; due and overdue and refer them to outreach services	Ongoing	PHO Lead	# of children referred to outreach services for immunization		On track	Referrals are made to the HBDHB Immunisation Team not Health Hawke's Bay. This information can be provided by the HBDHB Immunisation Coordinator Fiona Jackson. There were 412 referrals to the outreach team for the quarter ending March2016 of which 290 identified as Māori, 248 children were immunised for this quarter and there were immunisation outcomes identified for a further 57 children. – Fiona Jackson
3.1.5	Strengthen relationships with Māori service providers to ensure appropriate service delivery	Ongoing	HBDHB PHO		Reported levels of engagement with Māori service providers and frequency	On track	Education session held with TTOH staff this quarter.
3.2	**NIR is well coordinated - NIR is used to its maximum potential and assists HBDHB to reach and maintain its immunisation targets.**						
3.2.1	Update NIR Datamart regularly to measure coverage rate and show immunization trends	Ongoing	HBDHB		NIR provides valuable and accurate personal and population health data to inform	On track	Datamart report monitored fortnightly by Immunisation Coordinator

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
					implementation of immunization programme.		
3.2.2	Provide feedback to primary care providers on coverage rates	Q2 Q4	HBDHB		Primary care providers are informed on their areas of strength and weakness in immunization coverage	N/A	Letter sent out to primary care practices in March advising of their practices immunisation coverage for 8 month and 2 year olds and informing them of the HB regions coverage for 4 year olds and HPV (cervical cancer vaccination) in girls born 2002
3.2.3	Hold 6-monthly meetings with Tamariki Ora providers to share results and learnings	Q2 Q4	HBDHB	# of 6-monthly meetings held		Behind schedule	Meeting held with TTOH this quarter.
3.2.4	Carry out an audit of immunisations completed at the time of B4SC in primary care	Ongoing	HBDHB PHO	# of children immunized during B4SC		Behind schedule	Audit not carried out yet. This audit is to be completed in the 4th quarter.

Outcome: Increase the percentage of Māori ≥65 years having annual influenza vaccination

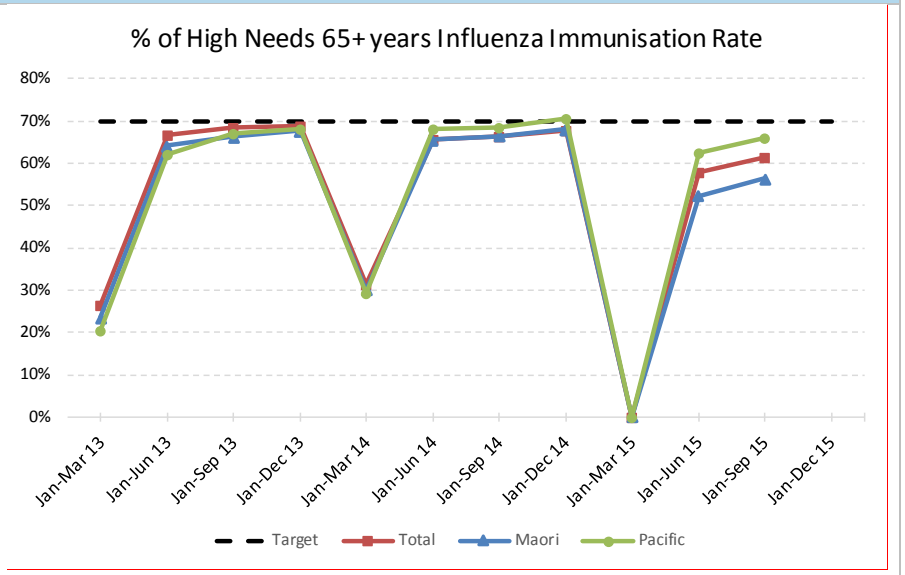
Key Performance Measures	Baseline [23]	Previous result[24]	Actual to Date[25]	Target 15-16	Trend direction
Māori	68.0%	52.4% (U)	56.5% (U)	≥75%	▲
Pacific	70.7%	62.4% (U)	65.9% (U)	≥75%	▲
Other	67.6%	61.9% (U)	65.1% (U)	≥75%	▲
Total	67.9%	57.9% (U)	61.5% (U)	≥75%	▲

Comments:
Contracts with Central Health, Te Kupenga Hauora and Takapau Health Centre in place to provide immunisation to those that are eligible for free influenza vaccination.

Working with Health HB PHO to be able to capture data which will give an indication of coverage for Māori 65 years and over.

There is no completely accurate tool available at present to reflect coverage.

Time series



17

23 January to December 2014

24

25 January to June 2015

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
3.3	**Increase the % of Māori ≥ 65 years having annual influenza vaccination.**						
3.3.1	Collaborate with Māori providers and HHB to promote uptake of the influenza vaccination for Māori ≥ 65years.	Q3 Q4	HBDHB	# of Māori ≥ 65years vaccinated for influenza		N/A	Met with Health HB PHO in February for preliminary discussions toward increasing uptake and being able to capture a measurement for this.
3.3.2	Carry out Practice PMS audit systems to identify those eligible for influenza vaccination	Q3 Q4	PHO lead	# of Māori ≥ 65years identified for influenza vaccination			Influenza was a PHO Performance Programme (PPP) Indicator, but is not an Integrated Performance and Incentive Framework (IPIF) Indicator. There is no data available from the Ministry of Health. The DrInfo Audit Tool indicates Health Hawke's Bay has 26,528 patients >65 years who are eligible for a free flu vaccination, as at 31 March 2016 35% of eligible patients have received a flu vaccination.
3.3.3	Work with the Practice to recall Māori ≥ 65years identified for influenza vaccination	Q3 and/or Q4	PHO lead	# of Māori ≥ 65years recalled and vaccinated for influenza			There are 6175 eligible High Needs (Māori, Pacific & Quintile 5) patients >65 years, 36% of whom have had a free flu vaccination.

4. Reducing Rheumatic Fever

Outcome: Less hospitalisations for ARF with a concentrated effort in areas with high Māori and Pasifika populations. Hawke's Bay baseline rate (2011/12) was 4.3 hospital admissions per 100,000 population. Hospitalisation rate per 100,000 - less than 1.9

Key Performance Measures	Baseline	Previous result	Actual to Date [26]	Target 15-16	Trend direction	
Māori	4.3 per 100,000	0 per 100,000	-	≤1.9 per 100,000		No new figures provided by the Ministry. **Comments:**
Non- Māori		0 per 100,000	-	≤1.9 per 100,000		On track to meet MoH target

Planned Activities and Progress

ID	Actions/Activity	Date	Lead	Quantitative Measures	Qualitative Measures	Progress	Progress Comments
4.1 Implement rheumatic fever prevention programme							
4.1.1	Implement new healthy homes programme	45 per Q	Liz	180 referrals resulting to housing improvements		**Complete**	Programme fully implemented and is now in 2nd year of operation
4.1.2	Promote and participate in cross-government promotional workshops	Ongoing	Liz	# of cross-government promotional workshops held	Workshops attended by the right people from the MSD and HNZ Meeting actions carried out	On track	Housing Coalition forum now in place and meeting monthly. Child Healthy Housing Programme governance quarterly meetings
4.1.3	Hold bi-monthly meetings of Healthy Homes Governance Group	Ongoing	Liz	# of meetings held	Meetings attended by the right number and right people Meeting actions carried out	On track	Terms of reference reviewed. Meetings are quarterly rather than bi-monthly now that programme is fully implemented. 1 meeting held this quarter
4.1.4	Implement Healthy Housing Initiatives according to the MOH reporting requirements	Ongoing	Liz	# Healthy Housing initiative reports	Healthy Housing Initiative reports meets the MOH reporting requirements	**Complete**	

26 July – September 2015

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
4.1.5	Initiate rheumatic fever prevention awareness in other non-Say Ah low decile schools	Ongoing	Shari	of non Say Ah at non-Say Ah low docile schools		On track	Extensive awareness raising activities planned for terms 2 & 3
4.1.6	Extend opportunist throat swabbing services in SBHS low decile secondary schools		Liz	# of SBHS low decile secondary schools covered # swabs taken in SBHS		On track	Delays receiving contract from MoH. Programme will now be implemented May 2016.
4.2 Prevent and treat Group A streptococcal throat infections							
4.2.1	Review school throat swabbing programme	Q2	Nicky/Caroline		A review report on school throat swabbing programme	On track	No change from Q2
4.2.2	Complete annual standing orders update	Q3	Nicky/Sonya	Annual standing orders updated - # of CME/CNE sessions held		On track	No change from Q2
4.2.3	Develop and monitor wider use of standing orders in primary care	Ongoing	Nicky Sonya	# of providers (GP and Hauora) using Standing Orders		On track	No change from Q2
4.2.4	Use coordinated primary options approach to fund access to free rapid-response sore throat management services in general practices	Ongoing	Nicky & Sonya	# of services funded		On track	No change from Q2
4.3 Actions to facilitate the effective follow-up of identified rheumatic fever cases.							
4.3.1	Monitor time between admission and notification of all new cases of rheumatic fever	Ongoing	Liz	% of patients notified within 7 days of diagnosis		On track	1 new case of ARF notified within timeframe
4.3.2	Carry out reviews of all cases, provide a report to the Ministry showing actions taken and lessons learnt	Ongoing	Liz	A report of case analysis, actions taken and lessons learnt		On track	Case review held and appropriate actions /follow up undertaken

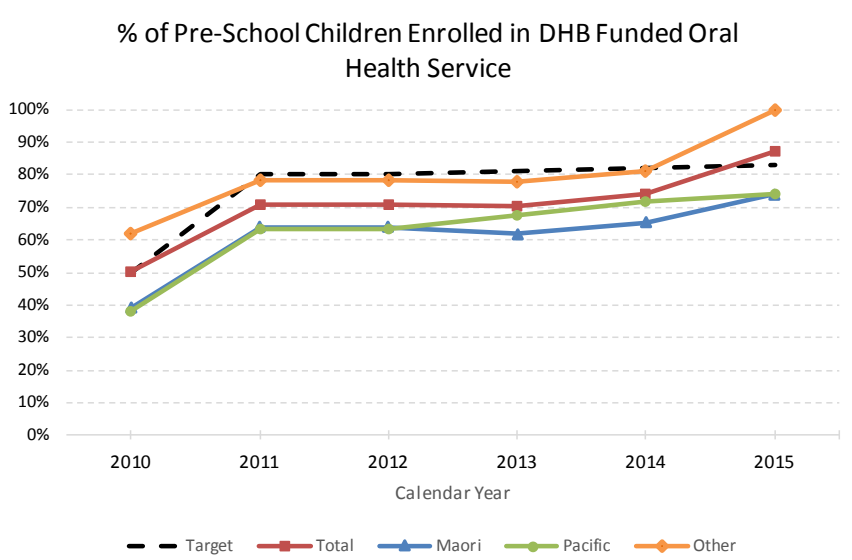
5. Oral Health

Outcome: More pre-school enrolments in the community oral health service (COHS) - 90% children under 5 years of age enrolled in community oral health services

Key Performance Measures	Baseline [27]	Previous result[28]	Actual to Date[29]	Target 15-16	Trend direction	Time series
Māori:	65.3%	65.3% (U)	74.1% (U)	≥90%	▲	
Pacific:	71.7%	71.7% (U)	74.2% (U)	≥90%	▲	
Other:	81.3%	81.3% (U)	99.8% (F)	≥90%	▲	
Total	73.9%	73.9% (U)	87.1% (U)	≥90%	▲	

Comments

Results available Early 2016 for the 2015 calendar year.



27 2013 calendar year

28 2014 calendar year

29

17

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
5.1	**Promote pre-school enrolment of children at community oral health services (COHS)**						
5.1.1	Co-ordinate COHS with new born enrolment process to increase enrolments of children by the 1st birthday	Quarterly	Ruth	% of children enrolled with COHS by their 1st birthday		**Complete**	Quadruple enrolment is embedded and continues as daily business practice – this is being led by the DHB maternity team prior to discharge postnatally.
5.1.2	Collaborate with immunisation outreach services to provide opportunistic oral health education and facilitate access COHS.	Q3	Ruth/Kelly	# of children provided with oral health education	All children who DNA are referred to COHS	**Complete**	Reported in the last quarter report
5.1.3	Carry out risk profiling of pre-school children to determine recall periods (6-12 months).	Ongoing	Ruth/Robin		Review periods (6-12 months) for pre-school children established	On track	No change from Q2.
5.1.4	Provide home intervention with fluoride varnish for children not attending clinics at Wairoa to reduce carries among 5 year olds	Q1 & 2	Ruth	# of children reached with fluoride varnish through home interventions	Desktop audit report on effectiveness of home interventions	On track	Since March 15 children have had fluoride applications provided at home or at Kōhanga visits.

6. Sudden Unexplained Death of Infant

Outcome: Reduce the number of SUDI deaths per 1,000 live births - Target <0.5 deaths per 1,000 live births.

Key Performance Measures	Baseline [30]	Previous Result[31]	Actual to Date[32]	Target 2015/16	Trend Direction	Time series
Māori	4.60	-	2.09	≤0.4	*	
Non Māori	2.14	-	-	≤0.4	*	
Total	0.00	-	1.16	≤0.4	*	

Comments:

Community based Safe Sleep Kaiawhina establishing wider networks across marae and community agencies. Focus area on supporting the development of weaving network in Hawke's Bay (Wahakura).

30 2010 calendar year

31 -

32 2010-2014 average annualised

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
6.1	**Carry out activities to address Sudden Unexplained Death of Infant (SUDI)**						
6.1.1	Coordinate quarterly multi-sectorial Safe Sleep action group	Quarterly	Jules/ Katie	# of safe sleep meetings held	Meeting minutes with appropriate quorums	On track	1 meeting held – These held quarterly
6.1.2	Train safe sleep champions within and outside HBDHB	Quarterly	Jules	# of training sessions carried out # of people trained	Profile of attendees	On track	19 training sessions offered. One on one education to 7 staff.
6.1.3	provide safe sleep education and pepi pod training to new WCTO staff and relevant HBDHB maternity and child health staff	Quarterly	Jules	Number of training sessions provided	Profile of attendees	On track	Education provided to 1 Plunket nurse. Staff Updates to 24 maternity staff, including LMC's. Paediatric staff update to 8 RN's. Visits to 13 GP Practices where safe sleep education given to 57 RNs & GP's.
6.1.4	Hold one on one safe sleep conversations (antenatal and postnatal) to ensure all whānau fully prepared and understand the importance of a safe sleeping environment and the risk factors for SUDI	Quarterly	Jules	% of mothers & whānau who have one on one safe sleep conversations at discharge (annual audit completed by Q2) % of Māori whānau provided with a Pepi-pod (Quarterly) % of Māori whānau who are not smoke-free provided with a pepi-pod		On track	In Q3, 79% (254) pregnant women received safe sleep conversation – this is in relation to data entry rather than actual conversations – on manual check all women and whānau are receiving safe sleep conversations prior to discharge. Work in progress with our admin support in relation to data entry. 66% (82) of Māori whānau received a Pepi pod. 100% of Māori Whānau who are not smoke free provided with a Pepi pod.
6.1.5	Establish Community Safe Sleep Coordinator role	Q3	Jules	Community Safe Sleep Coordinator role established		**Complete**	Position Filled
6.1.6	Provide safe sleep education and/or champion training in community settings	Quarterly	Katie	# of community based locations provided with Safe Sleep education//or champion training		On track	Attendance at ECE Seminar attended by 260 people – One on one safe sleep conversations with 50+ attendees.

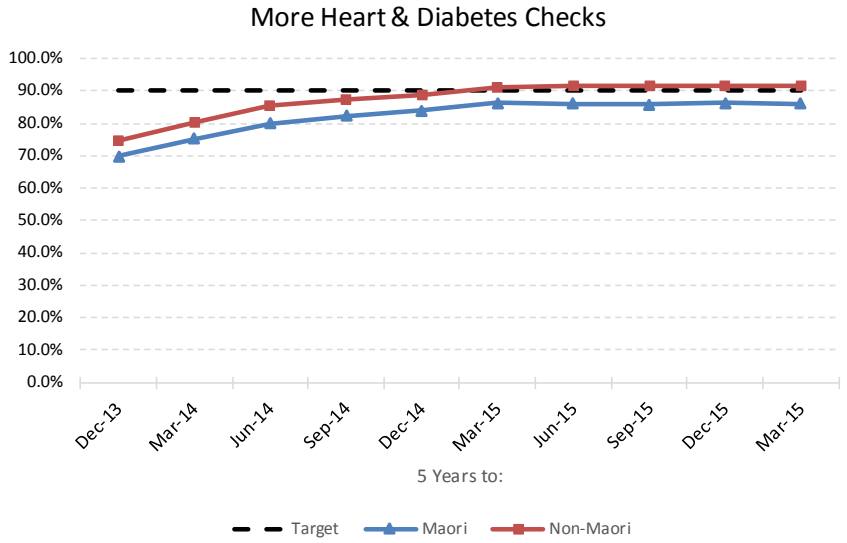
Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
				# of retailers provided with Safe sleep information/resources per quarter once role is established.			Safe Sleep Kaiawhina establishing in role. Revisiting retailer audit to establish education program.
6.1.7	Increase the number of women attending pregnancy and parenting education	Quarterly	Jules	% and number of Māori/Pacifica and teen attending DHB funded antenatal education		On track	One full set of classes held in this period with the next set commencing in late March 2016. 54 Women were enrolled to attend DHB funded classes. Of these: 19 were Māori, 2 were pacifica and 13 were aged <20 years. Much improved attendance noted with significant resource to increase visibility of classes in the community and working with key agencies and LMCs to receive referrals Feedback from classes suggests women are valuing classes but attendance to the MOH mandated 80% and booking numbers remain challenging.
6.1.8	Hold quarterly meeting with WCTO providers	Quarterly	Katie	# of meetings held		On track	Meetings held 6 weekly intervals as part of WCTO Quality project (2 meetings this quarter)
6.1.9	Ensure early notification and completion of referrals to WCTO provider enabling Safe sleep conversations to occur as part of core contact one	Q2/Q4	Katie	% of infants receiving core 1 by ethnicity % of infants provided with SUDI information at Core 1		On track	Data for period July to June 2015 shows that 63.3% of Māori babies were enrolled by 6 weeks of age, and 72.8% received SUDI information as part of core 1

7. Cardiovascular Disease

Outcome: Achieve the national Health Target: More heart and diabetes checks

Key Performance Measures	Baseline [33]	Previous result [34]	Actual to Date [35]	Target 15-16	Trend direction
Māori	83.9%	86.3% (U)	86% (U)	≥90%	▼
Pacific	83.7%	87% (U)	86.3% (U)	≥90%	▼
Other	87.0%	91.7% (F)	90.8% (F)	≥90%	▼
Total	87.7%	90.3% (F)	89.6% (F)	≥90%	▼
Māori Men 35-44	Data not yet available by age and gender				
Māori Women 45-55					
Non- Māori Total					

Time series



Comments:

The Ministry of Health has taken over the reporting for CVDRA's. Reporting up to 31 March 2016 is not expected until the 4th week of May 2016. As at 31 December 201 90% of Health Hawke's Bay's eligible population has received a CVDRA in the past 5 years. The coverage rate for Māori was 86%.

Health Hawke's Bay continues to focus on achieving equity for our Māori and Pacific enrolled population. Six general practices are now engaged with our CVDRA Rebel Sports Promotion where general practice are funded $20 per eligible Māori and Pacific patients so they can receive a free CVDRA and then the patient is rewarded with $20 Rebel Sports Gift Card.

33 5 years to December 2014

34 5 years to December 2015

35 5 years to March 2016

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
7.1	**Carry out activities to promote heart and diabetes checks**						
7.1.1	Carry out PMS audits with a particular focus on those who are coming due to cardiovascular risk assessment (CVRA).	Ongoing	PHO Performance Manager	90% of the eligible population have received CVRA PMS quality /clinical audits on interventions			The Ministry of Health has taken over the reporting for CVDRA's. Reporting up to 31 March 2016 is not expected until the 4th week of May 2016. As at 31 December 201 90% of Health Hawke's Bay's eligible population has received a CVDRA in the past 5 years. The coverage rate for Māori was 86%.
7.1.2	Work with health business intelligence team to refine predictor tools to assist Practices to manage the total cohort of their screened population	Ongoing	PHO Performance Manager	Predictor tools to assist Practices in screening their population		On track	Health Hawke's Bay continues to fund Karo to provide monthly and quarterly reporting to all 28 general practices; and DrInfo to provide monthly reporting. As at DrInfo indicates there are 1156 new patients becoming eligible for CVDRA in the next 12 months, and 411 patients who have had one > 5 years ago in the next 12 months. NB: This cannot be disaggregated for Māori.
7.1.3	Work with the General Practice facilitation team to support practices achieve expected benchmark.	Ongoing	PHO Performance Manager	# of Practices supported to achieve and maintain expected benchmark		On track	The Health Hawke's Bay General Practice Facilitators meet with General practices at least monthly. DrInfo indicates the eligible total population has increased by 96 patients in the last quarter. Eligible high needs patients (Māori, Pacific and Quintile 5) patients have increased by 2,609 in the last quarter.
7.1.4	Work with specific outreach nursing services to target workplaces with high Māori men (e.g. Napier port, Ravensdown etc.).	Ongoing	PHO Performance Manager	# of Māori men reached through outreach nursing services		Behind schedule	Health Hawke's Bay has funded an Independent Nurse to provide CVDRA in an outreach clinic in Raureka using point of care testing equipment.

Outcome: Patients with suspected Acute Coronary Syndrome receive seamless, coordinated care across the clinical pathway						
Key Performance Measures	Baseline [36]	Previous result[37]	Actual to Date[38]	Target 15-16	Trend direction	
% high-risk patients receiving an angiogram within 3 days						
Māori	66.7%	60% (U)	80% (F)	≥70%	▲	**Comments** Access to Angio at HBDHB is constrained due to Radiology Lab availability, staff availability and time constraints for Cardiologists to perform angiography on Fridays. Timely transfer to CCDHB for angiography is reliant on CCDHB lab availability also. Cardiologists have agreed on and implemented standard criteria for direct referral to CCDHB for in-patients admitted at times when access to the local service is unavailable within 72 hours. ANZACS-QI Interventional within 72 hrs. Is 98.7% as of 18/2/16.
Total	62.3%	67.1% (U)	71.1% (F)	≥70%	▲	
% of angiography patients whose data is recorded on national databases						
Māori	12.5%	71.4% (U)	100% (F)	≥95%	▲	A lack of resources to complete manual capture of data across systems continues to hamper efforts to improve this indicator. CCDHB (Capital and Coast District Health Board) has offered support recently to address delays in entering data. In addition, options for automation and/or process review are being considered. The service is also confirming a reallocation of resources to support this task over coming months so an increase in performance is expected. 19/2/2016. ANZACS-QI data "cleaned" Incomplete data currently sitting at 1%
Total	27.8%	84.1% (U)	100% (F)	≥95%	▲	

17

36 October to December 2014

37 October to December 2015

38 January to March 2016

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
7.2	**Carry out activities to promote better patient access to care services**						
7.2.1	Implement agreed protocol for patients' referrals to regional centres where local angiography services are not feasible within 72 hours	Ongoing	Gay	Acute ACS patients with ongoing cardiac pain and ECG changes are referred to Wellington for interventions.		On track	Acceptance of patients to C&C is reliant on bed availability at Wellington.
7.2.2	Explore other strategies to improve access to coronary angiography at HBDHB	March 2016	Gay	Other strategies to improve access to coronary angiography at HBDHB identified		On track	Cardiac service now has access to cardiac angiogram on Friday am in X-ray. This strategy is reliant on availability of Cardiologist to perform the angiogram.
7.2.3	Assign responsibility and resource for ANZACS-QI data capture		Gay	Lead responsible staff identified and resource for ANZACS-QI data capture in place		On track	ANZQIS-QI Capital & Coast staff are assisting HBDHB to input data 98% entered for February 2016
7.2.4	Establish measures of ACS risk stratification and timeliness for patients to receive appropriate intervention	June 2016	Gay	Measures of ACS risk stratification in place		**Complete**	Completed clinical pathways for assessing ACS. These pathways have been developed to commence in the PHO. The pathways will require discussion and acceptance by GP's to assist with ACS risk stratification.

8. Cancer Screening

Outcome: Achieve the National Cervical Screening Programme (NCSP) national target – 80% of 25-69 years

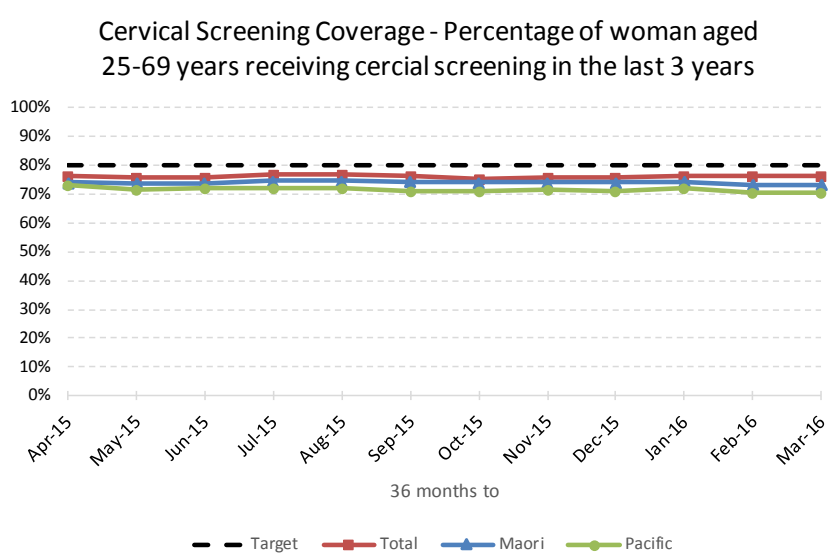
Key Performance Measures	Baseline [39]	Previous result[40]	Actual to Date[41]	Target 15-16	Trend direction
Māori	73.8%	74.1% (U)	73.2% (U)	≥80%	▼
Pacific	72.8%	71.2% (U)	70.4% (U)	≥80%	▼
Other	78.0%	76.5% (U)	77.2% (U)	≥80%	▲
Total	76.9%	75.8% (U)	76.1% (U)	≥80%	▲

Comments:

Hawke's Bay continues to be the top performing DHB for Māori cervical screening coverage.

The Best Practice in Primary Care project continues in addition to the separate campaign offering free cervical smear tests and $20 grocery vouchers to unscreened and under-screened priority group women.

Time series



Source: National Screening Unit

39 3 years to December 2014

40 3 years to December 2015

41 3 years to March 2016

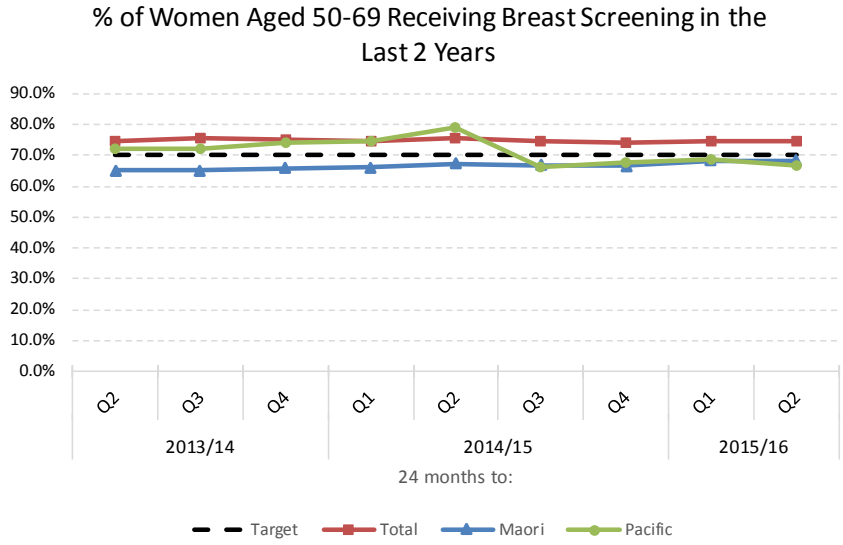
Outcome: Achieve the National Breast Screen Aotearoa (BSA) national target – 70% of 50-69 years

Key Performance Measures	Baseline [42]	Previous result[43]	Actual to Date[44]	Target 15-16	Trend direction
Māori	67.2%	68.4% (U)	68.4% (U)	≥70%	—
Pacific	79.0%	68.5% (U)	66.5% (U)	≥70%	▼
Other	77.2%	75.8% (F)	79% (F)	≥70%	▲
Total	75.8%	74.6% (F)	74.7% (F)	≥70%	▲

Comments:
Breast screening coverage is steadily improving. As at end of February 2016, there were only 33 additional Māori women and seven Pacific women to achieve the 70% target.

BreastScreen Coast to Coast's mobile screening unit visited Wairoa from 2-12 February. For the alternate year, these results are the best to date. 177 women were screened, 35 more than the previous visit in 2014. An increase in the numbers of Rescreens (+29), New screens (+6) and very positive results for Māori women with 27 more in total than 2014, 23 being new women.

Time series

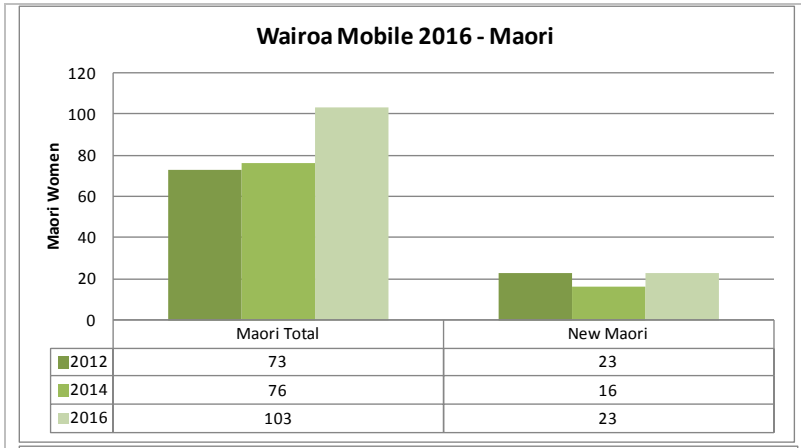


Source: National Screening Unit

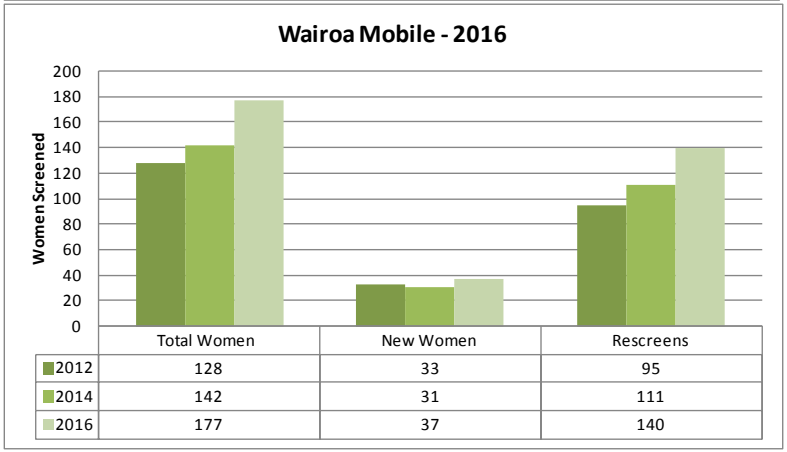
42 24 months to December 2014

43 24 months to September 2015

44 24 months to December 2015



	Maori Total	New Maori
2012	73	23
2014	76	16
2016	103	23



	Total Women	New Women	Rescreens
2012	128	33	95
2014	142	31	111
2016	177	37	140

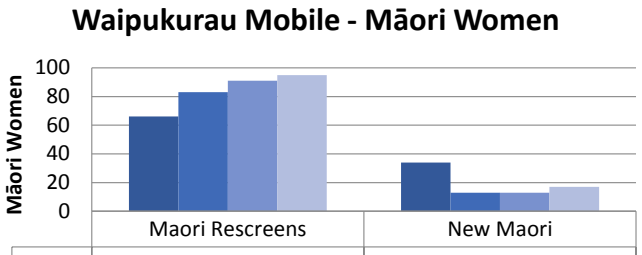
There were 212 women batch generated into sessions. Some additional appointments may have been made while the mobile was in Wairoa. 44 women DNA'd at least once. 38 of the DNA's were Māori women who were actively followed up by the ISP in Wairoa. 15 of these women then attended. 4 of the DNA's were opted out of the programme because they had either moved and/or were unable to be contacted.

17

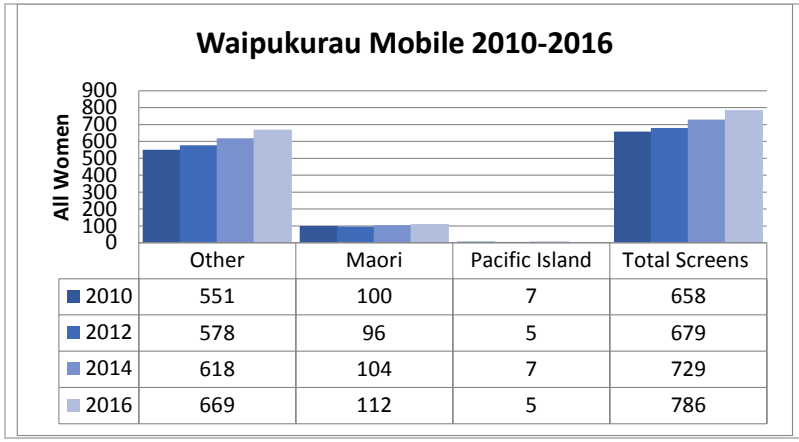
WAIROA DNA'S 2016			
	DNA	Screened	Total
Maori	38	15	23
Non-Maori	6	0	6
	44	15	29

Outcome	Maori - Not Screened	Non-Maori
Recall 2017	17	6
Non-BSA Mamm	1	0
Opted Out - Moved	4	0
Recall to Napier	1	0
Total	23	6

The mobile screening unit also visited Waipukurau from 29 February to 14 April. A total of 112 Māori women were screened, 17 of which were new screens.



	Maori Rescreens	New Maori
2010	66	34
2012	83	13
2014	91	13
2016	95	17



	Other	Maori	Pacific Island	Total Screens
2010	551	100	7	658
2012	578	96	5	679
2014	618	104	7	729
2016	669	112	5	786

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
8.1	**Carry out activities to promote breast and cervical screening**						
8.1.1	Fund high priority (Quintile 5 areas) Māori, Pacific, Asian, >30 years with no smear history, and 5 years lapsed history	Quarterly	PHO	# of Māori, Pasifika and Asian women funded women screened for cervical cancer		On track	508 x Māori 75 x Pacific 93 x Asian 6 x Unscreened >30yrs 1st smear 71 x Under-screened >30yrs no smear >5yrs 2 x Other women Quintile 5 (SIA Funded)
8.1.2	Carry out cervical screening promotional activities including extending $20 vouchers for Māori women who are overdue for screening in 2015-2016	Quarterly	PHO	# of Māori women receiving vouchers # of Māori women screened		On track	As at 31 March 2016, (updated as invoices come are submitted) 623/771 $20 Pak N Save Gift Cards were vouchers were given to Māori women (81%) since 1 July 2015. 146/179 in the last quarter (82%).
8.1.3	Support community cervical screening events with high numbers of Māori women participation	Quarterly	PHO	# of community screening events held		On track	Health Hawke's Bay participated in the Waitangi Day Celebrations held at the Hawke's Bay Sports park on 6th February 2016. Health

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
							Hawke's Bay and HBDHB worked in partnership to provide women with their cervical screening history and encouraged due and overdue women to access cervical screening at either their general practice or one of our five Māori Health Providers. All women who visited the stall were entered into a draw for two gift hampers.
8.1.4	Build the capacity of screening services in rural communities.	Quarterly	PHO	Screening capacity in place in the rural communities			No activity this quarter.
8.1.5	Manage one campaign promoting cervical screening during cervical screening month	Quarterly	PHO	Cervical screening campaign carried out	Campaign report	**Complete**	
8.1.6	Facilitate regional coordination of the National Cervical Screening Programme and Breast Screen Aotearoa pathways	Ongoing	Jenny Cawston	4 Steering Group meetings held per annum 6 Provider meetings held per annum.	70% of HB NCSP & BSA service providers represented at Steering Group meetings and Provider meetings.	On track	Steering group meeting held in February. 56% of providers represented at meeting Provider meeting held in March, of which 71% of service providers were represented at meeting.
8.1.7	Develop and implement annual Regional Action Plan for breast and cervical screening	Q4	Jenny Cawston		Regional Action Plan in place	On track	Regional Action Plan 2015/16 is being implemented. Draft Regional Action Plan for 2016/17 sent to National Screening Unit.
8.1.8	Pilot and roll out the quality improvement initiative 'Best Practice in Primary Care' (BPPC) project	Q4	Jenny Cawston	Best Practice in Primary Care initiative completed within three general practices.	% change between pre and post intervention audit per participating general practice.	On track	Action plans being implemented at each of the participating practices.
8.1.9	Ensure accuracy of data recorded on databases i.e. general practice patient management systems, laboratories, colposcopy /gyn, BSA and NCSP registers.	Ongoing	Jenny Cawston	# of HB general practices data matched with NCSP-R and BreastScreen Coast to Coast		On track	Eight general practices have been data matched against the NCSP Register in Q3.

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
	Conduct data matching between primary care patient management systems and BSA and NCSP registers.						
8.1.10	Advance competency for screening workforce	Ongoing	Jenny Cawston	Number of health professionals attending BSA and NCSP CME/CNE sessions and other locally offered training courses. Number of smear taker graduates.		On track	Preparing lecture content for EIT smear taker training course which is programmed for May 2016.
8.1.11	Employ recruitment and retention strategies targeting Māori and Pasifika populations.	Ongoing	Jenny Cawston	Number of identified Māori and Pacific women screened as a direct result of interventions	Evaluation reports reflect the different activities and outcomes of interventions targeting Māori.	Ongoing	Te Kupenga Hauora Ahuriri promotion day at Pukemokimoki Marae in January. 16 women spoken to, six were unscreened and followed up after the event. Three women completed cervical screening and one woman completed breast screening. Waitangi Day celebration. 129 women entered into the gift basket draw. 90% of these agreed to check their details on the NCSP Register, of which 19 addresses were updated and six women agreed to be followed up. Of these, two women have completed their screening to date. There were also a number of discussions regarding HPV Test of Cure and advice to talk to their Practice Nurse. Women were keen to see their details on the NCPS-Register. 371 letters posted to unscreened priority women and 884 letters to

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
							under-screened priority women in Q3. These women are clients of eight practices participating in the Pak n Save campaign where a $20 grocery voucher is offered to the women along with a free smear.
8.1.12	Work towards reducing DNAs for colposcopy first specialist appointment and follow up appointment, particularly for Māori women with CIN2 and CIN3	Ongoing	Jenny Cawston	Reduced number of DNAs for colposcopy FSA and follow-up appointments	% decrease in DNAs rates for colposcopy FSA and follow-up appointments	N/A	DNA data not available at present.
8.1.13	Support breast screening mobile unit visits at Wairoa and Waipukurau	Q4	Jenny Cawston	Number of new screens and rescreens	% increase of new screens and rescreens	**Complete**	Wairoa 2016 vs. 2014 *New screens:* Māori 44% increase *Combined new & rescreens:* Māori 36% increase Total Population: 25% increase Waipukurau 2016 vs. 2014 *New screens:* Māori: 31% increase *Rescreens:* Māori: 4% increase *Combined new & rescreens:* Māori: 8% increase Total Population: 8% increase
9. Smokefree							
Outcome: 86% of Māori women are smoke free at two weeks postnatal							

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**

Key Performance Measures	Baseline [45]	Previous result[46]	Actual to Date[47]	Target 15-16	Trend direction	Time series
Māori	58.0%	62.0% (U)	-	≥86%	*	*Data Source: Tamariki Ora Quality Improvement Framework September 2014*
Pacific	0.0%	96.0% (F)	-	≥86%	*	
Total	0.0%	79% (U)	-	≥86%	*	

Comments:
Please note this is WCP data and not maternity data. The maternity data is collected nationally and published in our MOH Clinical Indicator set – 2013 has recently been published and demonstrates for Hawke's Bay that 450 women of the 2004 who had a baby identified as smokers at 2 weeks post birth (22.5%) with the national average being 13.5%. This DHB is 5th highest in the country for non smokefree postnatal women.
What is encouraging to note in our local figures is an increase in smokefree postnatal women. This would primarily be due to the successful nappy incentive programme and the increased and sustained referral rate from DHB and LMC midwives to the programme.
April 2016 –The above comments still remain current

17

45 June 2014

46 July to December 2014

47 January to June 2015

Planned Activities and Progress							
ID	**Activity/Action**	**Date**	**Lead**	**Quantitative Measure**	**Qualitative Measure**	**Progress**	**Progress Comments**
9.1	**Increase LMC's confidence to provider Cessation support and to refer to cessation services**						
9.1.1	Complete Smokefree Education at Te Hapu Ora - change for children	Ongoing	Jules/Penny	Full workshop attendance at 2 study days			Te Hapu Smokefree Education is not being offered any more. Opportunities for up skilling LMC and DHB Health Professionals being explored

Outcome: 90% of pregnant women who identify as smokers upon registration with a DHB- employed midwife or Lead Maternity Carer (LMC) are offered brief advice & support to quit smoking

Key Performance Measures	Baseline [48]	Previous result[49]	Actual to Date[50]	Target 15-16	Trend direction	Time series
Māori	100.0%	95.2% (F)	86.2% (U)	≥90%	▼	Following the quarter two results the HBDHB completed an audit of those results complete with recommendations. The most pressing recommendation is too work with administration staff to clarify intervention process and identifying who the intervention relates too i.e.: the women or the partner. The HBDHB are currently auditing quarter three results.
Total	98.1%	96.5% (F)	88.6% (U)	≥90%	▼	

Planned Activities and Progress							
ID	Activity/Action	Date	Lead	Quantitative Measure	Qualitative Measure	Progress	Progress Comments
9.2	**Midwives and maternity services maintain ABC screening**						
9.2.1	Monitor reporting and identify trends in screening and where needed identify activities to increase screening	Ongoing	Jules	% of pregnant women who identify as smokers upon registration with a DHB - employed Midwife or Lead			Updated booking forms for LMC's are now being used for all new bookings. This includes more in depth information around smokefree status at booking and referral to Quit services.

48 October to December 2014

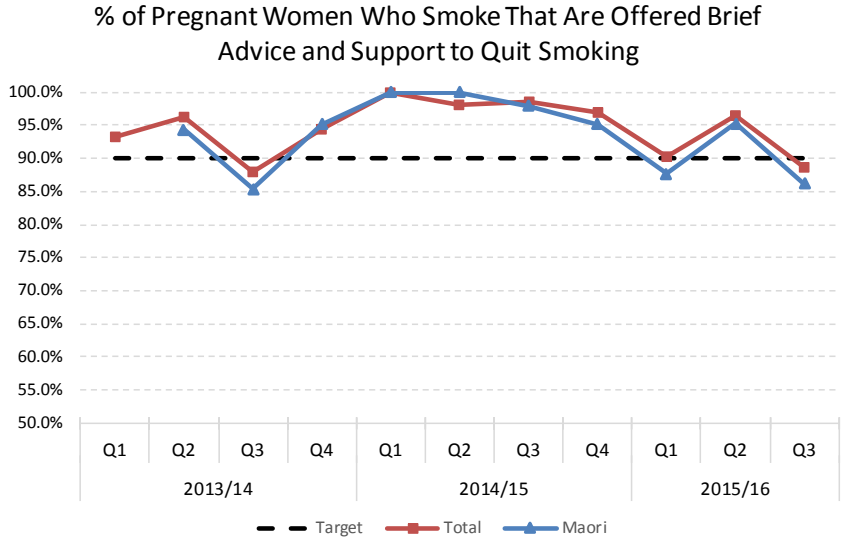
49 October to December 2015

50 January to March 2016

				Maternity Carer are offered advice and support to quit smoking.			Data from this not being reported yet as numbers not sufficient to be meaningful.
9.2.2	Provide training to Maternity staff including updates	Ongoing	Jules	Two study days and one update			This is included in our year on year refresher training for all Maternity Staff. It is part of student midwifery training

Comments:

The HBDHB understand that providing brief advice and referral through to cessation services is vital to smokefree pregnancies. Currently the HBDHB is working to implement the recommendations from the Increasing Smokefree Pregnancy Programme evaluation to help increase the attrition between referral and quitting.



Data Source: Ministry of Health

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
9.3	**Promoting smoking cessation among pregnant women**						
9.3.1	Promote incentivised smoking cessation programme targeted at young Māori women and their whānau	Quarterly	Penny and Pop Health advisor	of young Māori women are referred to cessation support		On track	79 referrals were received for the Increasing Smokefree Pregnancies Programme. 63 of the 79 were antenatal women. 18 Maori women who were also antenatal were referred in quarter three

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
9.3.2	Monitor and support smoking cessation programmes	Quarterly	Penny	# of monitoring and supervision meetings with provider and midwives # of implementation report	Implementation reports highlighting programme successes and challenges	On track	Smokefree Maternal and Child Health Coordinator attended the following meetings College of Midwives, Bi monthly interagency meeting, monthly clinical governance group, Smokefree Team and Choices monthly meetings,
9.4	**Reduce numbers of smokers to support the achievement of Smokefree 2025**						
9.4.1	Review the District-wide Smokefree Plan/strategy	Annually	Shari/Penny	District-wide Smokefree Plan/Strategy reviewed	One new Plan supports the 2025 goal	**Complete**	Plan approved by MoH and being delivered.
9.4.2	Develop a 5 year Smokefree Plan for the district	Quarter 2	Shari	5 year Smokefree Plan for the district in place		**Complete**	Extensive consultation and stakeholder involvement for the preparation of the plan. Has been tabled at the various committees and has been endorsed by the HBDHB Board in November. To be launched in February

10. Mental Health

Outcome: Reduced rate of Māori under compulsory treatment orders to < 81.5 per 100,000 (total population)

Key Performance Measures	Baseline [51]	Previous result[52]	Actual to Date[53]	Target 15-16	Trend direction	
Māori (per 100,000)	-	196 (U)	212.7 (U)	≤81.5	▼	**Comments**
Other (per 100,000)	-	93.4 (U)	99.6 (U)	≤81.5	▼	*All targets trending down which is more people going onto MHA.*
Total (per 100,000)	-	97 (U)	100.7 (U)	≤81.5	▼	

Planned Activities and Progress

ID	Actions/Activity	Date	Lead	Quantitative Measures	Qualitative Measures	Progress	Progress Comments
10.1	**Monitor mental health treatment activities and advice HBDHB as needed**						
10.1.1	Carry out an audit of patients subject to Compulsory Treatment Orders at HBDHB to determine factors associated with treatment under Mental Health Act in different patient groups	Report by Q3	Allison Stevenson	Audit report	Audit report highlight factors associated with treatment under Mental Health Act in different patient groups	Ongoing	Audit has commenced. Should have draft audit by next month.
10.1.2	Organize regular meetings between the hospital and community services providers to monitor progress of individuals subject to CTO and consider options		Allison Stevenson	Bi-monthly meetings and case reviews	Minutes of the meetings highlight progress of individuals and challenges under CTO where appropriate	Ongoing	Continue with meetings between community MDT meetings with DAMHS oversight.

51

52 *October to December 2015*

53 *January to March 2016*

11. Data Quality						
Outcome: Improved collection and reporting of Māori ethnic data.						
Key Performance Measures	Baseline	Previous result	Actual to Date	Target 15-16	Trend direction	Comments

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
11.1.	**Implement and monitor activities focused on enhancing collection and reporting of Māori ethnic data**						
11.1.1	Ensure General Practices forms and interview protocols enable self-identification of clients by ethnicity	Ongoing		% of client forms and interview protocols with complete ethnicity information			
11.1.2	PHO implementing the Primary Care Ethnicity Data Audit Toolkit???	Ongoing					
11.1.3	Increase workforce ability and confidence to ask about client ethnicity information	Ongoing		% of client information with ethnicity identification			
11.1.4	Work with providers to monitor and ensure correct ethnicity data quality			# of forms referred back to practices on missing or incomplete ethnicity data <1% “unknown” - reviewed quarterly			
11.1.5	Investigate and provide workforce development training opportunities on collecting ethnicity data			# attending workforce development training			To be scheduled

12. Obesity						
Outcome: Implement initiatives which align with an evidence based obesity prevention strategy						
Key Performance Measures	Baseline	Previous result	Actual to Date	Target 15-16	Trend direction	Comments

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
12.1 Complete a strategic obesity document which engages cross-sector partners							
12.1.1	Identify key partners to support improvements in obesity rate for Hawke's Bay particularly those able to influence Māori and Pasifika communities	Q2	Pop Health Team Leader		List of identified partners and their role in addressing obesity	On track	Presented as part of the Best Start: Healthy Eating and Activity Plan Stocktake complete
12.1.2	Consult with key communities to identify goals and activities which will address obesity - including Māori and Pasifika groups	Q3	Pop Health Team Leader	Consultation tool completed	Consultation includes sharing evidence-base which informed the strategy. Consulted groups include those engaging with Māori communities and whānau in key communities	On track	As per above
12.1.3	Draft a strategic document which supports the delivery of goals to achieve reductions in obesity	Q1	Pop Health Team Leader	Obesity strategic document approved	The obesity strategy reflects the health needs of Māori and Pacific population	**Complete**	Final draft for implementation plan (Best Start: Healthy Eating and Activity Plan), gone to Committee for approval.
12.1.4	Review effective tools, initiatives and programme in reducing obesity, nationally and internationally	2014/15		Project plan completed for initial programme	Strategy reflects the evidence-base. Programmes clearly identify effective tools and supporting evidence	**Complete**	Reflect co-design, WHO "Ending Childhood Obesity Report" recommendations and includes MRB feedback

12.2 Establish an inter-sectoral working group to support the implementation of the plan							
12.2.1	Identify key partners including those working with Māori, Pasifika and high deprived communities	Q2	Pop Health Team Leader	An inter-sectoral working group in place	An inter-sectoral working group includes identified partners including those working with Māori, Pasifika and high deprived communities	On track	No change from Q2.
12.2.2	Establish a process for cross-sector planning, delivery and monitoring for the obesity strategic document	Q3	Pop Health Team Leader	A process for planning, delivery and monitoring implementation of the strategy in place	Process with support the reduction of inequalities	On track	As per above
12.2.3	Maintain engagement with partners via meetings, work plans, shared activities and responsibility for outcomes.	On going	Pop Health Team Leader	3 meetings annually for Cross-sector group	Minutes reflect engagement including information sharing, work plan updates and consultation findings	On track	Meetings will commence once Plan is approved
12.2.4	Engage the working group members and agencies to advocate and promote the initiative	On going	Pop Health Team Leader	Number of advocacy and promotional activities carried out	Work plan includes advocacy and promotional activity Minute record completed advocacy and promotional activities.	On track	Training provided for Healthy First Foods, Healthy Conversations and Water Only Schools. Healthy First Foods promoted at Waitangi Day
12.3 Establish childhood obesity and reducing inequalities as DHB priority areas for delivery							
12.3.1	Gain DHB Board endorsement for DHB approach to addressing obesity across HBDHB.	Q1	Pop Health Team Leader	DHB Board endorsement of the strategy	Strategy has a preventive/population approach	**Complete**	Strategy endorsed, childhood focus, with a whānau approach and builds on existing effective programmes
12.3.2	Gain DHB members commitment and joint approach in advocating for initiatives to address obesity across HB	Q3	Pop Health Team Leader	Key DHB endorsed messages	Messages reflect evidence-base and community consultation	On-track	National messages supported- Big Change Small Start and Water Only Schools Local- Health First Foods
12.3.3	Develop business cases for the obesity programme to mobilize resources for implementation	2014/15		Business case complete	Business case align with strategy and is adequately resources	On-track	Draft prepared to present to EMT
12.3.4	Monitor obesity rate for children via B4 School Check data	On going	Pop Health Team Leader	Quarterly reporting via Population Health KPIs and TAW		On-track	No narrative report received.

12.3.5	Align obesity prevention activities with maternal nutrition, Kahungunu Hikoi Whenua, (KHW) child health, health promoting schools	2014/15			Activities reflect strategic direction, have consistent messages and engage relevant programmes	On-track	No narrative report received.
12.3.6	Implement the Breastfeeding Plan to support increased breastfeeding rates, among Māori and Pasifika women	/Q4 On going	Pop Health Team Leader	Breastfeeding plan developed and initiated Quarterly Breastfeeding data is report via Population Health KPIs	Plan engages key stakeholders	On-track	No narrative report received.
12.4 HBDHB to role model healthy eating and increasing physical activity							
12.4.1	Promote and monitor the implementation of the Healthy Eating Policy at HBDHB	2014/15	Pop Health	Project plan implemented	Activities, resources and communication raises awareness of the policy	On track	No narrative report received.
12.4.2	Develop a physical activity policy covering other initiatives including 'Journeys to Work', Occupational Health and Safety activities and events	Q4	Pop Health Team Leader	A policy supporting staff physical activity is developed and signed off	Policy includes journeys to work, OH&S and activities	On track	No narrative report received.
12.4.3	Develop a breastfeeding policy to support staff, visitors and client to be able to breastfeed on DHB premises	Q4	Pop Health Team Leader	A policy is signed off to support breastfeeding on DHB premises		On track	No narrative report received.
12.4.5	Promote three annual activities to support healthy eating and physical activity e.g. Cancer Society 'Relay for Life' and 'Iron Māori'	Q4	Human Resources	Health workplace plan is developed and includes activities which support healthy eating and physical activity	Staff are aware of the activities they can engage in including Relay for Life and Iron Māori	N/A	

13. Māori Workforce and Cultural Competency

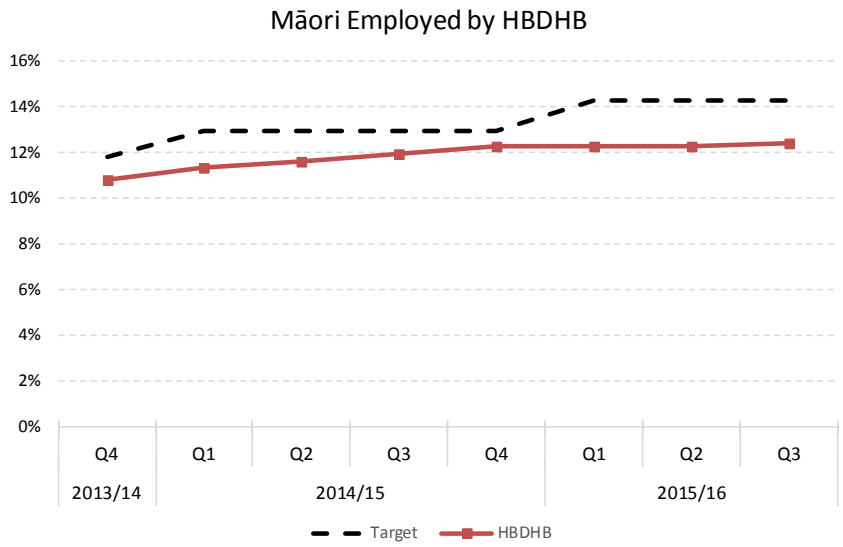
Outcome: Increased proportion of Māori employed by 10% yearly across HBDHB. Target 15/16 year 14.3%

Key Performance Measures	Baseline [54]	Previous result[55]	Actual to Date[56]	Target 15-16	Trend Direction
Medical	2.7%	2.9% (F)	3.2% (F)	-	▲
Management & Administration	15.7%	16.5% (F)	16.1% (F)	-	▼
Nursing	10.1%	10.6% (F)	10.7% (F)	-	▲
Allied Health	11.9%	12.6% (F)	12.4% (F)	-	▼
Support Staff	26.7%	28.2% (F)	30.2% (F)	-	▲
HBDHB	11.6%	12.3% (U)	12.4% (U)	≥14.3%	▲

Comments:

Overall we are also tracking the gap between current staffing and the DHB target of 14.3% and at 31st March the gap was 57 staff short of the target.

Time series



54 December 2014

55 December 2015

56 March 2016

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
13.1	**Promote and monitor increased proportion of Māori employed across HBDHB**						
13.1.1	Increase support for Māori nursing workforce through the Nursing Entry to Practice (NEtP) Programme	Ongoing	Di Wepa DON Māori Nursing	% of Māori nursing workforce supported through the NEtP Programme		On track	Recruitment for September intake underway. Applications close 10 May.
13.1.2	Maintain target focus and promote recruitment of Māori to all hiring managers	Ongoing	Di Wepa Paul Davies	# of Māori staff hired during the period	# of Māori staff hired during the period	On track	10.7% of nursing staff are Māori, a 0.6% increase over the last 12m. Current nursing staff who have started in the last 12 months; 16.7% were Māori.
13.1.3	Monitor increase of Māori recruited in Wairoa and in Allied Health roles	Ongoing	Di Wepa Paul Davies	# of new Māori staff employed in areas with high Māori usage in Wairoa		On track	40.0% of staff recruited at Wairoa in the last 12 months are Māori. 7.4% of staff recruited into Allied Health roles in the last 12 months are Māori.
13.1.4	Monitor increase of Māori recruited in Allied Health roles	Ongoing		# of new Māori staff employed in Allied Health roles		On track	12.4% of Allied Health staff are Māori. Meeting held in April with Recruitment and Allied Health Director and Professional leads to highlight ongoing need to increase Māori staffing and strategies to achieve this. Monthly end reports provided to Allied Health detailing staffing and gaps in each area e.g. Labs, Options, Physio, OT etc.
13.1.5	Use Māori and other relevant networks to promote vacancies to Māori	Ongoing	Di Wepa Paul Davies	# of Māori staff hired through relevant networks		On track	HBDHB use NKII now to advertise all vacancies weekly. HBDHB also use Te Pou (for mental Health roles and Mahi for advertising. All adverts on the DHB website, kiwihealthjobs and Seek now

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
							include the HBDHB values in Te Reo.
13.1.6	Connect Māori students with opportunities for health sector careers and career development through Tūruki Māori Health Workforce and Incubator programmes	Ongoing	Di Wepa	# of students connected to opportunities for health sector careers # of summer school paid positions Scholarships offered to Kahungunu students		On track	Scoping exercise underway by TTOH to ascertain where opportunities are in place with schools
13.1.7	Carry out a mid-term evaluation of Tūruki Māori Health Workforce strategy	Q3	Di Wepa Shane Whitley	A report on mid-term evaluation of Tūruki Māori Health Workforce strategy		On track	Dr George Gray is reviewing all documents supplied and has asked if there are any further documents that should be supplied. Dianne Wepa has added one more document for consideration.
13.1.8	Align Kia Ora Hauora students into DHB	Ongoing	Di Wepa	Consolidate scholarship and contact data between partner workforce development programmes including Tūruki and KOH in order to coordinate student support programmes such as scholarships, internships and mentoring and provide a graduating Māori workforce pool for HBDHB recruitment.		On track	Appointment of IT specialist has commenced to assist with developing an on-line shared data base to track students involved with KOH, Tūruki and Incubator programmes.
13.1.9	Incorporate mandatory cultural awareness training into new staff orientation process as standard	Ongoing				**Complete**	EEWM programme and Treaty of Waitangi online is part of the orientation programme for all staff. Online mandatory training reports available to all managers (via PAL$) where they can now see employee compliance against these mandatory cultural training courses.

Outcome: All staff working in the health sector have completed an approved course of cultural responsiveness training.

Key Performance Measures	Baseline [57]	Previous result[58]	Actual to Date[59]	Target 15-16	Trend direction
Medical	9.0%	19.2% (F)	32.4% (F)	-	▲
Management & Administration	43.0%	79.1% (F)	82.1% (F)	-	▲
Nursing	41.0%	70% (F)	74.7% (F)	-	▲
Allied Health	59.0%	77.3% (F)	80.4% (F)	-	▲
Support Staff	12.0%	35.6% (F)	38.6% (F)	-	▲
HBDHB	40.0%	65.5% (U)	70.6% (U)	≥100%	▲

Comments:

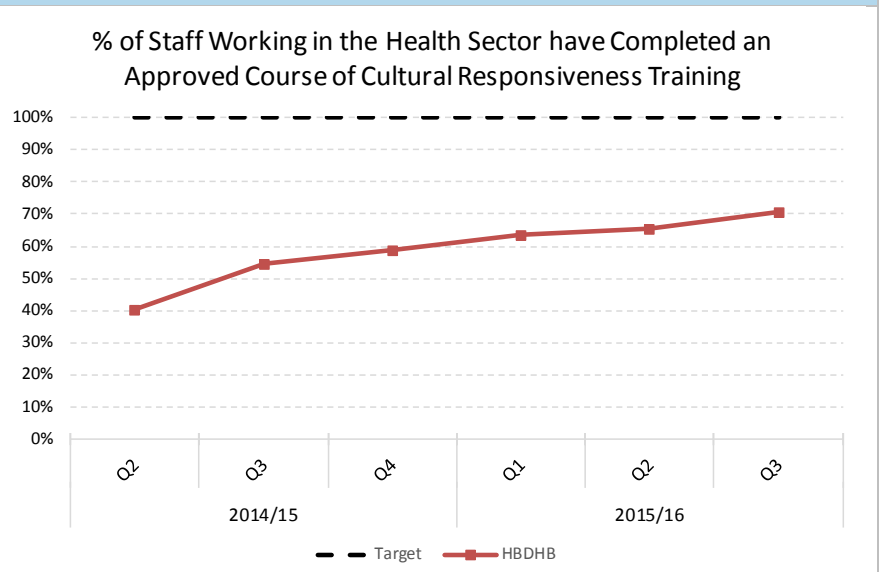
Current report shows DHB staff who have completed EEWM training or other cultural training.

The Education & Development Forum are establishing a communication plan to include Primary Care in EEWM training.

Managers now have access to reports within PAL$ to monitor staff completion rates of EEWM and Treaty of Waitangi.

Future development plans include access by Māori Health Service to reports by Department

Time series



57 December 2014

58 December 2015

59 March 2016

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
13.2	**Promote cultural awareness and responsiveness to Māori health needs to all staff at HBDHB**						
13.2.1	Promote mandatory cultural awareness training as a standard in new staff orientation process at HBDHB	Ongoing			Mandatory cultural awareness training incorporated into the standard orientation process of new staff at HBDHB	**Complete**	See 13.1.7 comments above
13.2.2	Continue to promote the "Engaging effectively with Māori" training package that was launched in 2014	Ongoing		% of staff completing the training by employment group		Ongoing	See graph above
13.2.3	Promote online cultural competence training through PHO and NGOs	Ongoing		# of PHO and NGOs staff completing the online training		**Complete**	Cross sector forum coordinated by Education and Development promotes EEWM to Primary Care
13.2.4	Explore cross-agency experiential learning for non-Māori for up to 3 months at a time	Ongoing		# of non- Māori employees engaged in cross-agency experiential learning Employees evaluation report on the programme		**Complete**	Findings of project received

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Cardiovascular Disease**
	For the attention of: **Maori Relationship Board (MRB), Clinical and Consumer Council**
Document Owner: Document Author(s):	John Gommans Gay Brown/Paula Jones
Reviewed by:	Health Service Leadership Team and Executive Management Team
Month:	May, 2016
Consideration:	For Information

RECOMMENDATION

That MRB and Consumer & Clinical Councils :

Note the contents of this report.

OVERVIEW

This report is from Dr John Gommans, champion for the cardiovascular indicators. The report focuses on the two acute coronary syndrome (ACS) indicators (high risk ACS accepted for angiogram within three days of admission and ACS patients who have completed data collection), which were introduced as indicators of District Health Board (DHB) performance by the Ministry of Health in 2013/14.

There has been a positive result with the HBDHB and all DHBs within the central region meeting both indicators for the first time in quarter three (December 2015 to February 2016).

Priority	Indicator	Measure	Champion	Reporting Month
Cardiovascular	• Total number (%) of all ACS patients where door to cath time is between -2 to 3 days of admission. • Total number (%) with complete data on ACS forms	70% of high risk >95% of ACS patients	John Gommans	April 2016

WHY IS THIS INDICATOR IMPORTANT?

To provide a national consistent reporting framework, all regions are required to report measure of ACS risk stratification and time to appropriate intervention using ANZACS-QI. HBDHB commenced using the ANZACS-QI system in September 2013. The DHBs actively monitor these two indicators of concern (figures 1 and 2)

FIGURE 1

% of Patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI and Cath/PCI registry data collection within 30 days.

ANZACS QI

Registry Completion Quarterly Report - Apr 2016

Central Region DHBs

Period *	Central Region DHB Performance						
	CAPITAL AND COAST	HAWKES BAY	HUTT VALLEY	MID CENTRAL	NELSON MARLBOROUGH	WAIRARAPA	WHANGANUI
2014/2015 Q2 (Sep 2014 - Nov 2014)	6/75 (8.0%)	45/66 (68.2%)	19/38 (50.0%)	15/48 (31.3%)	78/89 (87.6%)	1/10 (10.0%)	2/14 (14.3%)
2014/2015 Q3 (Dec 2014 - Feb 2015)	47/64 (73.4%)	60/69 (87.0%)	34/36 (94.4%)	37/53 (69.8%)	68/80 (85.0%)	15/21 (71.4%)	14/17 (82.4%)
2014/2015 Q4 (Mar 2015 - May 2015)	68/69 (98.6%)	69/70 (98.6%)	46/46 (100.0%)	39/52 (75.0%)	76/88 (86.4%)	11/11 (100.0%)	27/28 (96.4%)
2015/2016 Q1 (Jun 2015 - Aug 2015)	68/68 (100.0%)	74/74 (100.0%)	47/47 (100.0%)	66/68 (97.1%)	64/66 (97.0%)	16/16 (100.0%)	21/21 (100.0%)
2015/2016 Q2 (Sep 2015 - Nov 2015)	82/83 (98.8%)	83/83 (100.0%)	52/52 (100.0%)	52/53 (98.1%)	58/70 (82.9%)	15/15 (100.0%)	24/24 (100.0%)
2015/2016 Q3 (Dec 2015 - Feb 2016)	73/73 (100.0%)	82/82 (100.0%)	42/42 (100.0%)	81/81 (100.0%)	64/64 (100.0%)	15/15 (100.0%)	33/34 (97.1%)

Quarter containing the date of admission signifying the start of each episode of care; Number (%) with both complete Cath Lab and ACS forms (Target is >95%); Denominator: Cath Lab pati

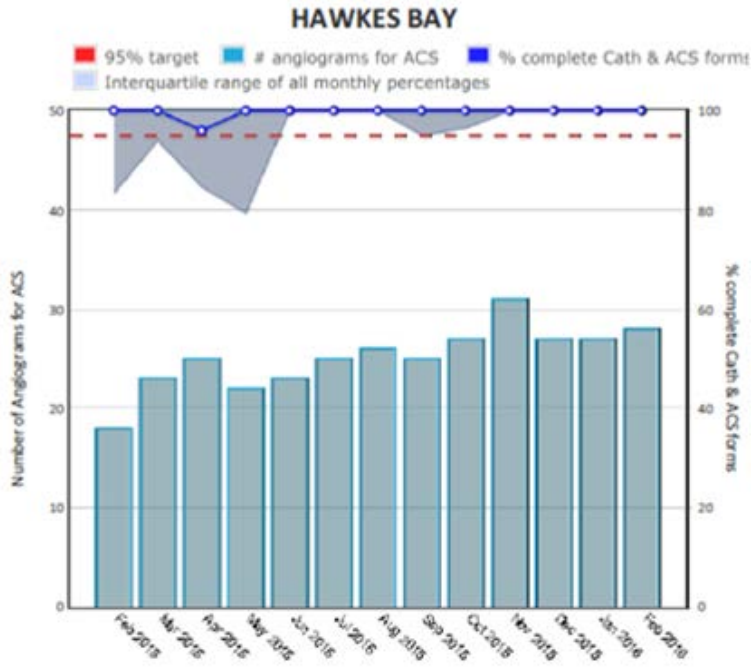
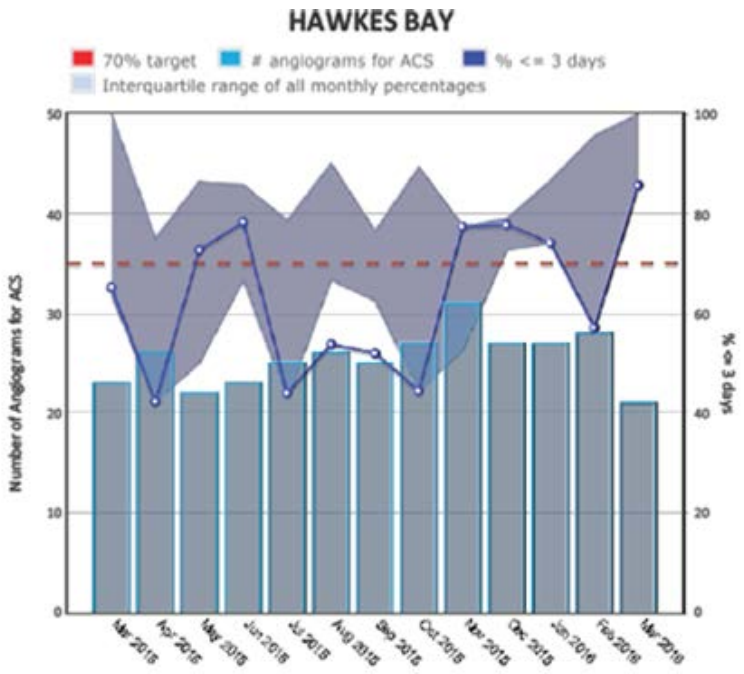


FIGURE 2
% of Patients Who Receive an Angiogram within 3 days of Admission

Door to Cath < 3-Days Quarterly KPI Report by DHB - Apr 2016

Period	Central Region DHBs						
	Central Region DHB Performance						
	CAPITAL AND COAST	HAWKES BAY	HUTT VALLEY	MID CENTRAL	NELSON MARLBOROUGH	WAIRARAPA	WHANGANUI
2014/2015 Q2 (Oct 2014 - Dec 2014)	64/76 (84.2%)	37/75 (49.3%)	26/35 (74.3%)	33/51 (64.7%)	74/86 (86.0%)	11/15 (73.3%)	10/13 (76.9%)
2014/2015 Q3 (Jan 2015 - Mar 2015)	53/57 (93.0%)	43/69 (62.3%)	28/41 (68.3%)	27/46 (58.7%)	87/90 (96.7%)	8/16 (50.0%)	12/21 (57.1%)
2014/2015 Q4 (Apr 2015 - Jun 2015)	65/69 (94.2%)	45/71 (63.4%)	30/42 (71.4%)	41/60 (68.3%)	68/78 (87.2%)	6/10 (60.0%)	17/28 (60.7%)
2015/2016 Q1 (Jul 2015 - Sep 2015)	65/73 (89.0%)	38/76 (50.0%)	41/51 (80.4%)	52/69 (75.4%)	60/67 (89.6%)	11/19 (57.9%)	13/21 (61.9%)
2015/2016 Q2 (Oct 2015 - Dec 2015)	76/83 (91.6%)	57/85 (67.1%)	32/50 (64.0%)	46/58 (79.3%)	62/68 (91.2%)	10/12 (83.3%)	14/27 (51.9%)
2015/2016 Q3 (Jan 2016 - Mar 2016)	68/76 (89.5%)	54/76 (71.1%)	40/42 (95.2%)	57/74 (77.0%)	55/57 (96.5%)	17/20 (85.0%)	22/31 (71.0%)

The dates are based on the dates of admission. Number (%) of all ACS patients where door to cath time is between -2 to 3 days. Target is 70%. Those with < -2 days are excluded from numerat



MĀORI PLAN INDICATOR:

HBDHB actively monitor the ethnicity breakdown for the ANZAC-QI and Cath/PCI registry data collection within 30 days. Refer to the tables (Figure 3 and 4) below for ethnicity breakdown for quarter three (December 2015 - February 2016).

FIGURE 3
% of Patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI and Cath/PCI registry data collection within 30 days.

HAWKES BAY

2015/2016 Q3 (Dec 2015 - Feb 2016)

	Maori	Pacific	Indian	Asian	Eur/Oth
Hawke's Bay	13/13 (100.0%)	3/3 (100.0%)	2/2 (100.0%)	1/1 (100.0%)	63/63 (100.0%)

FIGURE 4
% of Patients Who Receive an Angiogram within 3 days of Admission

HAWKES BAY

2015/2016 Q3 (Jan 2016 - Mar 2016)

	Maori	Pacific	Indian	Asian	Eur/Oth
Hawke's Bay	8/10 (80.0%)	1/2 (50.0%)	2/2 (100.0%)	1/1 (100.0%)	42/61 (68.9%)

Figures 5 and 6 below show overall HBDHB quarterly compliance from 2013/14.

FIGURE 5
% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI and Cath/PCI registry data collection within 30 days

		Target	Total	Maori	Pacific	Other
2013/14	Q2	95%	4.1%	6.7%	0.0%	0.0%
	Q3	95%	5.4%	0.0%	0.0%	0.0%
	Q4	95%	4.8%	0.0%	0.0%	0.0%
2014/15	Q1	95%	0.0%	0.0%	0.0%	0.0%
	Q2	95%	27.8%	12.5%		0.0%
	Q3	95%	61.1%	6.7%		0.0%
	Q4	95%	83.1%	90.9%	100.0%	81.0%
2015/16	Q1	95%	85.1%	91.7%	50.0%	85.0%
	Q2	95%	84.1%	71.4%		88.5%
	Q3	95%	100.0%	100.0%	100.0%	100.0%
	Q4	95%	0.0%	0.0%	0.0%	0.0%

FIGURE 6
% of patients who receive an angiogram within 3 days of admission

		Target	Total	Maori	Pacific	Other
2013/14	Q2	70.0%	68.9%	81.8%	100.0%	#DIV/0!
	Q3	70.0%	64.1%	45.5%	33.3%	70%
	Q4	70.0%	53.7%	72.7%	-	49%
2014/15	Q1	70.0%	75.7%	90.9%	50.0%	75%
	Q2	70.0%	49.3%	33.3%	-	52%
	Q3	70.0%	62.3%	66.7%	50.0%	62%
	Q4	70.0%	63.4%	58.3%	50.0%	65%
2015/16	Q1	70.0%	50.7%	38.5%	50.0%	53%
	Q2	70.0%	67.1%	60.0%	100.0%	71%
	Q3	70.0%	71.1%	80.0%	50.0%	70%
	Q4	70.0%	-	-	-	#DIV/0!

CHAMPION'S REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THIS INDICATOR?
Overall compliance against both indicators have increased over the last quarter and HBDHB met both indicators in quarter three of 2015/16.

This was achieved by close monitoring by the directorate leadership team and the development of an action plan in conjunction with the cardiology service.

18

Strategies to improve compliance to the data registry indicator included:

- Nursing staff, checking all incomplete forms and finalising or updating as required.
- All multiple Episodes of Care (EoC) checked and corrections made as required.
- Retraining on database process for staff using the system.
- Month and quarter reports discussed with cardiology staff using database.
- Patients transferred out from HBDHB before ACS EoC completed are followed up for database completion by CCDHB.

Strategies to improve compliance from the door to cath within three days indicator included:

- Increased access to angio suite confirmed each week.
- Potential angio patients admitted on Thursday are made priority to be seen first.
- Communication between CCDHB and HBDHB to support timely transfers of patients improved.

In addition to the above the TAS cardiology Network membership has recently been revised to include Central Region DHB Service Managers. This will ensure a continued focus on improving compliance.

Additional strategies that will continue to ensure sustained compliance for these indicators includes:

- Cardiologists revised roster, implemented 1 April 2016 which will support cardiologist availability for increased angio access.
- A specialty clinical nurse role currently going through the approval process will oversee and monitor the database in conjunction with the cardiology CNM to ensure adherence to the indicators.

RECOMMENDATIONS FROM TARGET CHAMPION

The Acute & Medical Directorate leadership team in conjunction with the cardiology service will continue to monitor and review it's strategies to ensure sustained compliance with both cardiovascular indicators. The service will continue to participate in TAS cardiac network activities to align with regional and national strategies.

CONCLUSION

There has been a positive result with the HBDHB and all DHBs within the central region meeting both indicators for the first time in quarter three (December 2015 to February 2016). The challenge for the service now is to sustain this improved compliance.

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Māori Health Target Champions 2016 – 2017 Reporting Schedule**
	For the attention of: **Māori Relationship Board**
Document Owner: Document Author(s):	Tracee Te Huia, General Manager Māori Health Patrick LeGeyt, Programme Manager Māori Health
Reviewed by:	Not applicable
Month:	May, 2016
Consideration:	For Decision / Monitoring

Recommendation

That the Māori Relationship Board:

1. **APPROVE** the new Te Ara Whakawaiora indicators for 2016-2017
2. **APPROVE** Te Ara Whakawaiora Report Schedule for 2016-2017

19

PURPOSE

The purpose of this paper is to provide the Māori Relationship Board the updated Te Ara Whakawaiora set of indicators and reporting schedule for 2016-2017.

BACKGROUND

Annual Māori Health Plans (AMHP) are fundamental planning, reporting and monitoring documents, which underpin the DHB's efforts to improve Māori health and reduce the disparities between Māori and non-Māori. An AMHP documents and details the interventions and actions the DHB plans to undertake to address health issues in order to achieve indicator targets set nationally, regionally and at district level.

Te Ara Whakawaiora (TAW) is an exception based report, drawn from AMHP quarterly reporting, and led by TAW Champions. Specific non-performing indicators are identified by the Māori Health Service which are then scheduled for reporting on progress from committees through to Board. The intention of the programme is to gain traction on performance and for the Board to get visibility on what is being done to accelerate the performance against Māori health targets. Once indicators are decided, EMT then identifies the Champions and Project managers for each indicator. The Board asked that only one indicator is reported to the Board monthly, hence the scheduling process.

TAW Champion reports contain the following:

- Brief description of indicator and why it is important;
- Review of activity to support improvement of performance against indicator;
- Financial implications; and
- Recommendations

PRIORITISATION

The prioritisation process was based on the AMHP national, regional and local indicators, literature reviews on health prioritisation processes, Transform and Sustain, MRB priorities and the 2015-2016 DHB performance to expected targets. The new indicator set includes an emphasis on prevention and early intervention. Therefore, the recommended Te Ara Whakawaiora priorities included in the schedule below are:

1. A culturally competent workforce
2. Breastfeeding
3. Child obesity
4. Child oral health
5. Young female smoking prevalence
6. Access to health services
   a) cardiovascular disease
      - heart and diabetes checks
      - quick access to angiograms
      - data is recorded on national databases
   b) ASH rates (0-4 years, 45-64 years)
7. Mental health and alcohol and other drugs
   - Rate of section 29 Compulsory Treatment Orders
   - Percentage of 0-19 year old clients discharged with a transition (discharge) plan
   - Improve non-urgent access to CAMHS and youth AOD services

The new indicator in 2016-2017 is mental health and alcohol and other drugs. The new indicator is a mix of national and local indicators and has a children and youth focus. Furthermore mental health section 29 Compulsory Treatment Orders has a large inequality gap between Maori and non-Maori, the percentage of children and youth transitioned back to primary care with a discharge plan is very low and the percentage of children and youth accessing mental health and AOD services is also very low. Diabetes has been included into the broader priority area of cardiovascular disease.

TAW indicators removed from the 2016-2017 list include cancer screening (cervical and breast cancer). This indicator has been removed as it is consistently trending in the right direction towards the expected performance target.

REPORTING SCHEDULE 2016 – 2017

Within the proposed schedule, some measurements are yet to be agreed or determined. Whilst the most prevalent ASH related conditions are known, ASH rate measurements for these conditions for 0-4 and 45-64 year olds are yet to be determined and therefore MOH expectation is to 'close the equity gap'. Furthermore the data collection timeframes will be confirmed mid-August therefore the schedule of reporting dates will be finalised by then and communicated with the Champion and responsible manager.

Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
Culturally Competent Workforce *Local Indicator*	1. HBDHB staff who are Māori 2. HBDHB staff have completed Treaty on Line training 3. HBDHB staff have completed 'Effective Engagement with Māori' Training	≥14.3% 100% 100%	Chris McKenna & John McKeefry	Paul Davies	**AUG 2016** **4 Aug 2016** to Kathy EMT 09/08/16 **4 Aug 2016** to Brenda Clinic 10/08/16 MRB 10/08/16

					Cons 11/08/16 **19 Aug 2016** to Brenda Board 31/08/16
Mental Health and AOD *National and Local Indicators*	1. Rate of section 29 Compulsory Treatment Orders per 100,000 population 2. % of clients discharged from Child and Adolescent Mental Health Services (CAMHS) and Youth Alcohol and Other Drug (AOD) services with a transition (discharge) plan 3. Improve non-urgent access to CAMHS and youth AOD services: • % seen within 3 weeks • % seen within 8 weeks	≤81.5 per 100,000 ≥95% ≥80% ≥95%	Sharon Mason	Paul Malan	*See above for Aug Committee and Board reporting timeframes*
Obesity *National Indicator*	% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	≥95%	Caroline McElnay	Shari Tidswell	**SEPT 2016** **18 Aug 2016** to Kathy EMT 30/08/16 **2 Sept 2016** to Brenda Clinic 14/09/16 MRB 14/09/16 Cons 15/09/16 **16 Sept 2016** to Brenda Board 28/09/16
Smoking *National Indicator*	Percentage of pregnant Māori women that are smokefree at 2-weeks postnatal	≥90%	Caroline McElnay	Shari Tidswell	**NOV 2016** **13 Oct 2016** to Kathy EMT 18/10/16 **28 Oct 2016** to Brenda Clinic 9/11/16 MRB 09/11/16 Cons 10/11/16 **18 Nov 2016** to Brenda Board 30/11/16
Access *Local Indicator*	Reducing acute admissions of Ambulatory Sensitive Hospitalisations (ASH): 1. 0-4 year olds - dental decay, skin conditions, respiratory and ear, nose and throat infections. 2. 45-64 year olds - heart disease, skin infections, respiratory infections and diabetes	Reduce Equity Gap Reduce Equity Gap	Mark Peterson	Mary Wills Tamsin Renwick	**FEB 2017**

Breastfeeding *National Indicator*	Improve breastfeeding rates for children at 6 weeks, 3 months and 6 months: 1. % of infants that are exclusively or fully breastfed at 6 weeks of age; 2. % of infants that are exclusively or fully breastfed at 3 months of age; 3. % of infants that are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)	 ≥75% ≥60% ≥65%	Caroline McElnay	Nicky Skerman	**MAR 2017**
Cardiovascular *National Indicator*	1. % of eligible 35-55 year olds that have received a heart and diabetes check 2. Total number (%) of all ACS patients where door to cath time is between -2 to 3 days of admission. 3. Total number (%) with complete data on ACS forms	≥90% ≥70% ≥95%	John Gommans	Gay Brown/ Paula Jones	**APR 2017**
Oral Health *National Indicator*	1. % of eligible pre-school enrolments in DHB-funded oral health services. 2. % of children who are carries free at 5 years of age	≥95% ≥67%	Sharon Mason	James Dawson	**JUN 2017**

IMPLEMENTATION PROCESS

1. A report is prepared by the responsible Project Manager, by due dates as per Board work plan for committee and Board reports, and provides it to the Champion.
2. The reports are presented to Clinical Council, Consumer Council and the Māori Relationship Board by the Project Manager or Champion.
3. The Champion partners with the Programme Manager Māori Health to address and progress any feedback and actions from the Councils and Boards.
4. All Champions will be provided with the detailed activities and progress for their indicator by the Service or Project lead. The Programme Manager Māori Health will support the Champion with relevant information such as the planned activity from the Māori Health Plan 2015-2016.
5. Champions are encouraged to investigate their areas and develop plans and strong recommendations to address improvements in the performance of their indicator. The Programme Manager and the General Manager Māori Health will be key contacts to support ongoing communication between the services and the target Champion.

APPENDIX ONE

HAWKE'S BAY District Health Board Whakawāteatia	**Report title in Lower Case Bold Arial 13pt**
	For the attention of: **Name of Committee**
Document Owner: Document Author(s):	Lower Case Arial 11pt Lower Case Arial 11pt (use this if applicable)
Reviewed by:	Executive Management Team or Senior Manager etc or n/a
Month:	Month, 2015
Consideration:	For Decision / For Discussion / Monitoring / For Information Please identify the most appropriate for your report.

RECOMMENDATION

That xxxxxxx:

Note the contents of this report...

OR

1. Note xxxxx, xxxxx.
2. Provide xxxxx, xxxxx.
3. Recommend xxxx,xxxx

Or

- x
- x
- x

19

OVERVIEW

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

UPCOMING REPORTS

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

MĀORI HEALTH PLAN INDICATOR: [this month's indicator]

[A brief description of the indicator]

WHY IS THIS INDICATOR IMPORTANT?

[Summarise what the indicator measures, the most up-to-date results/series, what it tells us and why that is a priority]

CHAMPION'S REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THIS INDICATOR?

[A synopsis of progress on the planned activity, risks and challenges faced based on discussions with the services involved – ***report completed by EMT Champion, details of planned activity and a synopsis of progress from associated leads***]

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

[A statement of commitment of actions to improve performance. Statement to include Action, Outcome, Responsibility and Timeframe – ***report completed by EMT Champion, details of planned activity and a synopsis of progress from associated leads***]

RECOMMENDATIONS FROM TARGET CHAMPION

[Any concerns or issues noted by the Champion and suggestions or advice about how s/he or the Board could further support accelerating performance in this area – ***completed by EMT Champion***]

CONCLUSION

[Final comments from the Champion]

[Champion name]
[Champion title/designation

HAWKE'S BAY District Health Board Whakawāteatia	**Draft Youth Health Strategy 2016-19**
	For the attention of: **HB Clinical and Consumer Council and Māori Relationship Board (MRB)**
Document Owner: Document Author(s):	Caroline McElnay, Director Population Health Nicky Skerman, Population Health Strategist Women, Children and Youth
Reviewed by:	N/A
Month:	May 2016
Consideration:	For discussion

RECOMMENDATION

That MRB and Consumer & Clinical Councils :

Discuss and make recommendations on the draft Youth Health Strategy 2016-19.

OVERVIEW

This is an opportunity for committees to provide input and make recommendations on the draft Youth Health Strategy 2016-2019 (Strategy). It is envisaged that this Strategy will support young people in Hawke's Bay to be a healthy and vibrant youth population.

BACKGROUND.

This Strategy has the potential to create opportunities across the region to improve responsiveness of services for youth. It aims to articulate a shared vision from both Hawke's Bay youth and stakeholders by identifying a common set of youth outcomes and indicators that cut across the work of many organisations/services working with youth.

Though there are many commonalities in how organisations/services talk about their goals and impact, the lack of shared knowledge across the domains can lead to missed opportunities for collaboration and collective impact.

The vision for this strategic framework is to enhance and support organisations/services individual or collective ability to define, communicate about, develop and implement youth development models that will influence outcomes to ensure all youth thrive in Hawke's Bay.

If we take a snapshot of where we are today in our responsiveness to youth, we know that the Hawke's Bay community is invested in youth across multiple levels and sectors, frequently sharing common population groups and mutual visions. Hawke's Bay DHB funds the most contracts locally for youth services alongside other funding sources such as; Ministry of Health, Ministry of Social Development, Education, Ministry of Youth Development and Councils.

Creating Healthy Opportunities for Youth 2016 – 2019

"Strong leadership to commit to what young people want"
17yo Hawke's Bay young person

OUR VISION

"HEALTHY HAWKES BAY"

"TE HAUORA O TE MATAU-A-MAUI"
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 / BEHAVIOURS

- **TAUWHIRO** - delivering high quality care to patients and Consumers
- **RARANGA TE TIRA** – working together in partnership across the Community
- **HE KAUANUANU** – showing respect for each other, our staff, patients and consumers
- **AKINA** – continuously improving everything we do

OUR GOALS FOR YOUTH

This Strategic plan for youth aims to articulate a shared vision for young people by identifying a common set of youth outcomes and indicators that cuts across the work of many organisations/services working with youth. Though there are commonalities in how organisations/services talk about their goals and impact, the lack of shared language across the domains can lead to missed opportunities for collaboration, alignment and collective impact. Our vision is that this framework enhances organisations/services individual and/or collective ability to define, communicate about, develop, and implement strength-based models to influence outcomes that ensure all youth are thriving in New Zealand.

OUR OUTCOMES FOR YOUTH

The youth development approach calls for a balance between services designed to prevent, intervene or treat health problems and efforts that promote development through preparation, participation and leadership experiences with youth. Creating synergy to meet the needs of youth in the full context of their lives will result in healthy opportunities for youth and sustainable benefits for the community overall.

This framework is intended to provide a basic listing of outcomes and corresponding indicators. It does not capture complex relationships among outcomes and indicators or developmental differences.

<table>
<tr><td>VISION
Hawke's Bay Health</td><td colspan="2">"HEALTHY HAWKE'S BAY"
"TE HAUORA O TE MATAU-A-MAUI"
Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community.</td><td colspan="2">Mai Māori Health Strategy
Māori taking responsibility for their own health at a whānau, hapū and iwi level.

Pacific Health Action Plan
Healthy and strong Hawke's Bay Pacific community that is informed, empowered and supported to improve the management of their health and the health of their families.</td><td>Youth are thriving in Hawke's Bay</td></tr>
<tr><td>AIMS</td><td colspan="2">The Hawke's Bay Health System - Transform and Sustain for 2013-2018:
The three broad aims are:
1. Responding to our population.
2. Delivering consistent high-quality health care.
3. Being more efficient at what we do.</td><td colspan="2">Māori Health - Mai focuses on engaging better with whānau, delivering consistent high quality care and more efficient use of resources. Mai seeks to work toward an integrated health sector that takes responsibility for responding to the needs of Māori in the way they prefer services and care.
Pacific Health Action Plan
Better health service response to Pacific health needs through a collaborative approach with Pacific communities that will lead to improvements in health and wellbeing.</td><td>To build and nurture "all the beliefs, behaviours, knowledge, attributes and skills that result in a healthy and productive adolescence and adulthood</td></tr>
<tr><td>GOALS
What do youth need for healthy development</td><td>Healthy & Safe</td><td>With Connections</td><td>Productive</td><td>Health System Resiliency</td><td>Community Inclusiveness</td></tr>
<tr><td>OUTCOMES
How will we know youth have achieved healthy development</td><td>Thriving
▪ Healthy/active living
▪ Social/emotional health
▪ Safety/injury prevention</td><td>Engagement & Inspiration
▪ Positive identity and relationships
▪ Social/emotional development
▪ Cultural competence
▪ Community connectedness
▪ Social responsibility and leadership development</td><td>Learning & Working
▪ Engagement in learning
▪ Learning and innovation skills
▪ Academic achievement
▪ Tertiary access and success
▪ Career awareness
▪ Workforce readiness
▪ Employment</td><td>Leadership and Youth Involvement
▪ Commitment to adolescents and youth development
▪ Partnerships and collaborations for health and development
▪ Programs and services
▪ Advocacy
▪ Youth involved in governance and leadership
▪ Youth as community change agents</td><td>Innovation and Integration
▪ Whānau and community supported
▪ Resources and opportunities
▪ Strength based focus
▪ Youth as part of the community
▪ Collaborative and multi-sectoral
▪ Outcome driven</td></tr>
</table>

20.1

CONTENTS

"Young People are a resource to be developed not a problem to be fixed". (Joy G Dryfoos 1998)

This statement began a journey of discovery in the 1990s to advocate for adolescent development and collaborative service models for ensuring that children are healthy and ready to learn. Two decades on and this emphasis on positive development for the wellbeing of the 'whole young person' is strongly echoed today and by youth in the Hawke's Bay.

WHO's Global Strategy emphasis is to transform societies to create opportunities for thriving children and adolescents, which in turn, will deliver enormous social, demographic and economic benefits.

Creating healthy opportunities and working together in communities will enable the rights of youth to wellbeing. Our goals have the enduring theme and commitment to:

- Youth are thriving in the Hawke's Bay
- Youth are fully prepared, fully engaged and actively participating in communities

Hawke's Bay District Health Board (HBDHB) are investing in a Youth Health Strategy 2016 -2019. This Strategy will encompass improving the responsiveness of Hawke's Bay health services for youth. In order to achieve this outcome, research indicates strengths based models utilising Positive Youth Development (PYD) are proven to be most successful.

'Shift the paradigm from preventing and "fixing" behaviour deficits to building and nurturing "all the beliefs, behaviours, knowledge, attributes, and skills that result in a healthy and productive adolescence and adulthood" (Karen Pittman Investment for Youth)

The PYD approach, calls for a focus on young people's capacities, strengths and developmental needs and not solely on their problems, risks or health compromising behaviours. It recognizes the need to broaden beyond crisis management and problem reduction to strategies that increase young peoples' connections to positive, supportive relationships and challenging, meaningful experiences. While health problems must be addressed and prevented, youth must also be prepared for the responsibilities of adulthood.

Professor Robert Blum (United Nations Advisor) recommends: A Framework for Healthy Adolescence *or what young people need for healthy development:*

Five Outcomes to achieve by age 15 for healthy development:

- Academic engagement
- Emotional and physical safety
- Positive sense of self/self efficacy
- Life and decision-making skills
- Physical and mental health

Youth in the Hawke's Bay report healthy is

Feeling supported and accepted

Positive relationships with parents and connections with others

Good headspace

Positive influences

Independence

Taking responsibility

Over the years, research continues to inform us of the sustainable benefits and high returns from investing in women's, children's and adolescents' health; evidence demonstrates 70% of preventable adult deaths from non-communicable diseases are linked to risk factors that start in adolescence.

We will utilise what we know about youth in the Hawke's Bay and work together on outcomes that ensure all youth are thriving in New Zealand.

our responsiveness to youth, we know the Hawke's Bay community is multicultural and invested in youth across multiple levels and sectors, frequently sharing common age groups. However, youth report they are uncertain around understanding and navigating access and utilisation of multiple services.

Case scenarios: 'everyday life for some teens'

14yo male living in a blended family, attending school with no learning difficulties, has reliable friendships and plays sport regularly for his school and a club. He has just broken up with his girlfriend of the last 9 months.

16yo female living in a single parent family with six siblings (oldest child), irregularly attending school – recently saw school counsellor for low mood due to bullying; smokes, has few friends, mostly spends time at home to help out with siblings.

One of these young people would be considered to be well supported and the other not. However the negative outcome for both could be the same. Currently there are funded services to meet the needs described.

Both young people have access to services in the community such as:

- Schools e.g. teachers, deans, school counsellors, social workers in schools (SWIS)
- School Based Health Services (SBHS)
- Youth One Stop Shop (YOSS)
- Primary Care Provider (PCP – GP practices)
- Primary Healthcare Organisation (PHO) Packages of Care (PCP and/or NGO)
- Non-Government Organisation (NGO) Youth Services
- Iwi Wraparound Services
- Pacific Services
- Child Adolescent & Family Service (CAFS)
- Community programs e.g. sports, after school, cultural groups
- Church support/programs/groups
- Accident & Medical

However, young people report barriers to accessing and utilising services. Services raise barriers around multiple services working in isolation of each other such as; services use separate client databases (e.g. limited ability for timely information sharing), differing eligibility criteria, differing standards for quality services and/or service requirements.

Returning to our two young people; access to services could highlight the young person has:

- potentially told their story seven or more times
- engaged via the same/different/no screening tool with different services with same/differing results
- problems identified and fixed, yet normal daily functioning still declining
- engaging with multiple providers and young person indecisive/unmotivated about care plan led by services
- could be receiving counselling from three different counsellors and possibly three different therapeutic interventions,
- young people put off by the negative stigma of needing help or perceived by peers to be needy/damaged therefore unwilling to access services
- young people put off due to lack of youth friendly service
- peers are the only source of information relating to chosen service – young person is misinformed or perceived lack of confidentiality
- not accessed any services as uncertain of what support they need or will receive

The only way to change the odds for all youth is to **work together** differently to **create healthy opportunities** for youth to thrive.

"Support 100% and work together "

"Walk the Talk and Take Action"

Pacific Youth

Over the last few years HBDHB have reviewed the needs of the multicultural communities and the changes this can impose across the region. The HBDHB strategic plans reflect the health system in partnership with Māori and Pacific. It is important to promote the synergy of all the strategic plans which the Youth Health Strategy is aligned to. The underlying principles are weaved throughout the goals and outcomes that all youth in the Hawke's Bay are thriving with healthy and productive adolescence and adulthood.

The Hawke's Bay Health System - Transform and Sustain for 2013-2018:
The three broad aims are:

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

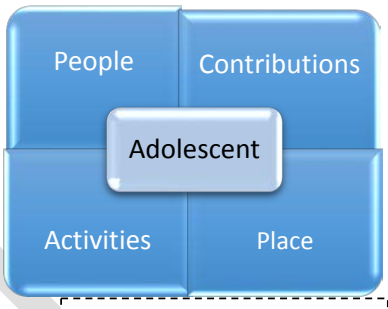
The strategy acknowledges "organisations need to work together with a focus on prevention, recognizing that good health begins in places where we live, learn, work and play long before medical assistance is required".

Mai - Māori Health Strategy 2014–2019: This strategy 'Mai' means 'To bring forth' and relates to Māori taking responsibility for their own health at a whānau, hapū and iwi level. Mai focuses on engaging better with whānau, delivering consistent high quality care and more efficient use of resources. Finally, Mai seeks to work toward an integrated health sector that takes responsibility for responding to the needs of Māori in the way they prefer services and care. (HBDHB MAI)

The Pasifika Health Action Plan is a four year building block: At the core of improving Pacific health is the need for families, community groups and services to do things differently. The six key priority areas are:

1. Pacific workforce supply meets service demand.
2. Systems and services meet the needs of Pacific people.
3. Every dollar is spent in the best way to improve health outcomes.
4. More services delivered locally in the community and in primary care.
5. Pacific people are better supported to be healthy.
6. Pacific people experience improved broader determinants of health.
   (HBDHB Pacific Action Plan)

This Strategy aims to determine how to get the best outcomes for youth to thrive in the Hawke's Bay, determine how it will be achievable, and how we will know if it has been achieved.



The PYD perspective is a framework for examining thriving in youth and has been useful in promoting positive outcomes for all youth.

The PYD perspective sees youth as resources to be nurtured and focuses on the alignment between the strengths of youth and resources in the settings that surround them as the key means of promoting positive outcomes.

PCAP – A Model for Promoting Youth Health & Development

Adolescents need to be connected to:

- People – an adult who cares, who is connected, a network of adults
- Contribution – opportunities to contribute
- Activities – school/ community to develop a sense of connection/ belonging
- Place – safe places for youth

Successful youth outcomes include the development of attributes such as competence, confidence, character, connection, caring, and contribution. The development of these positive attributes is thought to foster positive outcomes during adolescence such as:

- improved self-care
- greater academic achievement
- higher quality interpersonal relationships
- overall improved wellbeing

20.1

These attributes are also believed to be critical in promoting successful adult development and improved health outcomes. *(Gary R. Maslow, Richard J. Chung)*

This shows the healthy opportunities could continue through into adulthood due to the synergy with the principles in all the strategic plans supporting "for the people by the people - mo te iwi i te iwi".

New Zealand Research

During the 1990s New Zealand youth had high incidences of morbidity and mortality but little local research to help define what the needs were and therefore enable appropriate health provision to improve health outcomes. Two significant research groups have been key contributors to the evolvement of youth health over the last two decades.

1. The Christchurch Health and Development Study (CHDS) has been in existence for over 35 years. CHDS followed the health, education and life progress of a group of 1,265 children born in the Christchurch urban region during mid-1977. The cohort has now been studied from infancy into childhood, adolescence and adulthood resulting in many reports reflecting the life course.
2. Adolescent Health Research Group (AHRG) was established in the late 90s to undertake the Youth 2000 National Youth Health and Wellbeing Survey series. Over 27,000 young people have participated in 2001, 2007 and 2012. The samples of New Zealand secondary school students completed an anonymous comprehensive health and wellbeing survey. The results from these surveys provide comprehensive and up to date information about issues facing young people in New Zealand.

NZ Research

The Adolescent Health Research Group hopes the information from the Youth 2000 Survey Series will continue to be utilised by schools, health services, social services and communities to develop appropriate and accessible services, programmes and policies for New Zealand youth.

"I urge all those that work with adolescents to consider these findings ... so that we all may continue to work together with our young people themselves to ensure the best of all futures." (John Heyes, Principal of Mangere College).

This research along with other New Zealand and international evidence, continues to significantly transform developments for youth in policy, funding and provision of services, intersectoral partnerships and collaboration, programs, community integration, and workforce development.

It is important to acknowledge what we know in order to plan for the future of our youth:

- How healthy are young people in the Hawke's Bay?
- How well do we respond to their needs?
- In what areas do young people need us to improve?

WHO defines youth as 10-24 years old. The latest census in 2013 provides data to represent the state of the region in relation to populations. We have used this information to gauge the age and ethnicity breakdown of youth 10–24yo in Hawke's Bay.

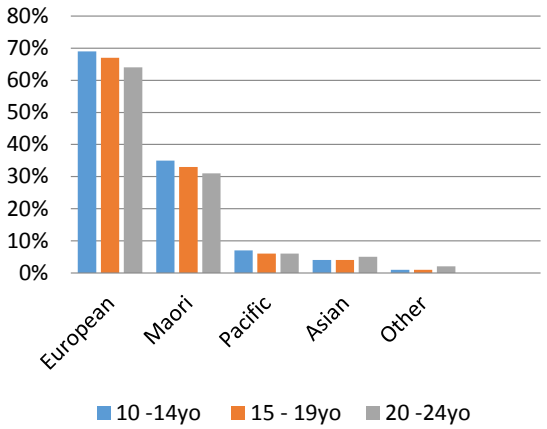
1. Hawke's Bay Region Census Data 2013:

Table 1: Demographics of Youth

	Total Population	**151,179**	
	Total Youth Population	29,199	19%
Gender	Male	14,016	48%
	Females	15,183	52%
Age Groups	10 -14yo	11,178	7%
	15 – 19yo	10,089	7%
	20 – 24yo	7,932	5%
District	Hastings	14,016	48%
	Napier	11,388	39%
	Wairoa	1,460	5%
	Central Hawke's Bay	2,336	8%

Nearly 20% of the population in the Hawke's Bay region are aged between 10-24yo. There are slightly more females than males. Most of the youth are between 10-19yo e.g. predominantly school aged. Most of the youth tend to live in the urban areas of Hastings 48% and Napier 39%. The rural areas have 8% in Central Hawke's Bay and 5% in Wairoa.

Table 2: Ethnicity



The 2013 census data presents a multicultural society in the Hawke's Bay. Two-thirds of youth are European, nearly one-third are Māori, nearly 10% are Pacific, and Asian and other ethnicities make up 5% of the remaining youth. The ethnicity make-up is consistent across the age groups.

The Hawke's Bay census data collated by the HBDHB highlighted the youth in Hawkes' Bay show some health trends and risk factors higher than the New Zealand average for:

- Teenage pregnancy
- Sexually transmitted diseases
- Suicide rate
- Diagnosed mental health disorders e.g. anxiety, depression
- Smoking prevalence
- Sole parents benefits for under 25
- Unemployed
- Involvement with justice e.g. apprehension

Stakeholders feedback

"We need to resource the family needs alongside the young persons to ensure positive outcomes can be sustainable"

This is consistent with information provided from NZ Epidemiology Group and Adolescent Health Research Group as shown below.

20.1

2. NZ Epidemiology 2015: Health Status of Youth in Hawke's Bay (draft)

This report is in draft so a general impression is given from the data provided in relation to the significant health features for youth in the Hawke's Bay.

The general trends show:

- Infections and illnesses are well below the national DHB average for 0-14yo or 0 -24yo
- Unintentional injuries, teenage births, seen by mental health services, and suicide are all above the national DHB average

This data would tend to indicate mostly youth have no physical health barriers to engage with learning or pro-social activities.

This data tends to mirror the youth 2012 data from young people showing young people having sex are not always using contraception (including condoms). Also the reflection by young people of feeling unsafe in their neighbourhood, or exposure to bullying may influence the high rate of unintentional injuries, and depressive symptoms or suicidal ideation.

Implications for health services:

Youth clearly identify barriers to access and utilisation of services which would support our higher trends for preventable risks. While some barriers lie outside the health system, such as financial barriers due to inequities e.g. income inequalities, ethnicity, age, sexual orientation, others are more directly the responsibility of health services.

Developing and implementing standards for quality youth health and development services is a way to minimize variability and ensure a minimal required level of quality to protect adolescents' rights in health care. (WHO 2014)

Young people report barriers to accessing services

- "Agencies need to be more approachable – people too bossy"
- Lack "Supportive and non-judgemental helpers"
- "Better PI Programmes that are relevant to youth"
- Workforce able to relate to their needs – "REAL" – life experience
- Re-brand from negative – ('problem focused') to normalised access for positive wellbeing – "remove stigma of being broken or damaged"
- Unable to get to services
- Later hours and longer hours for clinics
- Want access to knowledge – "ask them, not assume"

Youth Focus Groups & Pacific Youth Survey 2016

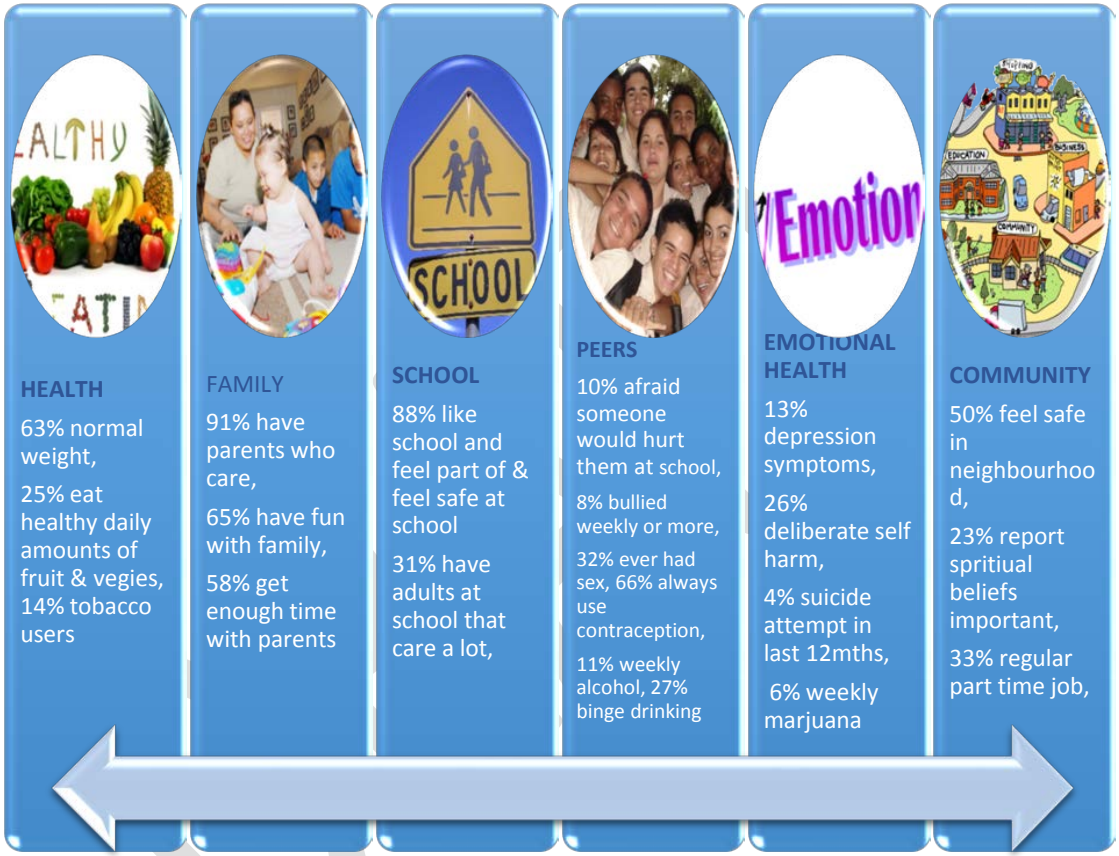
The health system must adapt to the needs of adolescents and their needs reside as much in preventive medicine as they do in curative medicine

– Michael Cohen

3. Youth 2012 (Auckland Health Research Group AHRG): Hawke's Bay Youth report

Dr Simon Denny (AHRG) provided a snapshot of information from Hawke's Bay youth surveyed in 2012 at school (482 students). A broad range of schools participated and were well represented across the decile school system for the Hawke's Bay. Dr Denny has provided an overview of the Hawke's Bay data alongside national trends.

Figure 1 : 'How a teen views the context of their lives' – trends from Youth 2000 survey series



In 2012 the questionnaire has a maximum of 608 questions – asking diverse questions about areas that affect young peoples' wellbeing; from languages spoken, to home and school life, employment, community contributions, and health behaviours.

Physical activity and eating fruit and vegetables have changed very little since 2007. The high proportion of students who are classified as overweight or obese by BMI also has not improved over time. In fact, nutrition and obesity is one of the areas where AHRG have seen things worsen for specific groups of young people. In this case Pacific young people have seen rates of obesity and severe obesity worsen significantly. Severe obesity has increased from 9% to 14% nationally - this is a huge increase.

Family relationships are incredibly important for young people to be healthy, safe and happy. Over the past decade young people are happier with 'how their family gets along'. The data trends are showing that parents increasingly want to know where their children are, and who they are with.

20.1

What hasn't improved for young people is their perception of getting enough time with their parents. Over 40% of young people feel they do not get enough time with their families.

Great news for schools! We know that students who feel safe and supported by their schools are likely to stay longer and do better academically. The findings show that increasingly students feel that adults at school care about them, and that their teachers are fair. Most students think school is okay or better.

Substance use is one of the most dramatic and exciting changes in the past decade. Smoking regularly has reduced 56% since 2001. Regular marijuana use has reduced 60% and binge drinking has reduced 43%. These reductions will account for a huge future health gains for New Zealand.

We are all aware that New Zealand has very high rates of suicide. The Youth 2000 survey series shows that suicide attempts have decreased since 2001, but have remained stable since 2007. Depressive symptoms dipped a bit in 2007 but then have gone back to 2001 levels. That is 13% of New Zealand secondary school students with significant depressive symptoms that will affect their ability to function in everyday life. While suicide rates have come down markedly since the late 1990s – it plateaued since the 2000s. These rates are still unacceptably high and the Hawke's Bay rate is above the New Zealand average.

Contrary to popular belief most young people in secondary schools are not sexually active. 75% of young people in 2012 in New Zealand secondary schools have not had sex. The survey data shows that the use of condoms and contraception however has not improved over time – it remains remarkably similar over the past 10 years. This suggests that we have not made significant improvements to improving access to contraception/condoms among sexually active young people in New Zealand. Teen pregnancy rates have decreased globally from 2008 but only more recently in New Zealand. This may be due to teens wanting to focus on economic pressure for their futures and different wider societal shifts.

The major cause of death and injury among New Zealand young people is motor vehicle crashes. Risky driving behaviours including being driven by someone who has drunk alcohol and being driven dangerously by someone have decreased significantly since 2001.

Violence is incredibly distressing for young people - and it is very heartening to see that fewer young people are being hit or harmed on purpose, been in physical fights and had been sexually abused. However, there is still considerable work to be done in this area.

Two of the issues that have worsened over the past decade are related to the socio-economic environments of young people. There has been a 38% decrease in young people who have paid part-time employment and a 50% increase in the number of young people who say their families worry about not having enough food. Both of these things affects a young person's ability to function well in society and can impact on their future.

Implications for health services:

- New morbidities will drive future health service need (nutrition, behaviour, mental health, comorbidities)
- Prevalence of new morbidities is high - primary care *vs* specialist/secondary care
- Young peoples' worlds are on-line and self-directed - information is everywhere

These implications will require a renewed look at workforce development to meet the changing needs and wider scope of professionals' involvement in health care for adolescents at the primary and referral levels. The workforce may need to be more multidisciplinary to minimize addressing needs in silos.

Training programmes need to be influenced by the changing nature of developmental needs driving outcomes. This may require more emphasis on chronic and preventive care models. This shift highlights the need for designing competency-based educational programmes that emphasize the developmental and contextual aspects of adolescent health, and enhance competencies in consultation, interpersonal communication and interdisciplinary care. *(WHO Core Competencies in Adolescent Health).*

Over the years, research continues to inform us of the sustainable benefits and high returns from investing in women's, children's and adolescents' health; evidence demonstrates 70% of preventable adult deaths from non-communicable diseases are linked to risk factors that start in adolescence.

A visiting global expert on teenage health gave New Zealand a glowing report card, with one exception – our high youth suicide rate. UN Advisor Professor Robert Blum, says fewer Kiwi teens are drink driving and smoking, but parents and teachers need to make them feel better connected. New Zealand's poverty levels too need attention." *(Ministry of Social Development)*

Professor Robert Blum recommends:

A Framework for Healthy Adolescence *or what young people need for healthy development:*

I. **Five Outcomes to achieve by age 15 for healthy development**
- Academic engagement
- Emotional and physical safety
- Positive sense of self/self efficacy
- Life and decision-making skills
- Physical and mental health

II. **Three Parental Behaviours Critical for Healthy Adolescent Development**
- Connection
- Encouraging autonomy
- Behavioural regulation

(Barber and Stoltz, 2005)

III. **Positive Communities create**
- Safety and structure;
- Belonging and group membership;
- Personal empowerment;
- Control over one's life;
- Competence;
- Closeness with peers and nurturing adults.

(Kirby & Cole)

The youth in Hawke's Bay clearly reinforces what global experts tell us about what is important for their resiliency and healthy development.

We can work together to increase opportunities for young people to thrive such as improve responsiveness of services, safer neighbourhoods and ensure access to high quality education and resilient health system. These are only points where they might linger or leave at any time. The journey is more successful when the young people own it, have the sense of identity, and abilities to be pro-active and seek out supports and opportunities to meet their needs.

We are very fortunate to have New Zealand based literature and evidence to support models of PYD including Māori and Pacific. Below is a brief outline of each to highlight the common theme and principles to support the paradigm shift from "fixing to nurturing" and recognise the full context of wellbeing for youth.

1. Positive Youth Development in NZ (PYDA)

In essence this PYDA framework suggests that both informal and formal initiatives, activities and programmes intentionally weave connections by integrating two key focuses and adopting three key approaches. This model supports creating key partnerships and systematic change.

The framework outlines:

1. Key outcomes:
   - Developing the whole person
   - Developing connected communities
2. Key approaches
   - Strength based
   - Respectful relationships
   - Building ownership and empowerment

2. **WHĀNAU ORA (Māori Health Strategy MAI):** The philosophy and policy of Whānau Ora begins with acknowledgement of whānau as the tahuhu (backbone) of Māori society. A key principle of our transformation is that consumers and whānau are at the centre of care rather than any provider or care setting. Whānau Ora embodies six key outcomes:
   - Whānau self-management
   - Healthy whānau lifestyles
   - Full whānau participation in society
   - Confident whānau participation in Te Ao Māori
   - Economic security, and successful involvement in wealth creation
   - Whānau cohesion

3. **Kautaha:** A strengths-based approach to building health and wellbeing
   Kautaha is a model for working together towards a common goal. It is underpinned by a set of related and coherent principles that takes a unified approach and focuses on strengths, potential and solutions rather than on accentuating problems and deficits. For these reasons the kautaha approach has been highly effective across history and could be successfully adapted to collective endeavours such as Fanau Ola, socio-economic and community development. *(Health Promotion)*

All the models presented endorse the underlying principles of strength-based approaches. These models' successes relies on the young person/rangatahi in the centre with strong connections to family/whānau for nurturing, and areas that enable and empower the young person to developmentally mature, filling their kete with skills, knowledge, and abilities to cope with life experiences through connections with family/whānau, school, work, peers, and community. This is particularly voiced by the young people as what 'matters for their wellbeing'.

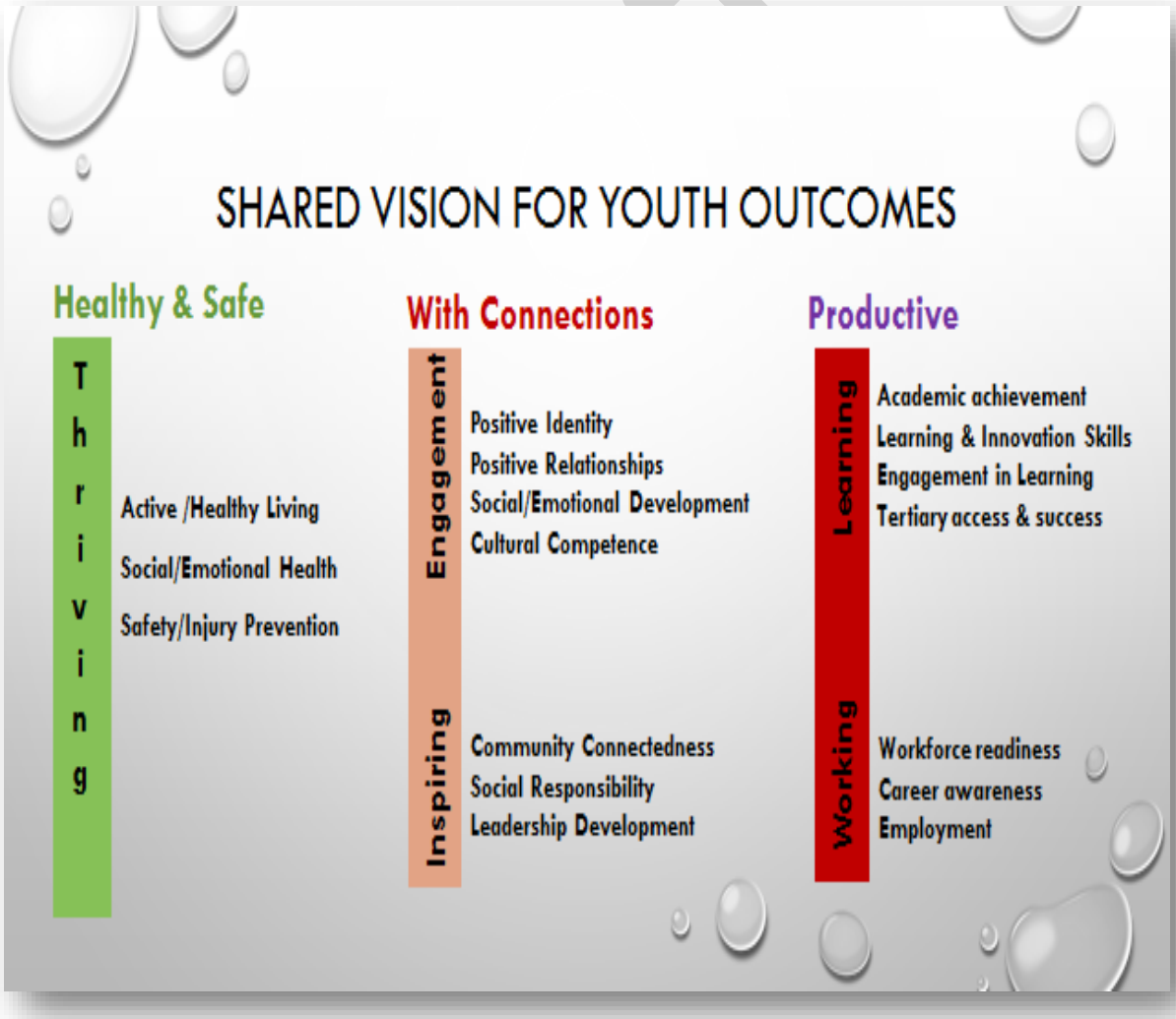
This is even more critical when we focus on vulnerable youth. Because "problem-free is not fully prepared, and fully prepared is not fully engaged". It is dangerous to be caught in the "fix then develop" fallacy. This argument holds that we must address problems facing young people who are vulnerable, involved in risky behaviours or experiencing adversity before they can take advantage of any opportunities focused on their growth. While it may be intuitively satisfying, this approach is not supported by research. *(Karen Pittman)* It is a misguided belief that has led to an over-emphasis on problem reduction as an acceptable goal for some sub-populations of young people, which, in turn, has often resulted in service dependency and lack of control for one's own wellbeing, or practices that either do not match the developmental practices necessary for positive outcomes or, in some cases, explicitly runs counter-productive to them; e.g. the need to fix problems far outweighs the capacity and capability to build strengths.

This is an opportunity for services to encourage:
- the development and evaluation of consistent/universal standards of quality care for youth
- promote excellence and innovation in the education and training of child and youth health professionals e.g. incorporate WHO core competencies for working with youth
- stimulate and promote the development of new knowledge
- promote the uptake and implementation of evidence-based practice and policy that can lead to improvement in child and youth health outcomes

Good habits formed at youth make all the difference. Aristotle"

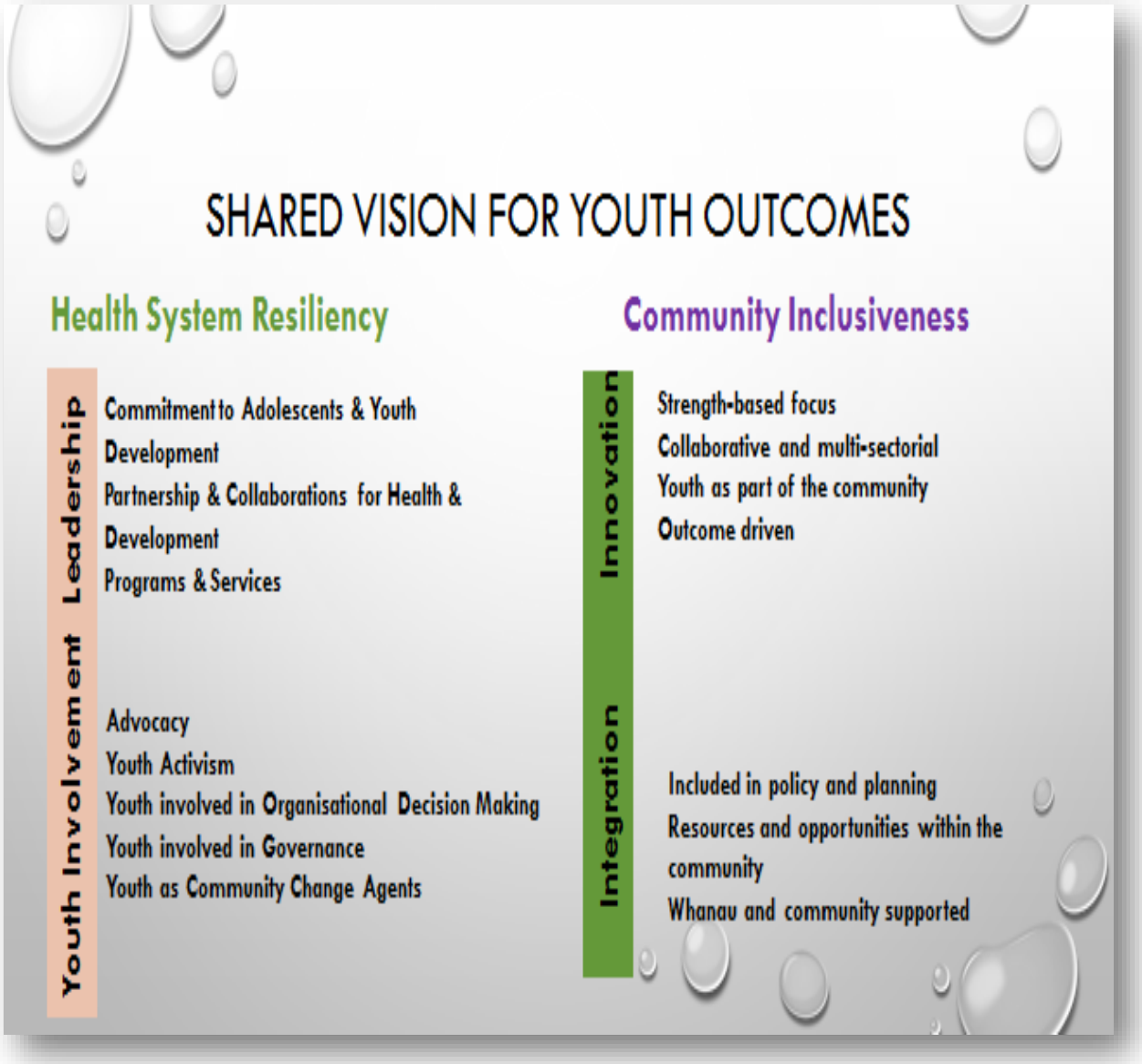
This Strategy aims to articulate a shared vision for young people by identifying a common set of youth outcomes and indicators that cuts across the work of many organisations/services working with youth. Though there are commonalities in how organisations/services talk about their goals and impact, the lack of shared language across the domains can lead to missed opportunities for collaboration, alignment and collective impact.

Our vision is that this framework enhances organisations/services individual and/or collective ability to define, communicate about, develop, and implement strength-based models to influence outcomes that ensure all youth are thriving in New Zealand.



The youth development approach calls for a balance between services designed to prevent, intervene or treat health problems and efforts that promote development through preparation, participation and leadership experiences with youth.

Creating synergy to meet the needs of youth in the full context of their lives will result in healthy opportunities for youth and sustainable social and economic benefits for the community for generations to come.



20.1

Goal 1: Healthy and Safe				
Principle	**Outcome**	**Indicator**	**Activities**	**Workforce Development**
Thriving	**Active/ Healthy Living**	• Youth live in maintained dry, clean, and safe housing • Youth develop and maintain healthy eating habits • Youth develop and maintain regular exercise habits • Youth participate in scheduled wellness checks/screens/ assessments • Youth develop health literacy • Youth participate in preventive care • Youth with chronic conditions or disability participate in their care and are included in the community	**EXISTING HEALTH PROVISION** • PHN – Puberty Education • Immunisations (11yo, HPV) • Oral Health • Health Promotion • National Heart Foundation • School Based Health Services (SBHS) • Rheumatic Fever Program (STC) • Diabetes • Dietetics • Green Prescription • Primary Care – U13 free care • Primary Care 13 -24yo • PHO programs **OTHER NGO/SECTORS PROVISION** • HNZ • Work and Income • CAB (e.g. budgeting, legal rights) • School Curriculum • School Policies for Healthy Food • School Sports • Sports Clubs • Community Parks and Recreation Facilities	• Te Tiriti o Waitangi • Ottawa Charter • Health Promoting Schools • Core competencies (WHO Guidelines) • Youth screening tools • Special issues • ASK model • FPA certificates and life skill courses • Collaborative processes • Community workshops

Goal 1: Healthy and Safe				
Principle	**Outcome**	**Indicator**	**Activities**	**Workforce Development**
			RECOMMENDATIONS 1. Increase access and utilisation by: • Normalise access to general services by promoting positive strength based access and utilisation such as 'Healthy Choices' (holistic not silo e.g. sexual health focus) • Implement wellness screens for all young people 11-13yo through PCP or SBHS. • Provide health education promoting youth development and planned support for developmental milestones. Utilise incentive based frameworks to positively influence self-management of preventive care • Develop youth friendly facilities and services through engagement with youth clientele through relevant surveys via social media tools 2. Improve communication tools relevant to youth • Coordinate youth developed campaigns to embrace healthy choices, healthy lives, healthy community that enable same message across all sectors for young people and families e.g. partnerships between health, education, and City Councils	
	Social/ Emotional Health	• Youth identify, manage and appropriately express emotions and behaviours. • Youth make positive decisions and access external supports. • Youth prevent, manage and resolve interpersonal conflicts in constructive ways. • Youth develop healthy relationships.	**EXISTING HEALTH PROVISION** • YOSS • PCP Depression (PHO Packages of Care) • E-Therapy • CDU • CAFS • ACC Mates & Dates Program • SAFE/Wellstop • Multiagency Abuse Services **OTHER NGO/ SECTORS PROVISION**	

20.1

Goal 1: Healthy and Safe				
Principle	**Outcome**	**Indicator**	**Activities**	**Workforce Development**
			• Mentoring programs • School curriculum • Pastoral care • RTLB • Special education • CYF • HCN • ACC • Restorative justice programs • DOVE • Police programs • Church youth groups **RECOMMENDATIONS** 1. Improve access and utilisation by: • Develop key relationships/partnerships within matching areas to streamline ease of access • Build consistency of strength-based models • Develop transparency and fluidity of progressive support from one service to another (e.g. transition, shared care, transfer) 2. Improve communication tools relevant to youth: • Provide a licence card for young people to own that shows all service available with ability to stamp a service to show it has been used/active e.g. like coffee cards • Develop an app that shows map of services – e.g. AOD Collaborative, Napier City Council • Advertise services through social media promoting positive influence and support	
	Safety/ Injury Prevention	• Youth avoid risky behaviours. • Youth avoid bullying behaviours. • Youth use refusal skills.	**EXISTING HEALTH PROVISION** • Health Promotion (e.g. smoking cessation, violence free) • YOSS • PCP Depression (PHO Packages of Care)	

Goal 1: Healthy and Safe				
Principle	**Outcome**	**Indicator**	**Activities**	**Workforce Development**
		• Youth avoid using illegal substances.	• PHO Sexual Health Program • Children's' Team • Youth AOD Services & Programs • CAFS/YFS • Adult Mental Health (including AOD) • ACC Counselling **OTHER NGO/SECTORS PROVISION** • Police Programs • CYF • Private Specialist Services • School Curriculum and anti-violence programs • School Pastoral Care • RTLB • Special Education • HCN • Family Services • AOD Counselling • Psychological Services • Church supports and/ programs **RECOMMENDATIONS** 1. Improve access and utilisation by: • Consistent, timely, and reliable information sharing processes • Planning is focused on the needs of the young person and includes active participation of young person • Provide screening, consultation and liaison by youth health services in GP practices with high percentage of Māori and Pacific youth or high percentage of truancy identified in youth • Provide consultation and liaison by youth mental health services in GP practices and schools with high percentage of Māori and Pacific youth or high percentage of depression identified in youth	

20.1

Goal 1: Healthy and Safe				
Principle	**Outcome**	**Indicator**	**Activities**	**Workforce Development**
			• Provide transition planning and promote relationship building when changing to shared/transfer of care. Include whānau or supportive caring adult in this planning • Provide appropriate screening training to all services for youth to build consistency and increased anticipatory opportunities • Promote health and development opportunities for youth and separately for families/whānau – build consistent messages and support 2. Increase communication tools relevant to youth by: • Utilisation of social media to promote and normalise access to services	

PERFORMANCE MEASURES	**What contracts are utilised?**	**How much did we do?**	***Results Based Accountability Framework*** **How well did we do it?**	**Are Youth Healthy & Safe -THRIVING?**
	• SBHS • Oral Health • YOSS • Health Promotion	• Immunisations • Dental Care • Health Education • Wellness Screens • Health service enrolment and utilisation	<u>Impact to Health Status</u> • Reduction in obesity • Reduction in diabetes • Increased access to Dental services • Increased planned access to healthcare • Reduction in acute access to healthcare for preventable issues • Reduced hospital admissions • Reduced unplanned pregnancy • Increased participation in youth activities • Youth participate in safe risk taking activities • Youth maintain emotional wellbeing	Utilise collaborative measures
PARTNERSHIPS	**What is new or now available?**	**Who is working together?**	**What new partnerships have been formed outside of health?**	**What else is needed?**
	• New Investment • Established service/ program • Changed service /program	• New relationships or partnerships • Changes to existing partnerships • Transfer of services	• Mapping of needs and outcomes to relevant services required and forming a multiagency partnership • Strengthened capacity and capability to meet needs of youth and provide innovative and/or integrated supports more able to suit to enabling positive development (e.g. sum of all efforts) • Enhanced and consistent workforce development	• What youth needs are not met? • What supports are required to enable positive development? • Who needs to provide it? • What outcome will be achieved and by when?

20.1

Goal 2: With Connections				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**ACTIVITIES**	**WORKFORCE DEVELOPMENT**
ENGAGEMENT	**Positive Identity**	• Youth develop a strong sense of self. • Youth develop positive values.	**EXISTING HEALTH PROVISION** • YOSS (includes transgender) • Māori Services • Pacific Services • Wraparound Services • TPU • Health Promotion • CDU (includes disability) **OTHER NGO/SECTOR PROVISION** • School curriculum • RTLB • Special education • Church • Youth groups • Mentoring groups/programs • Sports/Fitness/Arts/Culture Groups • Family programs • Parenting programs **RECOMMENDATIONS** • Develop strength based models to support positive influence of life skills • Coordinate programs consistency with principles of PYD • Utilise workforce youth are able to consider 'REAL' and relevant with appropriate life experiences • Promote non-judgemental and acceptance for diverse cultures significant to youth • Support developments across sector partnerships for activities and facilities for youth to do and be • Support development and training of peer supports	• Cultural competency • Hart Ladder • Peer to Peer Support • Motivational interviewing • Brief interventions • Solutions Focus Brief Therapy • Werry Centre E-Learning • Undergraduate/ Postgraduate Study – youth health, mental health, psychology, youth work, social work, speech language • Diversity training e.g. transgender, values • Whānau Ora • COPMIA • Social media training and development • Youth development in chronic illness and development • Leadership development
	Positive Relationships	• Youth develop positive, sustained relationships with caring adults. • Youth develop positive relationships with peers. • Youth affiliate with peers who abstain from negative behaviours.		
	Social /Emotional Development	• Youth develop social skills • Youth demonstrate pro-social behaviour. • Youth develop friendship skills. • Youth develop coping skills		
	Cultural Competence	• Youth develop cultural competence. • Youth advance diversity in a multicultural world. • Youth respect diversity		

Goal 2: With Connections				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**ACTIVITIES**	**WORKFORCE DEVELOPMENT**
			• Health partner with education to deliver health curriculum in schools – increase health literacy • Support development and provision of parenting programs for 'parenting teens' • Provide opportunities for youth to volunteer • Provide opportunities for youth to use cultural skills and promote cultural inclusiveness	
INSPIRATION	**Community Connectedness**	• Youth feel a sense of belonging. • Youth participate in community programs.	**EXISTING HEALTH PROVISION** • YOSS • Youth led conferences • Youth Focus Group (Directions) **OTHER NGO/SECTOR PROVISION** • School • City Council youth groups • Mentoring programs • Church participation • Volunteer groups **RECOMMENDATIONS** • Provide opportunities to develop and train youth as teachers in health settings • Provide opportunities for youth guides in hospitals • Provide opportunities for youth as peers supports • Provide opportunities for youth to develop leadership abilities and utilise these skills	
	Social Responsibility	• Youth demonstrate civic participation skills • Youth feel empowered to contribute to positive change in their communities. • Youth volunteer/participate in community service. • Youth consider the implications of their actions on others, their community, and the environment.		

20.1

Goal 2: With Connections				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**ACTIVITIES**	**WORKFORCE DEVELOPMENT**
	Leadership Development	• Youth educate and inspire others to act. • Youth demonstrate leadership skills • Youth model positive behaviours for peers. • Youth communicate their opinions and ideas to others.	• Provide opportunities for youth involvement in governance and advisory groups	

PERFORMANCE MEASURES	What contracts are utilised?	How much did we do?	Results Based Accountability Framework How well did we do it?	Are Youth Engaged and Inspired with CONNECTIONS?
		• Rates of anxiety and service access • Access to SBHS, PCP, YOSS, Mental Health • Success stories – qualitative data	Impact to Positive Development • Active participation in youth focus groups • Increase in youth led/inspired health and/or social forums • Access improvement and timeliness to mental health services • Fluid transition process between services for shared/transfer of care • Improved timely information sharing	
PARTNERSHIPS	What is new or now available?	Who is working together?	What new partnerships have been formed outside of health?	What else is needed?

Goal 3: Productive				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**ACTIVITIES**	**WORKFORCE DEVELOPMENT**
LEARNING WORKING	**Academic Achievement**	• Youth are on track for high school graduation. • Youth graduate from high school. • Youth perform at or above age level. • Youth improve education achievement.	**EXISTING HEALTH PROVISION** • SBHS including Alternate Education (Yr 9 Assessments) • NEET programs • AOD programs • PCP (Tertiary) • Health Promotion **OTHER NGO/SECTOR PROVISION** • NEET programs • School Pastoral Services • RTLB • Special education • Youth Transition Services • Transition Coordinators (Disability) • Mentoring programs • Private learning programs • Tutoring programs • Tertiary education open days • Tertiary education support	• Disability • FASD • Health literacy • Oral language • Life skills development • Emotional wellbeing screening/assessment • Motivational interviewing • CBT
	Learning and Innovation Skills	• Youth demonstrate critical thinking skills (e.g. reasoning, analysis). • Youth solve problems. • Youth work in groups to accomplish learning goals. • Youth think creatively		
	Engagement in Learning	• Youth express curiosity about topics learned in and out of school. • School attendance improves. • Youth spend time studying. • Youth spend time reading. • Motivation to learn.		

Goal 3: Productive				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**ACTIVITIES**	**WORKFORCE DEVELOPMENT**
	Tertiary Access/ Success	• Youth plan to attend Tertiary education. • Youth enrol in Tertiary education. • Youth complete some type of Tertiary qualification	**RECOMMENDATIONS** • Annual YHD review linked to School Pastoral Services (e.g. holistic support for individualised learning pathways) • Upskill workforce to screen for anxiety around normal daily functioning and provide brief interventions to increase coping skills without needing secondary intervention • Coordinate and prioritise transition programs for chronic illness, vulnerable, or disability to all areas relevant to development needs at an early stage for pro-active planning. Enable youth to participate and lead their plan supported by family/whānau as able • Implement support programs that youth have responsibility in setting end timeframes	
	Workforce Readiness	• Youth develop communication skills. • Youth work effectively in groups. • Youth develop critical thinking and decision-making skills. • Youth develop positive work habits.	**EXISTING HEALTH PROVISION** • PCP • YOSS • PHO Packages of Care • Options - Disability **OTHER NGO/SECTOR PROVISION** • Career expos • Work and Income career advisors • Citizens Advice Bureau • Disability expos • Disability Support and Employment Services • Residential carers and homes	
	Career Awareness	• Youth develop knowledge about occupations. • Youth are aware of their interests and abilities (passion and strengths).		

20.1

Goal 3: Productive				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**ACTIVITIES**	**WORKFORCE DEVELOPMENT**
	Employment	• Youth are employed at wages that meet their basic needs. • Youth established in employment/career within five years of graduating from high school.	• Independent youth programs • Iwi services **RECOMMENDATIONS** • Youth with disabilities have support while at school to plan/ enable independent lives suitable to their needs as future goals	

PERFORMANCE MEASURES	**What contracts are utilised?**	**How much did we do?**	**Results Based Accountability Framework How well did we do it?**	**Are Youth PRODUCTIVE?**
		• Youth engagement at school • Youth involved in activities • Youth are role models • Youth volunteering	**Impact to Positive Development** • Youth complete high level of learning • Youth are not on benefits • Planned transitions • Ability to live independently • Ability to be financially independent	• How well prepared/ready are young people for each level of learning? • How well prepared/ready are young people for Tertiary Education? • How well prepared /ready are young people for employment?
PARTNERSHIPS	**What is new or now available?**	**Who is working together?**	**What new partnerships have been formed outside of health?**	**What else is needed?**
		• Cross-sector overseeing disability and chronic illness for independence		

20.1

Goal 4: Health System Resiliency				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**ACTIVITIES**	**WORKFORCE DEVELOPMENT**
LEADERSHIP	**Commitment to Adolescents and Youth Development**	• YHD Governance Group • Positive Youth Health & Development Advisory/ Research Group for knowledge brokering	**EXISTING HEALTH PROVISION** • Develop policies and contracts committed to principles of PYD • SLAT **RECOMMENDATIONS** 1. To improve leadership and sustainability of Positive Youth Health and Development • Develop and support Population Trends Advisory Groups • Develop MOUs to support key partnerships to support leadership, responsiveness, research, quality improvement, IT support • Develop collaborative partnerships with key agencies invested in long term gains for youth e.g. YOSS, SBHS, PHO, CDU, CAFS, Māori, Pacific, and youth involvement to support model of Excellence of YHD • Develop YHD Review Panel for complex cases including YOSS, SBHS, CAFS, Paeds (including Gateway), Children's Team, CYF, Police, HNZ, WINZ, MOE, to guide sectors on collaborative processes and best practice to support development needs • Support resourcing capacity and capability for development of YHD Leadership for a Centre/Model of Excellence across the region • Develop national links to support establishment of Centre/Model of Excellence e.g. Collaborative	• SLAT Development and ongoing support • Management and understanding of PYD • Collaborative workshops
	Partnerships and Collaborations for Health and Youth Development	• Establishment of Centre/Collaborative Model of Excellence to support EBBP and Workforce Development for Youth Health and Development • Establishment of Interagency Accountability Framework (Act, Monitor, Review)		
	• **Programs and Services (including program assessment, planning and evaluation)** • **Education and Technical Assistance** • **Collective Data Collection and Surveillance**	• Youth understand and know all services available and how to access the right service at the right time with services they trust and respect • Youth are appropriately matched to their developmental stages for managing chronic illness and disability • Programs provide critical supports, services and opportunities • Programs(and/with partners) address related interdisciplinary adolescent issues		

Goal 4: Health System Resiliency				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**ACTIVITIES**	**WORKFORCE DEVELOPMENT**
		• Programs go beyond a focus on individual behaviour change, creating positive environments in family • Collective data management and reporting	(Christchurch), Centre for Youth Health (Auckland), SYHPANZ (National) • Development of outcome measures across sectors 2. To improve outcomes for youth when accessing multiple providers by enabling information to travel with the young person from service to service in a timely manner • Develop portals to support and enable improved information sharing e.g. a single PMS for community services with access to public health database • Develop collective reporting tools to match broader partnerships and mutual outcomes/results • Develop collective data management across the sectors to match strategic vision to capture healthy youth, healthy whānau, healthy community – holistic and strength-based	

Goal 4: Health System Resiliency				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**ACTIVITIES**	**WORKFORCE DEVELOPMENT**
YOUTH INVOLVEMENT	• **Youth involved in Organisational Decision Making** • **Youth involved in Governance** • **Youth as Community Change Agents**	• Youth hold governance positions • Youth hold leadership positions in health services • Youth designed programs are implemented • Youth are involved in training workforce • Youth lead developments with social media communication • Youth involved in evaluation programs	**EXISTING HEALTH PROVISION** **OTHER NGO/SECTOR PROVISION** **RECOMMENDATIONS** • Youth and families participate in designing and delivery of expos, Health Promotion forums, Family/Parenting workshops • Provide opportunities of leadership for families • Provide support to families/whānau to encourage and support their children's involvement in leadership roles • Provide opportunities to celebrate youth and family success or appropriate avenues to share learnings that will grow positive development for youth and families/whānau • Negotiate with EIT around involvement of youth students (e.g. nursing, teaching, social work, disability) are able to have course requirements incorporated into involvement in research or youth projects relevant to youth health and development	

Goal 4: Health System Resiliency				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**ACTIVITIES**	**WORKFORCE DEVELOPMENT**
PERFORMANCE MEASURES	**What contracts are utilised?**	**How much did we do?**	**Results Based Accountability Framework How well did we do it?**	**Are Youth better off?**
	• How many services are working across multiple PYD outcome areas?	• Successful partnerships • Collaborative processes and systems • Accessible youth services		
PARTNERSHIPS	**What is new or now available?**	**Who is working together?**	**What new partnerships have been formed outside of health?**	**What else is needed?**

20.1

Goal 5: Community Inclusiveness				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**ACTIVITIES**	**WORKFORCE DEVELOPMENT**
INNOVATION INTEGRATION	**Strengths-Based Approaches**			
	Development Focused			
	Developing the 'Whole' Young Person			
	Social Connectedness	Supporting the whānau and the community		
	Independence and Empowerment			

PERFORMANCE MEASURES	What contracts are utilised?	How much did we do?	Results Based Accountability Framework How well did we do it?	Are Youth better off?
PARTNERSHIPS	What is new or now available?	Who is working together?	What new partnerships have been formed outside of health?	What else is needed?

20.1

Sources of NZ Information

The Adolescent Health Research Group (AHRG)

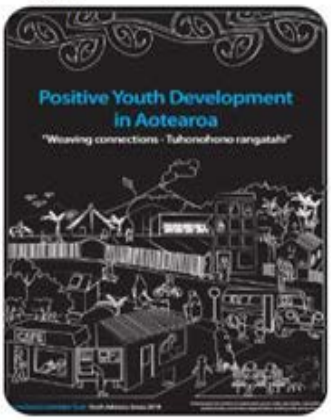
Youth2000 survey series

Christchurch and Dunedin Longitudinal Studies

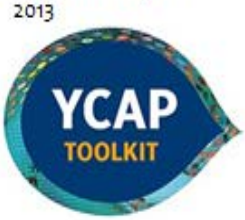
And more.....
The Pathways to Resilience Project (Massey)
The Collaborative (ChCh)
.....

2002
along with Youth Health: A Guide to Action and E Tipu e rea

2011



Vulnerable/ high risk - 2013



A resource manual for Primary Care - 2014

To be completed

HBDHB	Hawke's Bay District Health Board
PYD	Positive Youth Development
CHDS	Christchurch Health and Development Study
CAFS	Child Adolescent & Family Service
AHRG	Adolescent Health Research Group

HAWKE'S BAY District Health Board Whakawāteatia	**Endoscopy Service Transition Update**
	For the attention of: **Maori Relationship Board (MRB), Clinical and Consumer Council and Finance Risk and Audit Committee (FRAC)**
Document Owner: Document Author(s):	Sharon Mason Paula Jones and Mandy Robinson
Reviewed by:	Health Services Leadership Team, Executive Management Team
Month:	May, 2016
Consideration:	For Information

RECOMMENDATION

That MRB and Consumer & Clinical Councils and FRAC:

Note the contents of this report.

OVERVIEW

This report provides an update on the Improved Endoscopy Services Project, and more specifically the Gastroenterology service optimisation and facility development phase two. This reports focusses solely on the service transition management component of the project. It excludes the facility planning of which an update was provided to FRAC in March 2016. Geotechnical and seismic aspects of the project were also reported at that time.

BACKGROUND

A supplementary paper to support the 2012 Business Case for Improved Endoscopy services was approved at the HBDHB Board meeting on 29 July 2015. The paper included details of the three further project phases. Phase two of the project focused on service operation and transition management.

Project Goal Phase Two

The plan was to continue with the design and documentation phase of the project, including resource and building consents through to tendering and negotiating the preferred construction contract.

Planned transition arrangements included:

- Logistical integration of out-patients and in-patients operational management.
- Clinical integration of the medical gastroenterology and interventional gastroenterology teams.
- Service provision and model to meet increasing demand and health targets.
- Review development of joint working with the private sector.
- Confirm the RFP process for utilisation of latent capacity.

Logistical integration of out-patients and in-patients operational management

As of July 2015, the endoscopy service was moved from Elective and Surgical Services to Acute and Medical Directorate. A new cost centre was established and the integration of the gastroenterology medical outpatient component with the endoscopy team occurred reporting to the Nurse Manager, Oncology and Medical Subspecialties. The transfer of the personnel has been partially completed and the transfer of the non-personnel costs is occurring in stages. Operationally the nursing team has established a strong vision for the nursing services and are committed to achieving success. The consumables are more complex to untangle from the surgical supplies and therefore it will be a phased approach starting with the obvious endoscopy only purchases, and the outpatient consumables, including pharmacology. The plan is to progress the separation of all non-personnel items from the medical subspecialty and surgical cost centres by July 2017.

The administration support for the gastroenterology service is status quo. A review of the essential functions and responsibilities will be undertaken by November 2016 to confirm the activities and roles for a fully integrated service to be ready for the new unit. The unit will plan to operate two procedure rooms and full clinics from the outset. The logistics of the file management, clinic scheduling, reception, patient bookings, discharge planning, clinical letters, and secretarial support are key aspects of an efficient clinical department. There will be changes to the HBDHB hospital infrastructure within this period, such as referral management, patient focused booking and National Patient Flow. These changes may well impact on the administration support functions and therefore determine the scope of roles. A clearer view of the environment is required prior to embarking on a review and change management process for the administration support partners in the gastroenterology service.

Clinical integration of the medical gastroenterology and interventional gastroenterology teams

A positive outcome of the development of the integrated gastroenterology service is the co-location of the clinical personnel and the administration team. All members of the medical and nursing teams have worked together although they have been dispersed across the hospital campus. The unit will bring the disciplines together.

In July 2015, the nursing team commenced planning for “one team” and this was successfully completed by December 2015. Each team member has been confirmed into their role with an understanding of the challenge to be competent across all aspects of an integrated service. From January 2016, the orientation into gastroenterology medical outpatients commenced for a member of the endoscopy team, and this will continue to ensure confidence and capacity for endoscopy bowel preparation, Inflammatory Bowel Disease (IBD) services, and pre/post procedural care. The additional resources signed off in the business case will be required to complete a comprehensive transition to the integrated service.

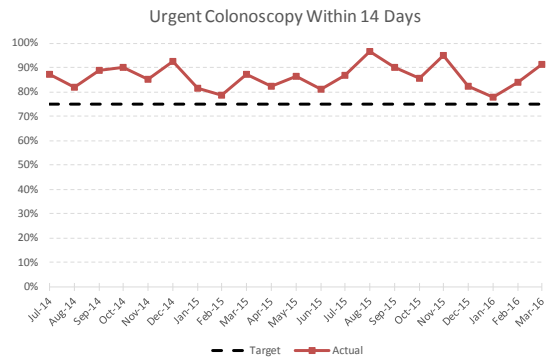
The gastroenterologist consultant work force is below full capacity currently and there are additional resources to be released as per business case. The credentialed scope of the roles is confirmed and gaps in capacity will be addressed with recruitment. Additional consultant capacity will be essential to meet the proposed national bowel screening programme demand.

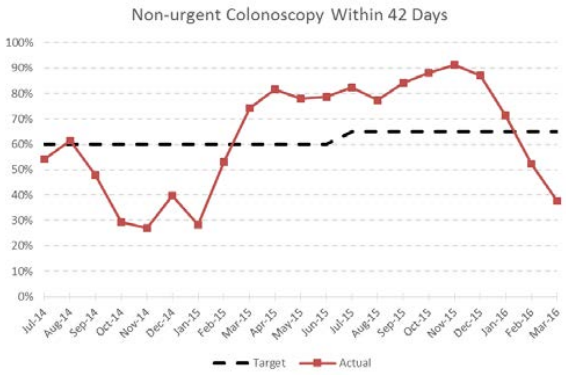
The proposed national bowel screening four year pilot (2012-2015) at Waitemata DHB has been extended until December 2017. This pilot is providing essential information that will help determine if a bowel screening programme should be rolled out nationally. Information from the Waitemata DHB bowel screening pilot is helping the MOH prepare a business case to seek funding and approval for a proposed national bowel screening programme. To date, no decision have been made if a national programme will be introduced.

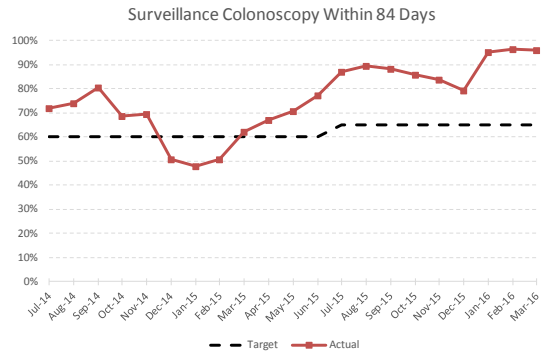
Service provision and model to meet increasing demand and health targets.

- **Health Targets**

The current constraints on physical space and clinical resource ensures service provision is well planned and efficient. There is a focus to ensure every scheduled session is maximised either by the gastroenterologists or a member of the surgical team. All the referrals for medical and endoscopic review are triaged by a senior nurse to enable a streamlined prioritisation process by the consultants. The booking coordinator for endoscopy monitors referral wait times to ensure the delays are minimised for patients and the service achieves the colonoscopy indicators for the Ministry of Health's performance monitoring. The graphs below demonstrate performance against these indicators since July 2014. Non-urgent referrals did not meet the indicator for February and March 2016 due to reduced service delivery as a result of two Public Holidays (Easter) and Consultant leave. The option of Saturday sessions has been trialled successfully and at this time the service is planning one per month to address the waiting list and demand. Additional Ministry of Health funding for period 23 February 2016 to 30 June 2016 will support additional colonoscopy lists and ensure continued compliance with the Ministry of Health colonoscopy indicators. These extra colonoscopy lists will be configured so that non urgent waiting times improve to meet the 65% indicator by the end of June 2016.







The service monitors actual colonoscopy volumes against those projected in the business case and the provisional colonoscopy volumes for the proposed national bowel screening programme that were provided by the Ministry of Health in August 2015 as follows.

Actual Colonoscopy volumes compared to Business case

Calendar Year	Actual	Business Case	Difference	% Differential
2014	1,204	1,166	-38	-3%
2015	1,495	1,428	-67	-5%
2016 Jan – Mar	289			
2016	1,510	1,459	-51	-3%

The table above demonstrates the service is undertaking slightly more procedures than predicted. This is due to managing the demand and facilitating additional sessions to facilitate compliance with the Ministry of Health Colonoscopy Indicators.

Actual Colonoscopy volumes compared to the Ministry of Health provisional volumes for the proposed national bowel screening programme

Calendar Year	Actual	Ministry of Health provisional volumes	Difference	% Differential
2014	1,204	1,646	442	27%
2015	1,495	1,645	150	9%
2016 Jan - Mar	289			
2016	1,510	1,635	125	8%

The table above demonstrates the service is undertaking slightly less procedures than predicted. This is due to alignment of the release of business case funds to increase the capacity within the team to meet these predicted volumes. The service is confident that as funds become available in 2016-17 these predicted volumes will be met. Extra capacity will be sourced through weekend sessions and external contracts.

- **Referral management**

There has been an internal review of the referral management process for the outpatient and elective booking systems. The inefficiencies of crossing between two systems has highlighted the delays and associated clinical risks, in the internal referral management process. A comprehensive referral management map has been designed as the ideal process for an integrated service. Information Services is reviewing the software options to enable the process electronically. The solution would remove all delays in the referral process, and facilitate each activity to be viewed and responded to in real time. There would be clarity of the referral pathway for all members of the team and enable timely responses and decisions to support service production and delivery. For the patient there will be assurance that no referral will be lost and waiting times are minimised.

- **Bowel preparation**

All endoscopy procedures require the patient to be adequately prepared for an examination of the bowel. The process requires a lead in time of a minimum five days. The referrals prioritised as urgent are scheduled within 14 days and therefore the booker and the bowel preparation nurse are communicating with the patient promptly. The current space constraints within the day surgery environment are challenging and access to computers and quiet space continues to be a problem.

There are a number of patients who require two nights admission in order to ensure the preparation is successful without compromising their health status, and then post procedural monitoring if at risk of adverse effects as a consequence of the procedure and the sedation. Access to beds is very competitive and unless a patient can be assured of an admission the endoscopy will be postponed. There often is an associated clinical risk with delay. To address this problem the clinical team have defined specific criteria for the at risk patient to determine who requires admission for an endoscopy procedure. Therefore the request for a bed is clinically justified.

A review of alternative management of the overnight stay i.e. in aged residential care facility or in the community, has identified potential options which are clinically safe and release the need for an inpatient bed for two days (estimated an average of 10 patients per month). A pilot is under development to evaluate the effectiveness and a 2016-17 budget bid has been submitted to implement on a permanent basis. Therefore, demand and need for inpatient beds and delays to clinical diagnosis may be mitigated by reducing the potential postponement of procedures.

Review development of joint working with the private sector.

There has been some progress on this aspect of service development. The consultants have successfully become credentialed to work in the private sector at Royston. In 2015 the team led by a gastroenterologist undertook a full session of endoscopies in Royston. The planning logistics for capture and integration of clinical documentation and provation reporting were successful, and the ability to work in the private sector environment is recognised.

Confirm the RFP process for utilisation of latent capacity.

Although the RFP process for utilisation of the latent capacity has not been confirmed to date, there has been some discussion and the Steering Group have tasked Trent Fairey to develop a concept paper outlining what the latent capacity could potentially be used for.

CONCLUSION

The service transition management component of the gastroenterology service optimisation and facility development phase two project is progressing on time and within budget. The project team and consumer engagement group are well engaged and ensuring all milestones are being met.

GLOSSARY OF COMMONLY USED ACRONYMS

A&D	Alcohol and Drug
AAU	Acute Assessment Unit
AIM	Acute Inpatient Management
ACC	Accident Compensation Corporation
ACP	Advanced Care Planning
ALOS	Average Length of Stay
ALT	Alliance Leadership Team
ACP	Advanced Care Planning
AP	Annual Plan
ASH	Ambulatory Sensitive Hospitalisation
AT & R	Assessment, Treatment & Rehabilitation
B4SC	Before School Check
BSI	Blood Stream Infection
CBF	Capitation Based Funding
CCDHB	Capital & Coast District Health Board
CCN	Clinical Charge Nurse
CCP	Contribution to cost pressure
CCU	Coronary Care Unit
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHB	Central Hawke's Bay
CHS	Community Health Services
CMA	Chief Medical Advisor
CME / CNE	Continuing Medical / Nursing Education
CMO	Chief Medical Officer
CMS	Contract Management System
CNO	Chief Nursing Officer
COO	Chief Operating Officer
CPHAC	Community & Public Health Advisory Committee
CPI	Consumer Price Index
CPO	Co-ordinated Primary Options
CQAC	Clinical and Quality Audit Committee (PHO)
CRISP	Central Region Information System Plan
CSSD	Central Sterile Supply Department
CTA	Clinical Training Agency
CWDs	Case Weighted Discharges
CVD	Cardiovascular Disease
DHB	District Health Board
DHBSS	District Health Boards Shared Services
DNA	Did Not Attend
DRG	Diagnostic Related Group
DSAC	Disability Support Advisory Committee
DSS	Disability Support Services
DSU	Day Surgery Unit
ED	Emergency Department
ECA	Electronic Clinical Application

ECG	Electrocardiograph
EDS	Electronic Discharge Summary
EMT	Executive Management Team
EoIs	Expressions of Interest
ER	Employment Relations
ESU	Enrolled Service User
ESPIs	Elective Service Patient Flow Indicator
FACEM	Fellow of Australasian College of Emergency Medicine
FAR	Finance, Audit and Risk Committee (PHO)
FRAC	Finance, Risk and Audit Committee (HBDHB)
FMIS	Financial Management Information System
FSA	First Specialist Assessment
FTE	Full Time Equivalent
GIS	Geographical Information System
GL	General Ledger
GM	General Manager
GMS	General Medicine Subsidy
GP	General Practitioner
GP	General Practice Leadership Forum (PHO)
GPSI	General Practitioners with Special Interests
GPSS	General Practice Support Services
HAC	Hospital Advisory Committee
H&DC	Health and Disability Commissioner
HBDHB	Hawke's Bay District Health Board
HBL	Health Benefits Limited
HHB	Health Hawke's Bay
HQSC	Health Quality & Safety Commission
HOPSI	Health Older Persons Service Improvement
HP	Health Promotion
HR	Human Resources
HS	Health Services
HWNZ	Health Workforce New Zealand
IANZ	International Accreditation New Zealand
ICS	Integrated Care Services
IDFs	Inter District Flows
IR	Industrial Relations
IS	Information Systems
IT	Information Technology
IUC	Integrated Urgent Care
K10	Kessler 10 questionnaire (MHI assessment tool)
KHW	Kahungunu Hikoi Whenua
KPI	Key Performance Indicator
LMC	Lead Maternity Carer
LTC	Long Term Conditions
MDO	Maori Development Organisation
MECA	Multi Employment Collective Agreement
MHI	Mental Health Initiative (PHO)
MHS	Maori Health Service
MOPS	Maintenance of Professional Standards
MOH	Ministry of Health
MOSS	Medical Officer Special Scale
MOU	Memorandum of Understanding

MRI	Magnetic Resonance Imaging
MRB	Māori Relationship Board
MSD	Ministry of Social Development
NASC	Needs Assessment Service Coordination
NCSP	National Cervical Screening Programme
NGO	Non Government Organisation
NHB	National Health Board
NHC	Napier Health Centre
NHI	National Health Index
NKII	Ngati Kahungunu Iwi Inc
NMDS	National Minimum Dataset
NRT	Nicotine Replacement Therapy
NZHIS	NZ Health Information Services
NZNO	NZ Nurses Organisation
NZPHD	NZ Public Health and Disability Act 2000
OPF	Operational Policy Framework
OPTIONS	Options Hawke's Bay
ORBS	Operating Results By Service
ORL	Otorhinolaryngology (Ear, Nose and Throat)
OSH	Occupational Safety and Health
PAS	Performance Appraisal System
PBFF	Population Based Funding Formula
PCI	Palliative Care Initiative (PCI)
PDR	Performance Development Review
PHLG	Pacific Health Leadership Group
PHO	Primary Health Organisation
PIB	Proposal for Inclusion in Budget
P&P	Planning and Performance
PMS	Patient Management System
POAC	Primary Options to Acute Care
POC	Package of Care
PPC	Priority Population Committee (PHO)
PPP	PHO Performance Programme
PSA	Public Service Association
PSAAP	PHO Service Agreement Amendment Protocol Group
QHNZ	Quality Health NZ
QRT	Quality Review Team
Q&R	Quality and Risk
RFP	Request for Proposal
RIS/PACS	Radiology Information System Picture Archiving and Communication System
RMO	Resident Medical Officer
RSP	Regional Service Plan
RTS	Regional Tertiary Services
SCBU	Special Care Baby Unit
SLAT	Service Level Alliance Team
SFIP	Service and Financial Improvement Programme
SIA	Services to Improve Access
SMO	Senior Medical Officer
SNA	Special Needs Assessment
SSP	Statement of Service Performance
SOI	Statement of Intent

SUR	Service Utilisation Report
TAS	Technical Advisory Service
TOR	Terms of Reference
UCA	Urgent Care Alliance
WBS	Work Breakdown Structure
YTD	Year to Date