Māori Relationship Board Meeting

Date:	**Wednesday, 10 August 2016**
Meeting:	**9.00am to 12.00pm**
Venue:	**Te Waiora Meeting Room, District Health Board Corporate Office, Cnr Omahu Road & McLeod Street, Hastings**

Board Members:

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

Apologies: 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
Member of Ngāti Kahungunu Iwi Inc.
Member of Health Hawke's Bay Public Health Organisation (HHB PHO)
Members of the Māori Health Service
Members of the Public

Our vision

HEALTHY HAWKE'S BAY

TE HAUORA O TE MATAU-Ā-MĀUI

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

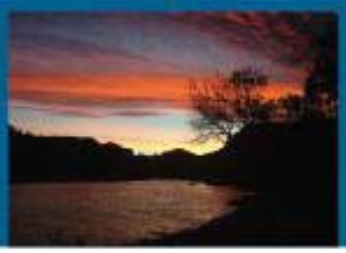
Our values

Tauwhiro – delivering high quality care to patients and consumers

Rāranga te tira – working together in partnership across the community

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

Ākina – continuously improving everything we do



PUBLIC MEETING

Item	Section 1 : Routine	Time
1.	Karakia	**9.00am**
2.	Whakawhanaungatanga	
3.	Apologies	
4.	Interests Register	
5.	Minutes of Previous Meeting	
6.	Matters Arising - Review of Actions	
7.	MRB Workplan 2016	
8.	MRB Chair's Report	
9.	General Manager Māori Health Report	
	Section 2: Presentation	**9.20am**
10.	Health Equity Assessment Tool Implementation (Mary Wills)	20-mins
11.	Go Well - Travel Plan Update Verbal (Andrea Beattie)	20-mins
	Section 3: For Discussion	**10.00am**
12.	Draft Quality Accounts (Jeanette Rendle)	20-mins
13.	Annual Māori Health Plan Q4 Apr-Jun 2016 Exceptions Annual Māori Health Plan Q4 Dashboard (Tracee Te Huia and Justin Nguma)	20-mins
14.	Te Ara Whakawaiora: Culturally Competent Workforce (John McKeefry)	20-mins
15.	Te Ara Whakawaiora: Mental Health (Alison Stevenson)	20-mins
	Section 4: General Business	**11.45am**
	Light Lunch	**12.00pm**

Māori Relationship Board Interest Register - 4 August 2016

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict (if any)	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Declared
Ngahiwi Tomoana (Chair)	Active	Chair, Ngati Kahungunu Iwi Incorporated (NKII)	Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The HBDHB Chair	01.05.08
	Active	Brother of Waiariki Davis	Perceived Conflict of Interest. Non-Pecuniary interest. Waiariki Davis is employed by HBDHB and is the Health Records Manager.	Will not take part in any decisions in relation to Health Records management. All employment matters in relation to Waiariki Davis are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Uncle of Tiwai Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Tiwai Tomoana is employed by HBDHB and is a Kitchen Assistant in the Food and Nutrition Department at Hawke's Bay Hospital.	All employment matters in relation to Tiwai Tomoana are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Uncle of Iralee Tomoana	Iralee Tomoana is employed by HBDHB and works in the Radiology Department as a clerical assistant.	All employment matters in relation to Iralee Tomoana are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Brother of Numia Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital.	Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital.	The HBDHB Chair	01.05.08
Helen Francis	Active	Alzheimer's Napier previously a Committee member Patron and Lifetime Member	Alzheimer's Society holds a contract with the HBDHB to provide dementia specific daycare and community services.	Will not take part in any decisions or discussion in relation to HBDHB contract with Alzheimer's Society	The Chair	08.06.10 21.06.14
	Active	Employee of Hastings Health Centre	Actual Conflict of Interest. Pecuniary Interest.	Will not take part in any decisions or discussions in relation to Hastings Health Centre.	The Chair	18.02.09
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.11
	Active	HB Medical Research Foundation	Trustee	Declare this interest prior to any discussion in relation to the Foundation, and an appropirate mitigation action is decided on.	The Chair	20.08.14
Diana Kirton	Active	Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB.	Perceived Conflict of Interest. Non-Pecuniary interest.	Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO	The Chair	18.02.09
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on.	The Chair	16.01.14
	Active	Son, Chris Kirton, GP in Wairoa employed by HBDHB	Non-pecuniary interest: Will not take part in discussions around employment of GP's in Wairoa	All employment matters are the responsibility of the CEO.	The Chair	26.02.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
Denise Eaglesome	Active	Deputy Mayor of Wairoa District Council	Advocate as Deputy Mayor for Wairoa District, whereas HBDHB covers whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	28.02.11
	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussions in relation to the Trust.	The Chair	05.03.14
	Active	Coordinator for Health Contract for Rugby Academy in Wairoa	Health Contract with Wairoa Rugby Academy	Will not take part in any decisions or discussions in relation to this contract.	The Chair	25.05.15
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract	Will not take part in any discussions or decisions relating to the Contract with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15
Tatiana Cowan-Greening	Active	Husband, Parris Greening, Service Manager of Te Kupenga Hauora (TKH)	Contracted health provider of HBDHB	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.03.14

Maori Relationship Board 10 August 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	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussions in relation to the Trust.	The Chair	19.03.14
Kerri Nuku	Active	Kaiwhakahaere of New Zealand Nurses Organisation	Nursing Professional / Industrial Advocate	Will not take part in any discussions relating to industrial issues	The Chair	19.03.14
	Active	Trustee of Maunga HaruruTangitu Trust	Nursing Services - Clinical and non-Clinical issues	Will not take part in any discussions relating to the Trust	The Chair	19.03.14
George Mackey	Active	Wife, Annette Mackey is an employee of Te Timatanga Ararau Trust (a Trust aligned to Iron Maori Limited)	The Trust Holds several contracts with the HBDHB	Will not take part in any discussions relating to the Trust	The Chair	19.03.14
	Active	Wife Annette is a Director and Shareholder of Iron Maori Limited (since 2009)	The company is aligned to a Trust holding contracts with HBDHB	Will not take part in any discussions relating to Iron Maori Limited	The Chair	04.08.16
	Active	Trustee of Te Timatanga Ararau Trust (a Trust aligned to Iron Maori Limited)	The Trust Holds several contracts with the HBDHB	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.06.14
	Active	Director and Shareholder of Iron Maori Limited (since 2009)	The company is aligned to a Trust holding contracts with HBDHB	Will not take part in any discussions or decisions relating to the Contract aligned to Iron Maori Limited).	The Chair	04.08.16
	Active	Employee of Te Puni Kokiri (TPK)	Working with DHB staff and other forums	No conflict	The Chair	19.03.14
Lynlee Aitcheson [married 12 May 2016] now Lynlee Aitcheson-Johnson	Active	Chair, Maori Party Heretaunga Branch	Political role	Will not engage in political discussions or debate	The Chair	19.03.14
	Active	Chair of Te Whare Whanau Purotu Inc.	Maori Womens Refuge	No conflict	The Chair	22.12.15
	Active	Trustee, Kahuranaki Marae		No conflict		14.07.16
	Active	wahine co-Chair for Ikaroa Rawhiti Electorate for the Maori Party	Political role	No conflict		14.07.16
Na Raihania	Active	Wife employed by Te Taiwhenua o Heretaunga	Manager of administration support services.	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.03.14
	Active	Member of Tairawhiti DHB Maori Relationship Board		No conflict	The Chair	19.03.14
	Active	Employeed as a Corrections Officer		No conflict	The Chair	19.03.14
Trish Giddens	Active	Trustee, HB Air Ambulance Trust	Management of funds in support of HB Air Ambulance Services	Will not take part in discussions or decisions relating to contracts with HB Air Ambulance Service.	The Chair	19.03.14
	Active	Manager, Taruna College		No conflict	The Chair	15.04.15
	Active	Assistant Director Governor, Rotary District 9930		No conflict	The Chair	15.04.15
	Active	Member of the Lotteries Board		No conflict	The Chair	15.04.15
Des Ratima	Active	Chair Takitumu Maori District Council	Maori Community Development Act 192	No conflict	The Chair	Dec 13
	Active	Chair Ahuriri District Heatlh Trust	Maori health post settlement equity group	Potential Conflict if contractural arrangements in place	The Chair	Dec 13
	Active	Chair Whakatu Kohanga Reo	Early Childhood	No conflict	The Chair	Dec 13
	Active	Chair Wanautahi Charitable Trust	Community Trust	No conflict	The Chair	Dec 13
	Active	Deputy Chair Maori Wardens NZ Maori Council	Maori Community issues	No conflict	The Chair	Dec 13
	Active	Chair of the Kaupapa Maori Comittee	Maori Community Issues	No conflict	The Chair	Dec 13
Ana Apatu	Active	CEO of U-Turn Trust (U Turn is a member of Takitimu Ora Whanau Collective)	Relationship	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	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, 13 JULY 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 Ana Apatu Tatiana Cowan-Greening Lynlee Aitcheson-Johnson Trish Giddens Diana Kirton Helen Francis Des Ratima George Mackey Na Raihania
Apologies:	Denise Eaglesome Trish Giddens Tatiana Cowan-Greening Des Ratima
In Attendance:	Peter Dunkerley (HBDHB Board Member) Graeme Norton (Chair, HB Consumer Council HBDHB) Dr Kevin Snee (Chief Executive Officer, HBDHB) Ken Foote (Company Secretary, HBDHB) Chris McKenna (Chief Nursing Officer, HBDHB) John McKeefry (General Manager, Human Resources HBDHB) Nicholas Jones (Acting Director, Population Health HBDHB) Matiu Eru (Pouahurea Māori Health Service HBDHB) Tracee Te Huia (General Manager, Māori Health Service HBDHB) Patrick Le Geyt (Programme Manager, Māori Health Service HBDHB) Justin Nguma (Senior Health and Social Policy Advisor, Māori Health Service HBDHB) Rachel Eeyre (Public Health Specialist, Healthy Families HBDHB) Leigh White (Portfolio Manager Long Term Conditions, Planning, Funding and Performance HBDHB) Liz Stockley (Chief Executive Officer Health Hawke's Bay PHO) Nicola Ehau (Head of Health Services Hawke's Bay PHO) Rill Meihana (Chair, Ngāti Kahungunu Inc. Wairoa Taiwhenua) Bill Blake (Pakeke, Ngāti Kahungunu Inc. Wairoa Taiwhenua) Mereana Hammond (Pakeke, Ngāti Kahungunu Inc. Wairoa Taiwhenua) Jean Te Huia (Chief Executive Officer Kahungunu Health Services - Choices) Julia Ebbett (General Manager, Hauora and Oranga Noho Te Taiwhenua o Heretaunga) Sarah Paku (Service Manager, Kahungunu Executive, Wairoa) Audrey Robin (Chief Executive, Te Kupenga Hauora Ahuriri, Napier) Pam Kupa-Sherran (Service Manager Te Waireka Central Health Ltd)
Minute Taker:	Lana Bartlett (MRB Administrator Māori Health Service HBDHB)

SECTION 1: ROUTINE

1. KARAKIA

Bill Blake opened the meeting with a karakia.

2. WHAKAWHANAUNGATANGA

N Tomoana (MRB Chair) welcomed everyone to the meeting and made special acknowledgement to the Māori Providers in attendance.

The Chair expressed his condolences to DHB Board Member Peter Dunkerley for the recent loss of his brother.

3. APOLOGIES

Apologies were received from D Eaglesome, T Giddens, T Cowan-Greening and D Ratima.

4. INTERESTS REGISTER

There were no amendments to the Interest Register. In addition, there were no conflicts of interest declared with any on the agenda items.

5. MINUTES OF THE JUNE MEETING

The minutes of the MRB Board meeting held 8 June 2016, were confirmed as a correct record pending the following amendments:

Page 9, Health Equity Update 2016: Tackling Health Inequities, last bullet point
"The genetic composition … could contribute to a longer life expectancy". Remove the bullet point.

Item 14, Te Ara Whakawaiora: Oral Health, page 12, last paragraph
"It was agreed by MRB .. make a stand either for or against", should read 'It was agreed by MRB … make a stand either for or against'.

Item 16, Suicide Prevention and Postvention Plan, page 12
Add additional point "MRB would like further development of this role".

Chris McKenna (Chief Nursing Officer HBDHB) advised the HB Clinical Council approved funding to further investigate suicide prevention to develop a feasibility case.

Moved: A Apatu
Seconded: L Aitcheson
CARRIED

6. PUBLIC EXCLUDED MINUTES OF THE JUNE MEETING

The Public Excluded Minutes of the MRB Board meeting held 8 June 2016, were confirmed as a correct record.

Moved: A Apatu
Seconded: L Aitcheson
CARRIED

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

There were no matters arising.

REVIEW OF ACTIONS

The Action and Progress List as at July 2016 was taken as read. The following action was discussed:

Date Issue Entered 08/06/16

4. Fluoridation

MRB asked that the Te Ara Whakawaiora: Oral Health Champion proceed with the Fluoridation presentation instead of delaying it until 2017 when legislative requirements for DHBs is established. MRBs preference to be educated and better informed earlier rather than later is so that members are able agree their stand on the matter. Therefore, MRB requested the presentation by the Te Ara Whakawaiora: Oral Health Champion proceed. **ACTION**

8. MRB WORKPLAN 2016

The MRB Workplan was taken as read.

9. MRB CHAIR'S REPORT

The Chair's Report for July 2016 was taken as read. N Tomoana thanked Deputy Chair H Skipworth for a job well done stepping up in his absence.

The following topics were discussed:

Health Equity Update 2016: Tackling Health Inequities

The following matters were discussed:

Increase Māori Staff to 25% over a five year period – Rationale for Board Comment

Focusing on specific professions i.e. medical and nursing staff, rather than targeting the entire health sector, was the reason for the Board's comment about the 25% target taking longer than five years.

There was a short discussion about the factors impeding on our ability to achieve the Māori workforce target and the need to look at the core issues impeding on our ability to achieve. There is a need to investigate the system structure to identify whether the structure is discriminatory, otherwise the recruitment strategy will be flawed and building a culturally competent workforce will not make a difference to eliminating inequity. K Nuku and GM Māori Health to discuss further offline.

A wider societal approach is also required along with raising the discriminatory issues within the education system. Inequity was identified recently in the Wealth Report published last week highlighting a substantial wage disproportion between non-Māori and both Māori and Pacifica.

Youth Health Strategy 2016/19 – Board Compliment

N Raihania acknowledged the Board for their initiative to engage gangs and solo parents as part of the Youth Health Strategy.

10. GENENRAL MANAGER (GM) MĀORI HEALTH REPORT

The GM Māori Health report for July 2016 was taken as read. Tracee thanked N Raihania for his positive feedback on the work being undertaken by the team.

There was a brief discussion regarding the following topics:

Mandatory Cultural Training Figures to 30 June 2016

Perhaps look at incentives to encourage staff to complete Cultural Training to improve the completion rate. Cancellation of sessions is a concern particularly as the contract ends in August. Leadership needs to start at top level management to filter down to middle and frontline managers, and non-managerial staff. There are a number of top level management areas that have not reached 100% completion for Engaging Effectively with Māori.

2016 Enrolments for Programme Incubator, and Earn and Leave

Note that Programme Incubator is an annual report and not quarterly. Low numbers for Flaxmere College was of concern. The solutions to increase the number of Māori students and develop an interest in a career in health would have been valuable.

Under 18 years Primary Care Co-Payment Subsidy Project

N Raihania commented it was great to read increased utilisation and engagement with youth was the focus instead of clinical factors. He also complimented the reports by the MRB Chair and General Manager Māori Health that are both excellent in their content, informative and relative to the issues at the MRB table.

SECTION 2: PRESENTATION

11. INCREASING MĀORI STAFF REPRESENTATION

John McKeefry (General Manager Human Resources HBDHB) was in attendance to give a presentation on Increasing Māori Staff into DHB. The purpose of the presentation was to inform MRB about the activities currently underway to assist in achieving 'Increasing the Māori Staff' target. EMT is currently discussing the increased target from 10% year on year to 25% over five years. The Cultural Competency TAW paper will be presented fully to MRB at the August meeting following the FRAC meeting. Hiring protocols are being looked into now to consider how we might change the way we do things to improve the Maori applicant and recruitment process. The DHB does not have a conviction policy. We do have a policy that we do look at the conviction and the role, and how the conviction may impede on the potential candidates ability to fulfil the role. The target for employing more Maori is being discussed with EMT at present with a view to set KPIs on hiring managers. This is reported monthly through HR to all hiring managers. The system has been tested and is working well.

Hiring managers are being trained to use the Managers Toolkit reviewed by Maori Health and HR, more effectively. Maori Health Service staff are involved in recruitment of some posts, this process will be considered for how we strengthen this approach.

Additional activities include:

- Mapping Māori working in both New Zealand and Australia across all groupings
- Developing a campaign to make the DHB an attractive place to work
- Focus on the Māori staff turnover and retention
- Increasing the number of Māori managers
- Managers leading out on Engaging Effective with Māori and engaging with the community.

MRB and Māori Providers who were in attendance for the workshop offered the following advice:

- We would like to see the midwifery workforce as part of the strategy as Māori midwifery representation is less than 2% for DHBs. The GM HR will look into this with the Chief Nursing Officer **ACTION**
- MRB raised almost two years ago the issues and the need for Māori nursing students to receive formal coaching, pastoral care and Tuakana/Teina support. While EIT are still working on these student services and the DHB are partnering with EIT to develop these services, MRB were somewhat disappointed that these issues have still not been addressed
- There seems to be a gap in the Hiring/Selection process. Recruitment panels need strengthening to ensure they understand the need to employ more Māori and why
- Introduction Relationship Based Management Skills training is being led by Andrew Phillips (Director Allied Health HBDHB). It was suggested that we utilise Māori to support the training to add more value because of their first-hand knowledge and experience
- There is a lot of comprehensive work around having Māori review recruitment processes to ensure Māori priorities and realities are implemented. We could be identifying what is ***not*** attractive about the DHB as well as trying to make the DHB look attractive. The barriers of the recruitment processes need to be identified through forensic audits.

The Chair stated this is a Chief Executive Officer (CEO) Key Performance Indicator (KPI) and therefore we expect this issue to be performance managed from that level. Unless Hiring Managers agree and adopt the policy and target, the strategy is flawed from the outset. Perhaps DHB could better sell the story on why we are increasing Māori staff numbers. This might help Hiring Managers buy in.

Kevin Snee (CEO HBDHB) suggested looking into more detail of the individual groups and what are the measures and the impact. There is a deeper societal issue that we need to address as an organisation and resolving this issue would require investigating and developing all areas as it's not just the job of the DHB. Employing more Maori is a key objective of the Regional Economic Development plan for Hawkes Bay which is about to be launched in August.

SECTION 3: FOR DISCUSSION

12. REDUCING ALCOHOL RELATED HARM – POSITION STATEMENT

RECOMMENDATION

That Māori Relationship Board:

1. **Note** the contents of this report.
2. **Feedback** on the questions.
3. **Endorse** the proposed approach of developing a HBDHB Position Statement

Moved: A Apatu
Seconded: N Raihania
CARRIED

Nicolas Jones (Acting Director Population Health HBDHB) and Rachel Eeyre (Public Health Specialist, Healthy Families HBDHB) were in attendance to speak to the Position Statement. A short film will be emailed to MRB and Providers for viewing **ACTION Anna Kirk, Communications Manager**

MRB noted the contents of the report and provided feedback about the Position Statement:

- The DHB develop a more punchier and upbeat Position Statement
- The Position Statement is too generic and needs an equity lens applied
- Stronger wording is needed in terms of replacing 'reducing' with eliminating. Elimination of inequity is to be our starting point
- The Statement to start with a Vision that connects with whānau values so the community take responsibility. Youth leadership need to be included into the statement development, particularly at school and how the DHB could support that direction
- At a service level, there should be an expectation for anyone engaging with whānau that are challenged with alcohol related harm that they are competent to do so and are effective and engaging with them.

MRB agreed there was definitely an appetite to tackle the issues of alcohol related harm in our community. In fact all substance abuse needs to be tackled. Ideas to get buy-in and commitment to actions from across our DHB, how to engage intersectorally and work with communities were provided:

- A community led strategy supported by Iwi should be considered
- Rather than re-inventing the wheel, build on existing groups who are already addressing the issues of alcohol in the community, such as Patu, Iron Māori, Hikoi for Life, U-Turn Trust, Māori Women's Welfare League and other NGOs, and back these groups to give them additional support and training
- Build whānau leadership and role modelling. If there is a breakdown at that whānau level, it doesn't matter what we develop it will not make a difference unless we focus on building whānau leadership and role modelling in a positive way
- Use a strengths based approach with whānau
- This strategy needs to align with other behavioural services like mental health, sexual abuse, drugs and alcohol, counselling, smoking, over eating, etc., so that whānau are better served. Whānau don't delve into substance abuse because they like it, they do it to feel normal. They've been down trodden and encountered trauma. Clinicians need to be more skilled at working with trauma to get to the core of the problem as to why communities are keeping themselves numb.
- Promote constructive alternatives to drinking and encouraging whānau to do something positive with their lives
- Ensure services are culturally appropriate and staff are culturally competent
- The information is too quiet, the messages need to be much stronger especially for pregnant mums, there's not enough education going on
- The DHB to partner projects within our community and Iwi targeting eliminating inequity.

The next step is to draft a Position Statement. The draft to be presented to the advisory committees and final Position Statement to the Board in October.

13. LAST DAYS OF LIFE CARE PLAN AND TOOL KIT

RECOMMENDATION

That the Māori Relationship Board:

1. **Review** and Provide Feedback.
2. **Endorse** Ongoing Work

Moved: N Raihania
Seconded: A Apatu
CARRIED

Leigh White (Portfolio Manager Long Term Conditions, Planning, Funding and Performance HBDHB) was in attendance to speak to the Last Days of Life Care Plan and Tool Kit.

MRB reviewed the Care Plan and Tool Kit and endorsed the ongoing work. The following feedback was provided:

- Enduring Power of Attorney (EPOA) and Advanced Care Plan (ACP) as a lead in to the Last Days of Life Care Plan so the journey becomes more smoother
- Preparatory conversations with whānau need to be skilled and effective for dealing with sickness that could become terminal
- MRB asked how the Last Days of Life Care Plan and Tool Kit ties in with the DHBs position on the End of Life, Medically Assisted Dying and ACPs
- Great to see the Spiritual Care Assessment Tool (FICA) and having it as a central part of the strategy, its important
- Recommend having a workshop with our Marae, leaders and spiritual leaders about this process so it becomes more well-known and available to Māori communities.

Leigh was commended for her attempt to apply the Health Equity Assessment Tool (HEAT) however MRB advised the assessment did not clearly identify the health equity issues or how the proposed activity would address or improve the issues. Some examples of how they could be were provided. Send the example of the HEAT response to Leigh. **ACTION MRB Admin**

14. WAIROA HEALTH NEEDS ASSESSMENT DRAFT REPORT

Patrick LeGeyt (Programme Manager Māori Health HBDHB) provided an overview of the draft report. The Wairoa community were acknowledged for their input into the draft report as well as Justin Nguma (Senior Health and Social Policy Advisor Māori Health HBDHB) for his assistance with the development of this report.

MRB noted the draft report and the discussions were as follows:

- A list of income strands going into Wairoa and sources e.g. housing, oral health, employment and education would be helpful to identify the areas being addressed and by whom, and give a clear picture of how the health needs of that population are being addressed. Also, the list will assist with identifying vulnerable whānau and enable better directed services for best effect
- This is an opportunity for the DHB to pilot an initiative or programme in Waiora then template the initiative or programme to use in other areas
- The assessment was about both gauging the wellness of Wairoa and how Wairoa were performing against the DHB priorities. The DHB key role is to lead coordinate the intersectoral groups without interfering with other sectors but try to get better collusion in Wairoa as a whole. To spear down to health issues we need to identify the other social factors for vulnerable families. Wairoa has been asked to feedback on the HNA by the end of July.
- We need to be thinking about better engaging the whānau

The Wairoa Providers provided the following feedback:

- Very informative report
- Thankful for the opportunity to view the report and provide feedback and solutions. In relation to Last Days of Life, the Wairoa Pakeke programme support the process and whānau of a patient who has passed away.
- Kahungunu Executive Wairoa recommendations including the development a Leadership Group within Wairoa.
- The health of Wairoa hasn't improved for some time and needs to be addressed.
- Fragmentation has been an issue which has hindered the improvement of health in Wairoa. Providers must come together now. The entire objective of this exercise should be to collaborate for the betterment of the Wairoa people.

Send draft report to MRB and Māori Providers for feedback **ACTION MRB Admin**

SECTION 4: GENERAL BUSINESS

15. HBDHB WHĀNAU CENTRIC MODEL

G Mackey provided an overview of the DHB Whānau Centric concept that he and D Ratima developed following MRBs April Workshop. A lot of the discussion today were examples of the aim of the concept.

Critical factors of the concept are:

- Leadership and role modelling positive behaviour from the top to the bottom, having the HBDHB CEO walking the halls and talking to staff, and staff knowing management care
- A process to imbue whānau values in the organisation
- Causing a change in the attitudes. Where we make the decisions is where we need to make change because this is where unconscious bias gets challenged and shifted.
- Find innovative solutions and avoid reverting back to the same mechanisms that are not effective for Māori
- Identify the root causes instead of applying 'band aid' solutions be courageous
- This needs to be meaningful. We need to trust the system and the system needs to trust us

So if we are talking about Whānau Centre, it is about having whānau at the centre. The challenges at an organisational level would be how to involve whānau, hapu and the community to contribute to the development of strategies and solutions, involve Providers who will action these solutions, and involve whānau in policy design and funding decisions.

Comments raised were:

- There are a lot of activities and changes happening in the health sector. Working more collaboratively is key
- The Privacy and Confidentiality Acts hinder Whānau action. To permeate the barriers so that knowing communities who are involved receive the information, would mean dismantling legislation. These acts also disembowels what is happening within your own whānau
- The Obesity Strategy, now Best Start: Healthy Eating and Physical Activity Strategy is being used as a trial ground for implementing a whānau centric model by changing the language and changing emphasis to whānau rather than the individual. We need to watch this development and continue to advise. A Whānau Committee for the implementation stage should sit alongside the Population Health Team to advocate for their communities to get positive tangible outcomes
- Next steps, we know the issues and the answers. Developing the 'how' to get there is the difficult part.

SECTION 5: WORKSHOP WITH MĀORI PROVIDERS

16. TRANSFORM AND SUSTAIN REFRESH PRESENTATION

Tim Evans (General Manager Planning, Informatics and Finance HBDHB) provided a brief presentation on the update of the Transform and Sustain Refresh. Tim was accompanied by Kate Rawston (Project Manager Officer, Human Resources HBDHB).

There following feedback was received:

- The six priorities are really broad and may lose sight of accelerating Māori health outcomes because of the lack of connection to whānau and how these priorities will be interpreted
- Need to be planning the future and what this looks like in the long term
- Transform and Sustain programme needs to keep inequity at the forefront of all project development. It needs to be a principle in everything we do and we should be able to measure effectiveness against the inequity elimination strategy.
- The programme needs to connect with communities and whānau. As an example of information technology solutions leading to 'text to remind' for patient appointments in Wairoa outside of the cell phone range, that won't work.

17. HEALTH AND SOCIAL CARE NETWORKS

Purpose and Principles

RECOMMENDATION

That the Māori Relationship Board:

1. **Review and endorse** the purpose set out for the development of networks.
2. **Review and endorse** the principles against which networks will be developed.

Geographic Localities Proposal

RECOMMENDATION

That the Māori Relationship Board:

3. Review and endorse the proposed basis for network localities.

Liz Stockley (Chief Executive Officer Health Hawke's Bay PHO) recently submitted her resignation. The Chair wished her the best for the future. Liz introduced Belinda Slight (Project Manager Strategic Services HBDHB) who was also in attendance.

Liz explained the recommendation had not been updated for MRB who are required to endorse the Principles of the Business Case. The business case will be presented to the HB Clinical Council for endorsement.

MRB reviewed the Purpose set out for the development of the networks and the Principles against which the networks will be developed. The following feedback was provided:

- Inequity should be a main driver of the programme and the actions have to reflect the purpose. Need to ensure eliminating inequity is evident in the actions and should be endorsed by the Board
- A Tikanga Based Approach (TBA) is not evident throughout either of the documents. A TBA should be a driver of the HSCN. An Action Plan has not been outlined yet to demonstrate how TBA will be implemented. An action plan should come back to MRB for endorsement.
- Very clinically focused as opposed to a holistic model. Patient experience needs to help drive this development. Cultural competence in service delivery is paramount, which is not evident in Phase Two 2018-20. Liz Stockley (CEO Health Hawke's Bay PHO) to provide a response **ACTION**
- The steering group to apply the HEAT and send the report to MRB to provide feedback
- Transform and Sustain, the Wairoa Health Needs Assessment and the Health and Social Care Networks are all linked. Whanau, patients and people should be at the heart of this development. Currently this is not evident.

RECOMMENDATION

MRB endorse the Purpose and Principles under the knowledge of the following recommendations:

1. Apply the HEAT to the Purpose and Principles noting MRBs reservations about the unintended consequences that will need to be identified as part of the development and flag any risks that may be identified during the process.
2. Reapply the HEAT in a years' time once the forming stage is complete to ensure what we said we wanted to achieve, we measure.
3. Define the Purpose once an explanation of the Practices are established and are clear
4. Ensure eliminating inequity is evident in the actions that are yet to be developed. The action plan needs to be endorsed by MRB.

Moved by: N Raihania
Second by: H Skipworth
CARRIED

18. MATERNITY SERVICES (EXAMPLE PROPOSAL FOR CHATHAM ISLANDS)

Jean Te Huia (Chief Executive Officer Kahungunu Health Services - Choices) spoke to the example of the proposal for the Chatham Islands that has come about again and the reasons to build a maternity service to for the Chatham Islands, as follows:

- There are no midwives on the Chatham Island. Midwives are contracted for the Chatham Islands.
- 'Mana Whenua' (connected to the land by Whakapapa) status is lost, they are deemed a Kiwi instead of a 'Weka' and there is disconnect to the land.
- The issue with Canterbury DHB are the insufficient number of Māori midwives in the region to provide Tuakana/Teina mentoring programme to support the students through the training.
- HBDHB have an effective Midwifery Training Programme established.

Jean is wanting MRBs support for Chatham Islands candidates partnering with Canterbury DHB to support these students to undergo the HBDHB Midwifery Training Programme which is an excellent training.

Tracee Te Huia (GM Māori Health HBDHB) and Chris McKenna will examine if there is a possibility to partner with Canterbury DHB to support two students from the Chatham Islands, training possibilities and scholarship programmes available throughout the health sector. Tracee made it clear that the only role Hawkes Bay would have in this development is to support Canterbury DHB with training of students if required.

MOTION:

MRB moved a motion to endorse the proposal in principle and pending discussions with Canterbury DHB and our training staff.

Moved by: A Apatu
Second: N Raihania
CARRIED

19. ADDICTIONS CENTRAL HEALTH MAORI PROVIDER

Pam Kupa-Sherran (Service Manager Te Waireka Central Health) provided a brief overview of the addiction related issues in the community. The alcohol abstinence Kaupapa is not working as the whakapapa behind alcohol is not being considered. Targeting youth works. However, there are not a lot of services for youth.

Pam spoke briefly about 'P' and how it has taken over alcohol related issues. Services are at breaking point and with the second epidemic of 'P' fast approaching, services will not be able to deal with the epidemic. It will take services and community leaders to come together and make a stand. We should be working with the education services who make first contact with our youth.

SECTION 6: GENERAL BUSINESS

20. HB CLINICAL COUNCIL MRB REPRESENTATIVE - APPOINTED

Expressions of Interest were received from K Nuku and A Apatu. Therefore, a motion was moved to appoint K Nuku principal representative and A Apatu back-up. K Nuku was to attend her first meeting this afternoon.

Moved: N Raihania
Seconded: G Mackey
CARRIED

The meeting was closed at 12.14pm with a Karakia by Matiu Eru (Pouahurea Māori Health Service HBDHB).

Signed: _____
Chair

Date: _____

Date of next meeting: 9.00am Wednesday 10 August 2016
Te Waiora (Boardroom), HBDHB Corporate Administration Building

MĀORI RELATIONSHIP BOARD
Matters Arising – Review of Actions

July MRB Meeting

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at August 2016
13/07/16	**1. Midwifery Workforce Statistics** Look into the midwifery workforce statistics and include Māori midwifery in the strategy.	GM HR CNO	Aug 2016	**COMPLETE** Statistics cannot be broken down to midwifery. For more detail, refer to Te Ara Whakawaiora: Culturally Competent Workforce Report, agenda item 14.
	2. Reducing Alcohol Related Harm Short Film Email to MRB and Providers for viewing.	Anna Kirk Communications Manager	Aug 2016	**COMPLETE** Emailed to MRB and Providers 26/07/16.
	3. Example of HEAT applied to Last Days of Life Care Plan and Tool Kit Send example to Leigh White (Portfolio Manager Long Term Conditions, Planning, Funding and Performance HBDHB).	MRB Admin	Aug 2016	**COMPLETE** Emailed to Leigh White 26/07/16.
	4. Wairoa Health Needs Assessment Send draft report to MRB and Māori Providers for feedback.	MRB Admin	Aug 2016	**COMPLETE** Draft report sent to MRB and Providers for feedback by 04/08/16.
	5. Health and Social Care Networks Purpose and Principles – Phase Two Very clinically focused as opposed to a holistic measure and a patient's experience. Patient experience needs to help drive this development. Cultural competence in service delivery is paramount, which is not evident in Phase Two 2018-20. Provide a response.	CEO Health HB	Aug 2016	**COMPLETE** Reviewed the Purpose and Principles as follows: • Some of the language has been re-worded • Added a specific reference to Cultural Competence to Phase 2 • Removed the equity gap to Phase 2. • The HEAT has been re-applied and will be presented at the September MRB meeting.

June MRB Meeting

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at July 2016
08/06/16	**1. Health Equity Update 2016** ***NZ Territorial Authorities Statistics Gap in Years between Māori and non-Māori Life Expectancy by Gender and Region 2012-14*** MRB were interested in the reasons for the longer life expectancy of Māori in the Canterbury region and requested that Dr McElnay conduct further research to provide an update on the findings	DPH/ HE	Oct 2016	**POSTPONE OCT 2016** Dr McElnay will present to MRB in October 2016 as she is now on leave until then.
	2. Fluoridation Present information about the benefits and side effects of Fluoridation to get a clearer understanding of Fluoridation.	Clinical Director Oral Health	Nov 2016	**COMPLETE** Agenda item for November MRB meeting.

May MRB Meeting

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

April MRB Special Meeting

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at July 2016
13/04/16	**Change the system to accelerate Māori Health** a) Shift contracts to be more of a whānau focus with less contraints	Head of Strategic Services/ Head Health Services HBPHO	Aug 2016	**IN PROGRESS** High Trust Contracts being implemented. Learnings are being had.
	b) HEAT tool for all strategic papers to all governance groups	Head of Strategic Services/ Programme Manager Māori Health	Aug 2016	**COMPLETE** Agenda item for August MRB meeting.
	c) Reduce financial cost barriers to primary care for whānau. A paper on Primary Care developments.	Programme Manager Māori Health	Sept 2016	**COMPLETE** Free Primary Care for 13-17 Year Olds agenda item for September MRB meeting.

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MĀORI RELATIONSHIP BOARD WORKPLAN 2016

Meetings 2016	Papers and Topics	Lead(s)
10 Aug	Quality Accounts DRAFT	Kate Coley
	Travel Plan Quarterly Update VERBAL PRESENTATION	Sharon Mason
	Orthopaedic Review - Closure of Phase 1	Andrew Phillips
	Health Equity Assessment Tool Implementation PRESENTATION	Mary Wills
	Annual Māori Health Plan Q4 Apr-Jun 2016 Dashboard Report	Justin Nguma
	Annual Māori Health Plan Q4 Apr-Jun 2016 Non-Financial Exceptions Report	*Justin Nguma*
	Te Ara Whakawaiora: **Culturally Competent Workforce** (local indicator)	John McKeefry
	Te Ara Whakawaiora: **Mental Health and Alcohol and Other Drugs (AoD)**	Alison Stevenson
12 Aug	*Nominations Close / Electoral Roll Closes*	
19 Aug	*Public Notice of Candidates*	
Meetings 2016	**Papers and Topics**	**Lead(s)**
14 Sept	Orthopedic Review Phase 2 DRAFT	Andrew Phillips
	Family Violence Strategy Effectiveness FOR NOTING	Caroline McElnay
	Reducing Alcohol Related Harm DRAFT	Caroline McElnay
	HB Integrated Palliative Care DRAFT DISCUSSION	Tim Evans
	Developing a Person Whānau Centered Culture (includes Health Literacy Framework) FINAL	Kate Coley
	Health and Social Care Networks Update	Liz Stockley
	Free Primary Care for 13-17 Year Olds	Patrick LeGeyt
	Vulnerable Whānau PPRESENTATION	Dr Russell Wills
	Monitoring – for information - no presenters:	
	Te Ara Whakawaiora: **Obesity** (local indicator)	
16 Sept	*Delivery of Voting Documents*	

Meetings 2016	Papers and Topics	Lead(s)
8 Oct	*Election Day – voting closes at Noon*	
12 Oct	Reducing Alcohol Related Harm FINAL	Caroline McElnay
	Relationship Centered Practice PPRESENTATION	*Andrew Phillips*
	Bariatric Surgery Investigation Paper	*Mary Wills*
	Te Matatini Presentation	*Traci Tuimaseve*
13 Oct	*Official Result Declaration*	
Meetings 2016	**Papers and Topics**	**Lead(s)**
9 Nov	Tobacco - Annual Update FOR NOTING	Caroline McElnay
	Travel Plan Quarterly Update VERBAL PRESENTATION	Sharon Mason
	Fluoridation the Key Facts PPRESENTATION	Robin Whyman
	Developing a Person Whānau Centered Culture FINAL	Kate Coley
	Annual Māori Health Plan Q1 Jul-Sept 2016 Non-Financial Exceptions Report	*Patrick LeGeyt*
	Monitoring – for information - no presenters:	
	Annual Māori Health Plan Q1 Jul-Sept 2016	
	Te Ara Whakawaiora: **Smoking** (national indicator)	
	WORKSHOP with Māori Providers	
Meetings 2016	**Papers and Topics**	**Lead(s)**
5 Dec	*New Board comes into office.*	
DEC	**No Meeting in December**	
	The following papers will be emailed to MRB:	
	HBDHB Workforce Plan – DISCUSSION DOCUMENT	John McKeefry
	Health and Social Care Networks Update	Liz Stockley
	Orthopedic Review Phase 2 DRAFT	*Andrew Phillips*

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

8

Recommendation

That MRB

Note the content of this report.

PURPOSE

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

INTRODUCTION

For this month, I provide an update on the resignation of John McKeefry (GM Human Resources) and Liz Stockley Stockley (GM Primary Care and CEO of Health HB PHO), plus a very short overview of the Chief Executive Officers (CEO) report including the performance indicators over the past month, Under 19 Mental Health Wait Target (0 To 19 Year Olds), the Regional Economic Development Strategy, and the results of the National Patient Experience Survey 2015-16.

This month's report also provides a short overview of the Advisory Committee's reports to the Board and the discussions.

HBDHB Chair's Report - Resignations

The HBDHB Chair acknowledged the resignation of John McKeefry (GM Human Resources) effective end of August 2016. The Board sincerely thanked John for his contribution over the past seven years and wished him well for the future.

Liz Stockley (GM Primary Care and CEO of Health HB PHO) had tendered her resignation earlier in July, effective at the end of October 2016.

Chief Executive Officers (CEO) Report - Performance Indicators

For this year, the DHB ended well with improvement across a range of indicators:

- Shorter Stays in Emergency Department finished the year below target but the DHB held their own during a difficult winter to date
- Elective Admissions finished significantly ahead of plan
- Faster Cancer Treatment improved in performance in spite of the increase in expected numbers moving from 11.4 to 19 per month; Immunisation and Helping Smokers to Quit in Hospital

- Helping Smokers to Quit in Primary Care early indications suggested we ended the year at 83%, in improvement but not quite at the required level

Financially, the DHB has ended the year in a good position with a favourable variance of $266 thousand for June. End result of $376 thousand favourable.

The CEO commented that in the new year we must identify through our refreshed strategic plan how to make further progress across a number of key areas. If this is achieved and we work together as a whole system, the prospect to improve the health of our local community will be immense.

Under 19 Mental Health Wait Target (0 To 19 Year Olds)

The Child, Adolescent and Family Service (CAFS) had not been meeting the target resulting in a review of the services. There were a number of factors contributing to the poor result including problems with recruitment and retention, a poor understanding of the Key Performance Indicator (KPI) within the team, and poor reporting practice. Within a three week period, the target had lifted to 96% of the 80% target providing more timely access for consumers of the service. It is now sitting at 100%. Denise Eaglesome and I raised the issue of those that don't get these services particularly for drug substance abuse. They are meeting with Allison Stevenson (Service Director) to discuss.

Regional Economic Development Strategy

The Strategy had been launched the morning of the Board meeting with Ministers in attendance. There had been a number of announcements regarding investments to support infrastructure and the detail will go to the Board in August. The DHB have an important part to play going forward and welcome the opportunity to work alongside the Iwi and Post Settlement Group Entity (PSGE) to assist to change the status of Māori health and wellbeing in Hawke's Bay.

National Patient Experience Survey Results 2015-16

Kate Coley (Director Quality Improvement Patient Safety) provided an overview of the survey results. A 21% response rate was received with a slight increase in Māori respondents (50 people, 15% - compared to 38 people, 11% last year) and youth 15–24 years (7.6%) (last year 4.8%). The DHB scored positively across all four domains (communication, coordination, partnership and physical and emotional needs). In several areas we tracked higher than the NZ average. During the survey we captured 503 positive words and 140 negative. The plan now is to undertake a "local experience survey" and develop a "quarterly quality dashboard" to enable us to identify themes, trends and improvements made. In addition, the quality team will continue to look at how to get better responses for Māori patients.

Hawke's Bay Clinical Council and Consumer Council Board Reports

Both Councils supported the following papers at their July Meetings:

- The Purpose and Principles Paper and Business Case for the establishment of Health & Social Care Networks. Graeme Norton (Chair HB Consumer Council) commented we have come a long way and he felt the consumers have been heard. Dr John Gommans attended on behalf of the co-chairs and specifically mentioned the Council's support for the Executive Management Team's recommendation to move forward with Wairoa and Central HB in the first instance.
- The development of a Position Statement on reducing alcohol related harm.
- The Principles of the Transform & Sustain Refresh but with some strong recommendations around integration of the 6 priorities.

The HB Clinical Council also supported the following papers at their 13 July Meeting:

- The implementation plan for Clinical Governance Committees Structure
- Ongoing work of the Last Days of Life Care Planning

The Chair of the HB Consumer Council noted:

- Consumer members on steering groups still sense and experience siloed behaviours. The need to ensure a joint approach will ensure the goal of an integrated whole is achieved
- Feel it is important to focus on what else is occurring out there (locally and nationally) and not try to reinvent the wheel

I suggested the Health Awards be “alcohol free” in support of Iwi who have made similar decisions around their functions and gatherings.

Māori Relationship Board (MRB) Chairs Report to Board

I provided an overview of our meeting and the MRB Chairs Report for July emphasising the importance of the education session on Fluoridation to get better understanding prior to legislation being passed, this will be done in November as Septembers MRB agenda is full and the Clinical Director for Oral Health Robin Wyman is not available on our October meeting date. I made mention of the Māori Workforce target and how we are taking a leading role and solutions are being worked through that can make significant improvements. I highlighted that the HEAT Tool is not being applied across all papers provided to MRB. Presently, the tool is being piloted and will come to MRB for endorsement today. Also, I sought feedback from the DHB Board members at the table who were part of MRB. Board members responded positively about the value of MRB. They felt much better informed and aware of Māori health issues, as a result of participating in discussions of MRB.

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

RECOMMENDATION

That MRB

Note the content of this report.

PURPOSE

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

INTRODUCTION

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

- Restructure of Māori Health Operations Team
- Ethnicity Data Capture within Contracts
- Under 18 Primary Care co-payment Subsidy Project
- Mobility Action Programme (MAP) RFP
- Māori Child Oral Health Access Improvement Project
- Well Child Tamariki Ora Project
- Healthy Weight (Child Obesity) Māori Whānau Lifestyle Programme
- MAI Māori Health Strategy Mid-Term Review
- Wairoa Health Needs Assessment Report
- Te Matatini 2017

Restructure of Māori Health Operations Team

As part of the overall Māori Health Service (MHS) restructure, June saw the final decision paper released, and subsequently staff were informed of the model and role changes that were outlined in the change document.

The Operations Team new model differs from the current model, where the Kaitakawaenga support will follow Whānau from the hospital bed to the Whānau bed at home. This will include assisting to implement Discharge/Wellness Plans including referrals out to community services and realigning Whānau back to appropriate primary healthcare services.

In-line with extending service hours to Whānau, the Māori Health Operations team began a 'PM' shift in mid-July. Two Kaitakawaenga will work between the hours of 3.30pm to midnight, Monday to Friday each week. This will increase the MHS coverage to support Whānau from 8.00am till midnight Monday to Friday, with an on-call service provided over weekends and statutory holidays. Public advertising for vacant roles are occurring through to mid-August.

Ethnicity Data Capture within Contracts

Tūruki and the Contracts Team have completed the final phase of integrating ethnicity data capture of employees working in the community. The legal requirements have been confirmed and a reporting template has been developed. Training on how to communicate, record and report the information will commence in late July for the contracting team and management accountants. Roll out of the new contracts will begin in mid-August with a view to receiving our first report for the whole sector in February 2017.

Under 18 Primary Care Co-Payment Subsidy Project

This paper has been well consulted on in Primary and Secondary care. A final paper is being completed for presenting to the committees and Board in September.

Mobility Action Programme Mobility Action Plan Request for Proposal

Māori Health partnered the development of the Mobility Action Programme (MAP) Request for Proposal (RFP). The MAP RFP was submitted by the 7 July 2016 deadline.

The MAP RFP proposes a Whānau Ora model of care for Māori, Pacific and quintile 5 consumers who have experienced joint pain for more than 3-months and who are not eligible for ACC funding. The service will meet the needs of both the working age and elderly population. We plan in particular to improve access to services for people with previous or current employment in heavy labouring jobs and those with barriers to paid work, training or caring for whānau due to musculoskeletal conditions.

The service will be delivered in HBDHB's communities of highest deprivation (NZ Deprivation Index 10) and highest Māori and Pacific populations: namely rural sites of Wairoa and Takapau and urban sites of the suburbs Flaxmere (in Hastings) and Maraenui (in Napier). Any eligible consumer (Māori, Pacific, quintile five, joint pain >3/12, non-ACC) may join the programme at these delivery sites.

As any non-ACC joint pain (of any joint) of longer than 3-months duration is eligible, we will therefore be addressing the following range of conditions: osteoarthritis, mechanical spine pain, tenosynovitis (overuse), gout, rheumatoid conditions and boney malformations impacting on function.

The aim of the Mobility Action Programme (MAP) is to reduce pain and improve function by promoting early intervention and self-management. The focus is on improving access to high quality advice, assessment, diagnosis and treatment by reducing barriers such as cost, transport and cultural barriers to allow for early intervention. Furthermore, while the MAP will be based around already existing services within the community, as a Whānau Ora programme HBDHB aim to support developing local capacity and capability, and increasing social and cultural participation.

Programme Timeline:

The programme will run for 12-weeks. The first 1-2 weeks (depending on availability of the consumer) will be working with the Physiotherapist to assess their condition, carry out any treatment required and set up a MAT 10 week plan. The individual will then have 10 weeks funded access to an individualised self-management programme with the core MAT. Any other necessary non-core MAT services will be incorporated into the 12-weeks. Stanford will run at scheduled times throughout the year at each of the localities. This may or may not occur within the 12-weeks.

Māori Child Oral Health Access Improvement Project

The project was completed at the end of July 2016. There are a number of recommendations that have arisen from the project's workstreams. The recommendations include:

Community Dental Services

Review 'hub and spoke' model of care

- Introduce flexible clinic times and access to community dental clinics and mobiles
- Improve visibility and signage in community dental clinics
- Mobility and flexibility of mobile dental units
- Review and implement recommendations from the Health Impact Assessment for Flaxmere Community Dental Clinic
- Continue consumer engagement

Implement a monitoring systems for patient DNA and utilisation for community dental services

- Develop DNA Key performance indicators (KPI's) which address productivity in community dental clinics
- IT platform to measure the outcomes

Standardise a whānau centred booking system

- Implement changes to the patient appointment letter
- Introduce an efficient and innovative patient booking system
- Introduce a patient focused recall and reminder system
- Consider alternative parental consent methods

Improve engagement with community, whānau, schools and other community networks.

- Profile community dental staff
- Promote services and access

Māori Health Services

- Disestablish the current Oral Health Educators contract with Māori Health providers.
- Reinvest contract with Well Child Tamariki Ora (WCTO) providers

Population Health Services

- Implement health promotion strategies and recommendations as outlined by Oral Health Services

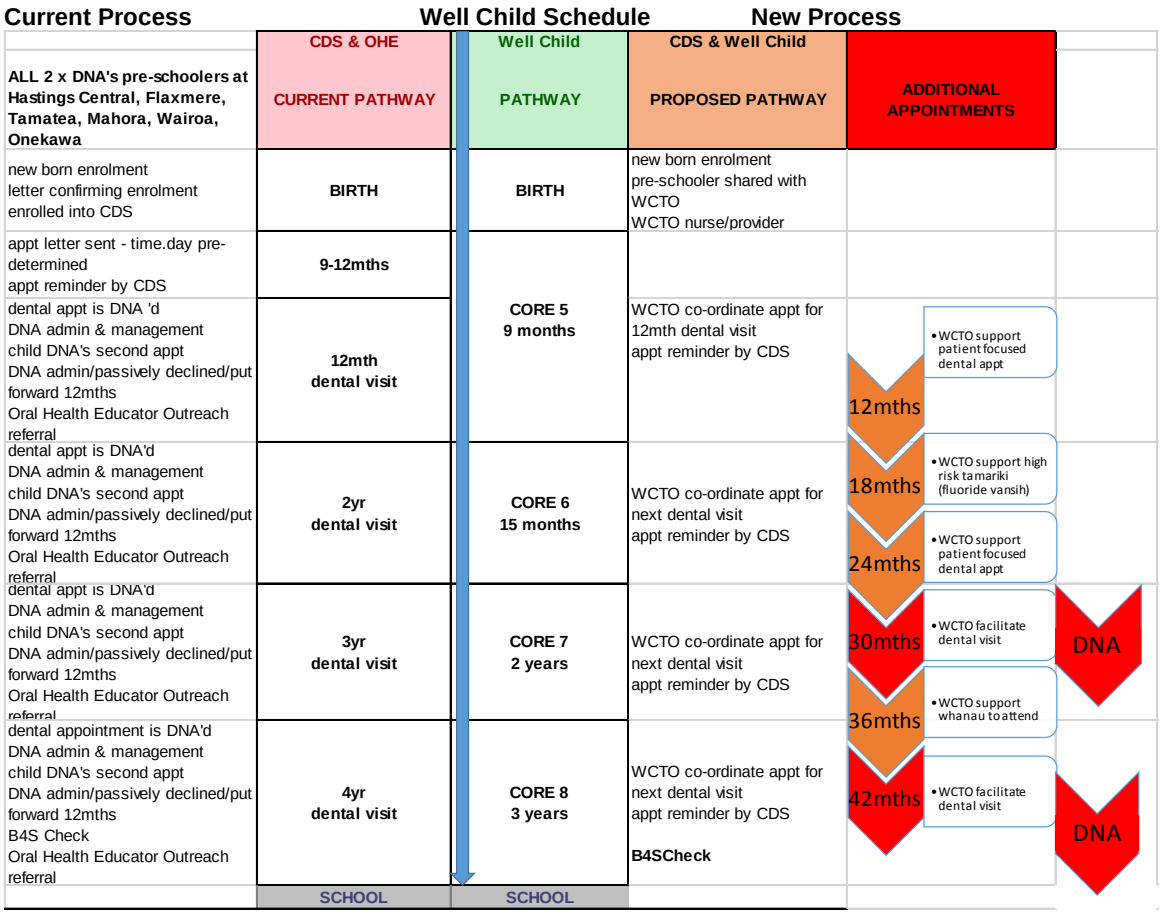
Business Intelligence

- Provide monthly community dental DNA and utilisation data for pre-schoolers

In relation to the recommendation for Māori Health Services and the Oral Health Educator contracts we are considering an improved oral health service engagement model based around services with strong relationships with mothers and children 0-4 years. Therefore we will build a service based around the best practice oral health appointment schedule and the Well Child Tamariki Ora core check appointment schedule.

WCTO providers have been invited to help co-design the new service. Proposed appointments may entail:

1. The provider and parent/guardian making an appointment with community oral health services for the child before they reach 12 months of age
2. Following up with the parent/guardian should the child not attend the appointment at 12 months of age and ensuring they attend an appointment before 15 months of age
3. The provider and parent/guardian making an appointment with community oral health services for the child at 18 months, 24, 30, 36, 42 and 48 months



Once the process is finalised HBDHB will enter into a tender process for contracted services to start in January 2017.

Well Child Tamariki Ora Project

The final project report has been completed. Recommendations from the investigation included:

1. Reducing the Age of Referral by LMCs to 3-weeks (local target only)

That the age of referral be voluntarily reduced by Lead Maternity Carers (LMW) to 3-weeks (local target only) as an interim arrangement whilst recommendation number 2 below is explored.

2. Improving the Timeliness of Referrals by

i. the Well Child Tamariki Ora (WCTO) providing feedback regularly to the LMCs how many days or weeks old the babies they referred were such as that done by the laboratory performing the PKU checks;
ii. improving the trust between LMCs and WCTOs;
iii. improving the communication between LMCs and WCTOs; and/or,
iv. discussion with individual LMCs who habitually refer late.

That these means of improving timeliness of referrals be investigated further.

3. Antenatal Referral

That LMCs actively refer women who meet the criteria for teen support or vulnerable women in the antenatal period to these services.

4. Working Together

That joint introductory visits be trialled for 6 months with feedback provided by the LMCs involved to their peers in order that LMCs can make an informed decision whether to continue with joint introductory visits and is currently being analysed before reporting the findings to key stakeholders and Ministry of Health (MOH).

Healthy Weight (Child Obesity) Māori Whānau Lifestyle Programme

The healthy lifestyle collective 'Mananui' has developed collective agreement, an outcomes framework and a proposal to develop an Active Whānau Programme. Mananui collective includes Iron Māori, Patu Aotearoa, Hikoi Koutou Trust, Evolution Fitness, AMPT Fitness and Te Taiwhenua o Heretaunga (TToH).

Mananui will design a physical activity and nutrition programme for up to 200 Tamariki between the ages of 5 and 12 years and their whānau (families). To support sustainable lifestyle change, the programme will comprise four (4) twelve (12) week blocks spanning twelve (12) months.

Mananui promotes self-selection by whānau of the type of programme best suited to their abilities and future goals. Following the assessment and screening phase, a Whānau Plan will be co-designed with whānau with activities tailored to each individual and their whānau needs, goals and ability levels. Specific activities can be selected from the comprehensive menu below:

Menu of Activities			
Assessment, screening, goal setting and planning Personal 1:1 Training Pairs/Group/whānau exercise Cardio Strength Flexibility/Neuromuscular stretching Boxing Swimming Pre and post-natal Navigation Social services Domestic violence Healthy Lifestyles Smoking cessation Mobile nursing services	Spin (stationary biking) Core Step Sports-specific training Movement and technique coaching Post-injury correctional training Run, Hop, Skip, Pass, Catch, Throw Tamariki programme Mental health services General practitioners	HIIT Raw (Dumbbell-based functional fitness) Cross-Fit Powerlifting/ Olympic Lifting Muscle endurance Box-Fit Zuu Zumba Walking Whānau activities/events Kaumatua programmes Mobility Recovery programmes	Atuatanga Nutrition education Literacy Injury prevention Indoor netball Indoor touch Sex Education (mid-wives) Weight Training Youth services Parenting programmes Youth groups Mental health residential services Duathlon Half Ironman

MAI Māori Health Strategy Mid-Term Review

Dr George Grey has been contracted to complete a mid-term review of the HBDHB MAI Māori Health Strategy 2014-2019.

Benefits: A review of HBDHB's performance against the objectives of MAI will:

1. Help the organisation plan more effectively for the future
2. Identify priorities which have been achieved and those that have not

3. Identify barriers, enablers, and the driving forces of performance
4. Facilitate learning between high performance leaders and others
5. Facilitate better relationships between HBDHB and the community
6. Enable the HBDHB Māori Health team to guide performance improvement at a

Scope:

1. Analysis of quantitative KPI performance data for the past five years
2. Comparison with planned objectives stated in MAI
3. Identification of high performance areas
4. Completion of interviews with high performance indicator leads
5. Identification of low performance areas
6. Completion of interviews with low performance indicator leads
7. Development of recommendations for HBDHB based on performance results
8. Completion of a draft report
9. Incorporation of client feedback
10. Completion of a final report
11. Presentation of results to the HBDHB Māori Health Team

Key informant interviews will be conducted during August 2016; a draft report will be completed by 30 September 2016 and a final report completed by 31 October 2016.

Wairoa Health Needs Assessment Report

A draft Health Needs Assessment Report has been completed and is being reviewed by Strategic Services, HHB PHO and Wairoa Centre Manager. Thanks to the MRB for your feedback along with others.

Based on the emerging themes from the analysis of the quantitative and qualitative data the report aligned with the NZ Triple Aim Framework, to support the planning and design of the Wairoa Health Services. It should be noted that financial analysis was not done at this early stage on potential costs or cost savings to the Wairoa district reconfiguration and design. It is expected, however, that any reconfiguration and design will encourage better use of existing financial resources and channel resource use where it is most needed.

Te Matatini 2017

Te Matatini planning by DHB has commenced in partnership with Ngāti Kahungunu Iwi Incorporated. We are planning for 35,000 plus attendees over the four days. All marae are being assessed for compliance by Hastings District Council at present with a view to support them to become compliant by February 2017 ready for use. DHBs input and contribution is yet to be finalised however emergency service, health promotion and health protection are engaged already. We are looking forward to what seems to be one of the biggest events ever in Hawke's Bay.

GENERAL MANAGER MĀORI HEALTH
Tracee Te Huia

HAWKE'S BAY District Health Board Whakawāteatia	**Health Equity Assessment Tool (HEAT) Implementation**
	For the attention of: **Māori Relationship Board**
Document Owner: Document Author(s):	Nick Jones Acting Equity Champion Mary Wills Head of Strategic Services Patrick LeGeyt Programme Manager Māori Health
Month:	August, 2016
Consideration:	For approval

RECOMMENDATION

That Māori Relationship Board:

Consider the use of the HEAT in new investment proposals and service redesign

OVERVIEW

In March 2016 Fiona Cram from Ko Awatea conducted a workshop on the application of the Health Equity Assessment Tool and Health Equity Framework. This provided an understanding of when to use the tools and the opportunity to apply tools in the workshop.

Following on from the workshop, the Strategic Services team have been working with Shari Tidswell Team Leader Population Health Advisor and Patrick LeGeyt Programme Manager Māori Health to learn together to use the HEAT. The aim is develop a collective understanding of the tool and when to use it.

Staff in Strategic Services have been developing their capability to apply the tool since March. We have used presentations of exemplar use, peer review to provide feedback and improvement in use of the tool and critiquing funding proposals, business cases and contracts presented to Funding Management Group.

Staff in Health Hawke's Bay already apply the tool routinely and have developed expertise in its use.

The aim is to develop expertise across Hawke's Bay DHB so an equity lens informs strategic and transformational change through service redesign and new investment decisions. It will not be applied to transactional changes such as responding to urgent demand driven pressures.

From 1 July the HEAT will be applied to:

- New investment proposals
- Change proposals
- New business cases
- New service redesign and service models
- Population health strategies

The most recent application of the tool is to the Health & Social Care Network which Belinda Sleight Project Manager will be presenting in a further paper.

Consumers (ability to) accessing a wide range of co-ordinated services closer to home (Health and Social Care Networks Programme)

Understanding Health Inequalities

Type of Inequality	What inequalities exist?	Who is most advantaged and how?	Why did the inequality occur?
Consider the range of inequalities	**What do you know about inequalities in relation to this health issue?**	**Who is advantaged in relation to the health issue being considered and how?**	**What causal chain(s) lead to this inequality?**
Ethnicity	Rates of premature deaths (those before age 75 years) in Māori and Pacific populations are much higher than non-Māori (73% and 63% vs. 31%); rates for deaths before 50 years are even more disparate (25% and 29% vs. 5%). The majority of deaths before 75 years are avoidable because of disease prevention or because of effective treatment and health care. (1) Key causes of avoidable deaths include ischaemic heart disease, road traffic accidents, lung cancer, self-inflicted injuries, and COPD. (1)	Non Māori, non-Pacific	Practices and activities associated with historic colonisation (land loss, language loss, urbanisation, assimilation) have led to disempowerment and disengagement across a wide range of functions of modern society (education, employment, governance, etc.).
Gender and sexuality	Men's lifestyles, attitudes and occupations tend to be less supportive of good health. Men are less likely to engage with health care providers, delaying seeking health care and attending less frequently than women. (2) Although on average women visit primary care more often, in 2014/15 they were	Women and children; straight people.	Parochial stereotype of the 'Kiwi male' as self-effacing and 'she'll be right' has contributed to a lack of advocacy for, and prioritisation of, men's health by both the men themselves and the health system.

	more likely to report unmet need due to cost and transport. (3) Gay, lesbian, bi, transgender and intersex people continue to experience societal prejudices despite improvements to their rights and status over the last ~20 years. This, in turn contributes to 'grossly disproportionate' numbers of Rainbow people reporting mental health distress, and delays in seeking assistance for a wide range of health issues. (4)		Issues of sexuality and gender identity are still difficult subjects for many NZers to address (talk about, understand). Rainbow community are largely excluded from public health policy; there is a lack of research, knowledge and resources targeting their needs. Well-intentioned but ill-informed health professionals can be a barrier to accessing care in a timely manner.
Socio-economic	Socio-economic status of a proportion of the Hawke's Bay population leads to difficulty paying for appointments and medications; the resulting debt at practices further limits access to health care. There is a socio-economic gradient apparent in a range of negative health behaviours (e.g. smoking, obesity, fruit/vegetable intake, hazardous drinking, physical inactivity). (1, 3) Poor literacy levels contribute to an inability to identify and understand (navigate) available services.	Higher income earners, those with higher levels of health literacy/engaged with their health care. These people tend to have the resources to pay for goods and services.	Poor socio-economic status for many people is linked to ethnicity and marginalised communities (e.g. Rainbow, those with mental health issues, new migrants).
Age	Youth-friendly services are lacking (one stop shop in a non-threatening, private environment). Older people report the lowest level of unmet need (3), but complexity of conditions adds to the burden.	Middle aged people.	People making decisions and designing systems are mainly middle aged.

Geographical	People living rurally mostly have to travel in order to access services; fewer services are available nearby (e.g. hospital specialists); emergency and acute care is an area of concern because travel distances/times can be significant. Primary care services in rural areas can be patchy due to staff turn-over (temporary/locums), closed practice books, difficulty getting appointments. Many rural areas have pockets of poverty, further exacerbating the above challenges.	People living in urban areas, who have easy access to transport (e.g. own car)	Rationalisation of services to main cities; decision-makers mostly live urbanely and are likely to have poor understanding of rural realities.
Disability	Increased difficulty accessing services.	Non-disabled people.	People making decisions and designing systems are mainly not disabled.

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Where/how will you intervene to tackle this issue?

Level	Determinants	Intervention
Consider each levels of the Intervention Framework	**Distribute the Causes of inequalities (above) across the appropriate levels**	**Brainstorm possible interventions at each level. These may or may not be the responsibility of the health system.**
Structural: *tackling the root cause of health inequalities – social, economic, cultural and historical*	Practices and activities associated with historic colonisation (land loss, language loss, urbanisation, assimilation). People making decisions and designing systems mainly conform to societal norms and 'middle class' status ("middle NZ"): middle aged, not disabled, employed, and living urbanely.	• Involvement of a wider range of people in developing policy, services, delivery mechanisms, and implementing the same; redefine power relationships to focus on partnership. • Kaupapa Māori approaches utilised, including recognition of collective impact at all levels of society. • Ground-up development and redesign of services across multiple sectors that impact health (heath, education, employment, housing, etc.).
Intermediary Pathways: *Material, psychosocial and behavioural factors. The impact of structural factors on health*	Stereotypes and role models (or lack thereof) that promote negative behaviours or attitudes. Poor socio-economic status and, therefore, health outcomes for many people is linked to ethnicity and marginalised communities.	• Engagement of a wide range of people in leadership and co-design. • Value diverse voices and allow plenty of opportunities for these to be heard. • Asset-based approach; building on what is good and strong about the community, not just what the gaps (deficiencies) are.
Health and Disability Services	Rationalisation of services to main cities; decision-makers mostly live urbanely and are likely to have poor understanding of rural realities. Sections of the community excluded from public health policy and decision-making; there is a lack of research,	• Focus on making improvements to services in areas that the community has identified need to change; ensure that ideas contributed by the community are clearly visible in the solutions that are implemented. • Robust knowledge is the basis for decision making; know your blind spots (and get input from others to make them visible).

	knowledge and resources targeting their needs. Further marginalisation due to low cultural competency of clinicians and other staff.	• Staff cultural competency across a range of factors causing inequities. • Population health approach and risk stratification to focus resources on those most in need.
Impact: *the impact on socioeconomic position*	Disempowerment and disengagement across a wide range of functions of modern society (education, employment, governance, etc.).	• Holistic approach; ensure we are working across the factors causing disparity and inequity (i.e. address the combined effect rather that the effects of each issue). • Pastoral care of people, tailored to the needs of them and their family. • Commitment to involving heard-to-reach groups in the design and implementation of Networks.

How will you improve Māori health outcomes and reduce health inequalities experienced by Māori?

Pathway	Questions	Responses
Tuatahi – *Developing whānau, hapū, iwi and Māori communities*	*How have Māori been involved in the use of HEAT?* *Have Māori health inequalities been fully considered?*	Need to get feedback from Māori stakeholders
Tuarua – *Māori participation in the health and disability sector*	*How will you involve Māori in the health and disability service interventions?* *How will you build Māori workforce capability?*	Māori (individuals, whānau, iwi) will be key stakeholders in the development of HSC Networks in each locality. There will be Māori people on the various leadership and service co-design groups, and these people are expected to be connected into their community to spread the word and gain feedback and input. Network leadership will be easy to reach/talk with and there will be communication channels set up to enable a wide range of people to be involved. Workforce: opportunities for leadership within the Networks, both in formal governance and managerial roles and as community and whānau influencers ('by us, for us'). Māori health and social care providers will be partners in each Network so there is opportunity for further learning, increase in scope, more diverse work.
Tuatoru – *Effective health and disability services*	*How will you ensure that the health and disability service intervention(s) proposed are timely, high-quality, effective and culturally appropriate for Māori?*	Māori will be members of the leadership and service redesign groups. We will be using co-design processes, collective impact change model so that the services fit those people who use them and work in them. Removing inequity is a key design principle for the Network initiative and we will be cognisant of this in all decision making. We will also be actively recruiting a wide range of people to get involved so that services address needs of youth, elderly, whānau, rural, low socio-economic, etc.
Tuawhā – *Working across sectors*	*How will you work collaboratively with other sectors to reduce Māori health inequalities?*	Central to the Network initiative is the recognition that we must work across health and the socio-economic determinants of health in order to change health outcomes for the better. We are initially focusing on services that are

		funded by the DHB (across health and social care), and are developing inter-sectoral relationships with MSD and MSD-funded services, local councils, NGO groups, etc. in order to agree collective priorities with the community (including service users). Network leadership and groups involved in redesign within each Network will have members from across all of these types of organisations and viewpoints so that we get a clear picture of needs and aspirations.

Reviewing and refining your intervention

Questions	Responses
Health inequality outcomes *What are the predicted outcomes of this intervention for health inequalities?*	Closing the gaps between Māori and Pacific, and non-Māori-Pacific, closing gaps between quintiles. Improvements in statistics for key conditions contributing to poor health outcomes.
Groups Benefiting *Who stands to benefit the most from this intervention?*	People who are currently disadvantaged by the existing system, i.e. particularly Māori and those living in low socio-economic areas.
Unintended Consequences *Are there any unintended consequences that can be foreseen?*	There may be decreased input to well people or those who have a condition but are stable/coping well; if they notice, this may annoy them. Potential to stigmatise people by stratifying them as being at high risk of condition exacerbation. Increased sharing of data could increase (perceived) risks of privacy breach.
Risk Mitigation *What needs to be done to ensure that the benefits accrue to the intended populations?*	Removing inequality must be central to the mission of each Network, and actions to address inequity must be visible in all outputs. Use HEAT tool in ideation, planning, and measurement. Ensure that the intended populations are well represented in the leadership and operations of the Network (including in the design stage); ensure that they are able to contribute by supporting them well.

How will you know if inequalities have been reduced?

Outcomes Hierarchy	Outcomes	Measuring Outcomes
What is the outcomes hierarchy proposed for your intervention	*What are the outcomes that you want your intervention to achieve?*	*How will you measure whether these outcomes have been achieved? What evidence do you need to collect?*
Short term (2 years)	GPs have more time to support the people who need the most assistance	Survey GPs Survey consumers
	Consumers are involved in their care planning and decision making	Manage My Health/ Patient Portal uptake and use Proportion of people (families) who have a care plan to manage their LTCs
	Improved access to primary services – people can get appointments when and where they need them	ASH rates for key conditions Unmet need Survey consumers
	Well trained and culturally responsive workforce	Closing gaps between Māori and Pacific, and non-Māori and Pacific health statistics Consumer and staff surveys
Medium term (4 years)	Earlier diagnosis and intervention	Rates of proactive care (immunisations, smoking cessation, cardio vascular disease risk assessment, cervical screening)
	People have increased ability to manage long term conditions	ED presentation and hospitalisation rates for a range of LTCs
	Increased community wellness across health and social determinants of health	Hospital admission for childhood illnesses with a socio-economic gradient Health behaviours – tobacco use, nutrition, alcohol, physical activity Evidence of joint working across agencies and providers that impact wellness
	Improved access due to a wider range of services that are located in the community	Number and range of services available in the community DNA rates
Long term (5+ years)	People are living well	Amenable mortality (especially ischaemic heart disease, diabetes, cancers) Avoidable and premature deaths Life expectancy

HAWKE'S BAY District Health Board Whakawāteatia	**Go Well Update Presentation**
	For the attention of: **Māori Relationship Board**
Document Owner: Document Author(s):	Sharon Mason (Chief Operating Officer) Andrea Beattie (Property and Service Contracts Manager)
Reviewed by:	N/a
Month:	August, 2016
Consideration:	For Information

RECOMMENDATION

That the Māori Relationship Board:

Note the contents of the report

INTRODUCTION

The early stages of Go Well have been about preparing foundation work for the implementation of the travel plan.

Much work has gone into structuring the project, researching initiatives, drafting communications, developing content for the webpages and policies and procedures as well as engaging with stakeholders, local councils and other community organisations.

The Go Well working group consisting of staff, consumer and local council representation are now meeting regularly and will be working on the parking layout review, promoting new bus services and assisting in developing rules around parking and parking charge exemptions.

The HEAT tool has been used to form the baseline of "where we are now". Later this month members of the steering group will meet to develop the monitoring and measuring framework for Go Well's implementation going forward.

SUMMARY

It has been a busy time till now, but the coming months will be even busier.

In September we expect to have a dedicated and focussed resource on-board to drive Go Well's implementation. New bus services will also commence and in the months following you will start to see physical changes on the hospital site including parking layout changes, consistent signage, improved cycling facilities and installation of the parking management technology.

HAWKE'S BAY District Health Board Whakawāteatia	**Draft Quality Accounts**
	For the attention of: **Māori Relationship Board, HB Clinical Council and HB Consumer Council**
Document Owner: Document Author(s):	Jeanette Rendle, Consumer Engagement Manager Quality Accounts Working Group and Service Directorates
Month:	August 2016
Consideration:	For Discussion

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RECOMMENDATION

That MRB, Clinical and Consumer Council

1. Note the contents of the Quality Accounts
2. Provide feedback on the contents of the report
3. Provide guidance on the communications plan

INTRODUCTION / PURPOSE

The publication of the annual Quality Accounts was initiated in 2013, following the Health Quality & Safety Commissions (HQSC) guidance publication in July 2012 and the MOH's request that Quality Accounts should be produced annually detailing our performance against both national and local quality and safety indicators. The Quality Accounts are predominantly aimed at our community and therefore the aim is to keep them as short as possible, be visual, easy to read and understand; using photo's, images, stories, quotes, and examples to enhance the results and achievements. The guiding principles are accountability and transparency, meaningful and relevant whole of system outcomes and continuous quality improvement.

A working group was established of representatives from Consumer and Clinical Councils, Māori Health Service and Clinical teams across the sector to write a document publishing positive stories and the impacts on health outcomes of our community.

CONCLUSION / SUMMARY

The Draft publication is attached for review and feedback. Please note data is still being compiled and there are some pages in the accounts that are yet to have numbers confirmed. Proper formatting will occur after all feedback considered and changes made. Therefore feedback is requested on the overall flow of information, language and images used.

A communication plan is being developed and feedback will also be sought as to how best we communicate the accounts to our community. Feedback will be incorporated and HB Clinical Council, HB Health Consumer Council and Māori Relationship Board will be given a further opportunity for final review in September before going to HBDHB and HHB Boards.

KA ARONUI KI TE KOUNGA

FOCUSED ON QUALITY

OUR QUALITY PICTURE 2016

OURHEALTH
HAWKE'S BAY
Whakawāteatia

DID YOU KNOW THAT EVERY DAY...

6 babies will be born

11 fragile babies will be cared for in the special care baby unit

An orderly can walk on average 15km

16 people will get their free annual diabetes check

20 women will have a mammogram and a further 29 a cervical smear test

35 operations will be completed

55 children will receive one of their vaccinations

100 people will be admitted to Hawke's Bay Fallen Soldiers' Memorial Hospital

153 visits/appointments will be made to support people with mental health issues

223 visits will be made by District Nurses and Home Service Nurses

248 children on average will be seen for their free dental health check

260 people will receive meals on wheels

1,334 people will see their local family doctor

4,400 prescriptions will be written

5,256 laboratory tests will be completed

5,915 items of laundry will be delivered to the hospital

Icons made by Freepik from www.flaticon.com

Te hauora o te Matau-ā-Māui: Healthy Hawke's Bay

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

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RĀRANGA TE TIRA PARTNERSHIP
TAUWHIRO CARE

HE KAUANUANU RESPECT
Showing ***respect*** for each other, our staff, patients and consumers. This means I actively seek to understand what matters to you.

RĀRANGA TE TIRA PARTNERSHIP
Working together in ***partnership*** across the community. This means I will work with you and your whānau on what matters to you.

ĀKINA IMPROVEMENT
Continuous ***improvement*** in everything we do. This means that I actively seek to improve my service.

TAUWHIRO CARE
Delivering high quality ***care*** to patients and consumers. This means I show empathy and treat you with care, compassion and dignity.

CONTENTS

All quotes are provided by our consumers


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NAU MAI KI TĀ TĀTOU WHAKAAHUA KOUNGA
WELCOME TO OUR QUALITY PICTURE

We are pleased to share with you our fourth Hawke's Bay Health sector's quality accounts demonstrating our commitment to high quality health care, living our values and sharing with you our successes and future plans. As you will see, we have come a long way and our teams have worked hard to achieve some excellent results in meeting the Ministry's health targets and the Health Quality and Safety Commission's Quality Safety Markers; however, there is still more to do. whānau

Every day people access the health and disability services across our sector and, for some, the experience, the care, and support they receive exceeds their expectations; however in some instances we fall short. As a sector, we believe our consumers should be at the centre of health care and treat them as if they were part of our own family/whānau, so as a sector our commitment is to continually improve the safety and quality of care for all.

In these quality accounts we have focused on some of the improvements currently underway across Hawke's Bay which, we believe, will better meet the needs of our community and give us the opportunity to deliver the best care possible. At the same time we need to continue to manage the risks of providing health care and reduce incidents of unintentional harm that can occur while receiving care. These accounts show how we are meeting these challenges – showing our successes and where we need to improve and focus in the future. We welcome any feedback, as well as any suggestions for future topics.

What quality means to us?

Ākina, one of our sector values means *that we continuously look for ways in which we can make improvements and learn when things don't go as well as we planned. Achieving high quality care across the sector means the care is the right care, in the right place, at the right time, every time. We want to help develop our staff to become far more person and whānau centred, really understanding our consumers' goals and needs, working in partnership to improve the health of our communities.*

KEVIN ATKINSON

CHAIR
Hawke's Bay District Health Board

BAYDEN BARBER

CHAIR
Health Hawke's Bay - Te oranga Hawke's Bay

CHRIS McKENNA

CO-CHAIR
Hawke's Bay Clinical Council

MARK PETERSON

CO-CHAIR
Hawke's Bay Clinical Council

GRAEME NORTON

CHAIR
Hawke's Bay Health Consumer Council

OUR CLINICAL COUNCIL AND CONSUMER COUNCIL

Establishing the Hawke's Bay Clinical Council (2010) and Hawke's Bay Health Consumer Council (2013) has helped us make change across our health sector – hearing the voice of both our clinicians and consumers.

The Clinical Council is made up of a number of health professionals from across our sector, including hospital specialists, family doctors, nurses and allied health (social workers, pharmacists) to provide leadership and oversight around safety and clinical improvements.

The Hawke's Bay Health Consumer Council provides a strong voice for the community and consumers on health service planning and delivery. The Council is tasked with enhancing the consumer experience, making sure our services meet our communities' needs.

A strong sense of teamwork and working together has been established between the councils which means that all service improvements and changes must be reviewed and recommended by both councils before they are discussed and approved by the Hawke's Bay DHB Board. The key to success to date has been the commitment at board and senior executive levels to support both these councils so that both clinical and consumer voices are able to grow.

As a further advance on working together, the Clinical and Consumer councils held combined monthly meetings in the past year. They worked on deepening their shared understanding of person and whānau centered care and how to advance this way of working across the health sector.

Each of the councils' annual plans has a section they share. Consumers are increasingly routinely invited to "co-design" services with clinicians, managers and other stakeholders. Trusting relationships are being built as a result, and we are getting better at it.

2015 was the year of the consumer with the Partnership Advisory Group for mental health being the supreme award winner at the Hawke's Bay Health Awards in November. Graeme Norton, Chair of Consumer Council also won the leadership award in 2015.


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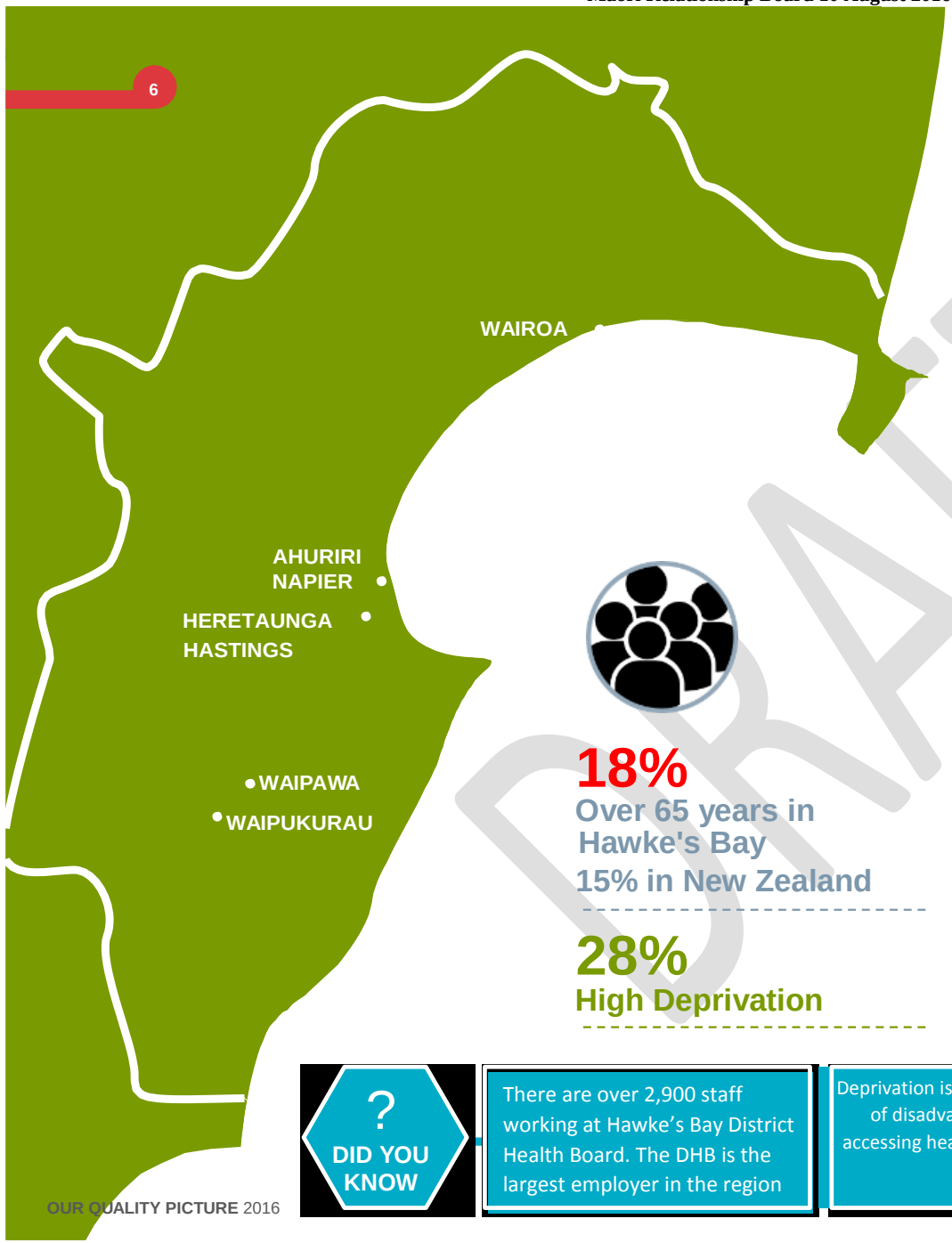


WHO ARE WE?

159,600
Hawke's Bay population 2015/16

26%
Māori in Hawke's Bay

4%
Pacific people in Hawke's Bay

18%
Over 65 years in Hawke's Bay
15% in New Zealand

28%
High Deprivation

? DID YOU KNOW

There are over 2,900 staff working at Hawke's Bay District Health Board. The DHB is the largest employer in the region

Deprivation is an indicator of disadvantage in accessing health services

The average income in Wairoa is $XX

X children are unable to attend appointments per year

TACKLING HEALTH INEQUITY

Many things in life are unequal but some things shouldn't be. Health inequities are inequalities in health that are avoidable or preventable. Hawke's Bay is a great place to live, but not everyone currently has the same opportunity to be healthy. Some parts of our community have better health than others and we need to make sure everyone enjoys the same level of health and wellbeing.

A recent update of the 2014 Health Equity Report shows that Hawke's Bay is improving in some areas.

Good progress is being made to achieve equity in the following areas:

- ✓ **Difference between Māori and non- Māori avoidable deaths almost gone.** If current trends continue there will be no difference between Māori and non- Māori avoidable death rates by 2017, largely due to disease prevention, effective treatment and/or medical care.

- ✓ **Reduction in hospital admissions for 0-4 year olds** that could have been avoided by prevention programmes and better access to treatment in primary care.

- ✓ **Reduction in teenage pregnancy** largely due to improved access to primary care contraceptive and sexual health services.

Life expectancy (how long we live) is improving but there is still significant inequity. It will take at least 50 years for Māori to have the same life expectancy as non-Māori in Hawke's Bay if current trends continue.

In the coming year, focus will be given to the areas where health equity is unchanged or worsening:

- × **Acute respiratory.** Child admissions are increasing and are associated with poor housing conditions.

- × **High smoking rates for Māori women.** Forty-three percent of Maori women giving birth in the past year were smokers. At the current slow rate of decrease it will take another fifteen years before rates are the same as non- Māori.

- × **Obesity in four year olds** has increased since 2009 with significant variation across communities. Nearly 12% of children living in places like Camberley and Tamatea are obese compared to less than 1% of four year olds in Havelock North Central or Poraiti.

- × **Oral health for five year olds.** There has been no improvement in oral health for five year olds. Māori and Pasifika children and children living in less affluent communities have significantly more dental decay.

HELPING PEOPLE STOP SMOKING

23% of all women who had a baby at the Hawke's Bay DHB facility during 2014 - 15 were current smokers.

Hapū mama who are Maori are five times more likely to be smokers. Encouraging hapū mama to stop smoking during pregnancy may also help them kick the habit for good and so provide better health benefits for mama and reduce contact to second-hand smoke by pepe.

The Increasing Smokefree Pregnancy programme is a collaboration between Kahungunu Choices Health Services, Hawke's Bay DHC Maternity Services and the Smokefree Team to provide support, education and incentives to hapū mama wanting to stop smoking. Incentives include free nappies at one, four, eight and twelve weeks if they remained smokefree. Those whānau members who smoke and are living with the hapū mama can also receive incentives at one, four, eight and twelve weeks if they remain smokefree.

RANGATAHI MAKE BETTER CHOICES

Smoking rates among Year 10 students are lower now than 15 years ago but one in four young Maori girls of this age remain regular smokers. Over 60% of Maori girls 14 – 15 years have used a tobacco product at some stage. Social supply and retail purchase are the main sources of cigarettes and tobacco for young people.

The "Breaking Cycles Challenge" engaged with Alternative Education providers in Hawkes Bay to provide education to youth aged 15-19 years old to lead healthy, active and smoke free lifestyles. The challenge was run over eight weeks with education, health, social, challenges and cessation components all factored in to the programme. The focus was smokefree and youth health, where engagement with providers once a week provided expert cessation advice and support to youth wanting help to stop smoking. In collaboration with Directions Youth Health Centre the aim was to support rangatahi to make better decisions for their health and wellbeing and create healthy lifestyles.

Kura Tutahi – ki te whakangao i ngā rangatira mo apopo

REDUCING INEQUITIES: Investing in tomorrow

Lifestyle factors such as smoking, diet and physical inactivity are the main causes of premature (early) death. Māori are doing badly in health statistics and the inequity gap is continuing to grow.

Central Health were once again the winners of the Commitment to Reducing Inequalities Award at the Hawke's Bay Health Awards in 2015. Their winning entry has a long term goal of seeing a new generation of Māori – strong, healthy and leading the way for their families/ whānau.

The biggest impact can be made when issues are addressed in children/ tamariki rather than waiting for them to become adults with poor health habits. This project aimed to improve nutrition, establish a habit of physical activity, prevent smoking uptake and access to nurse-led clinics to deliver early health care, and health promotion.

The project started out focusing on schools with the highest proportion of Māori and was later expanded to include the five kohanga in Central Hawke's Bay.

Innovations used were:

- 10 week touch rugby module for all schools to complete
- Kia Tunua – healthy cooking on a budget for children/ tamariki and their families/ whānau
- Supermarket Tour Toolkit
- Healthy Lunches Toolkit
- On-site nurse led clinics
- Social media resource (Facebook)
- Using advertising budget to become lead sponsor for Iron Māori Tamariki in Hawke's Bay

There were many success stories including The Terrace School in Waipukurau (70% Maori) which was awarded the NZ Heart Foundation's Healthy Heart Start Award (Healthy Heart Tick) for their healthy lunches programme. This is an astonishing achievement for a school which, until last year, only offered choices such as pies, sausages, and chips.

Increasing the Number of Healthy Weight Children

The best start for healthy weight children is keeping healthy during pregnancy, breastfeeding and healthy eating for our young children. The evidence suggests that getting it right from day one gives each child a good start in life and can protect against obesity throughout adulthood.

The Maternal Nutrition Programme delivers “Healthy First Foods” with Well Child Providers and gives information and practical skills to families/whānau on feeding children from six months.

Children under five who develop healthy eating behaviours are likely to maintain these over their lifetime. Also the whole whānau needs to model healthy eating and activity to support children.

The Pre School Active Families Programme, developed and funded by the DHB, is delivered by Sport Hawke’s Bay. They work with 45 families annually, providing support in the home and engaging whānau in community programmes.

Reducing the amount of sugar children consume not only supports healthy weight, it also improves oral health, concentration and overall wellbeing. “Water Only Schools” are being supported with resources, policy development and activities.

Image to be inserted appropriate to healthy eating

URGENT CARE

Emergency Department and general practice presentations continue to increase (include stat about numbers and increase on last year) and many of those who do come have coughs, colds or other minor medical conditions that would have been better treated by a nurse, family doctor or an accident and medical centre.

Last year we told you that the Urgent Care Alliance (a group of over 50 health professionals, managers and consumers across our region) was working to challenge and change the way health services are delivered, and to break down barriers like getting an appointment at short notice.

We highlighted several options we were looking at to improve some of the issues and these have been further developed in the last twelve months.

- Improved access to emergency dental treatment - As of 1 October 2016 there will be provision for 720 very low cost appointments available for anyone in Hawke's Bay who needs emergency dental treatment. Consumers can be referred by their own family doctor, by the hospital or simply walk in to Te Taiwhenua o Heretaunga for treatment.

- Communicating better with our community and helping consumers with more information so they can make better choices about where to go for treatment - This led to the implementation of the "choose well" campaign. The launch of a new health sector wide website (www.ourhealthhb.nz) supports our community with information, advice and alternatives. You may also have noticed "choose well" billboards and banners.

- Transport assistance is currently being reviewed and we expect a number of recommendations to be made in the next year to support this.

- Provision of urgent care services continues to be a priority. We are continuing to look at ways to improve access to health professionals both during and outside of normal working hours.

"I love building relationships with whānau, listening to their stories and knowing I have made a difference"

REDUCING OUR DID NOT ATTEND RATES

Rawakore means "without resources". Knowledge, transport, health literacy are examples of resources required to gain access to health services. At the DHB, we strive for equity and equal access to healthcare; however, we know there are many among us without these resources to help them on their journey.

To assist our community, the Māori Health Unit employs Kaitakawaenga to ensure that everyone is aware of their appointments, can get to their appointments, and can truly have equal access to healthcare.

Two of our Kaitakawaenga are Wirihana Raihania-White and Speedy White. Their work involves ringing people when they have appointments, visiting them in person, bringing them to appointments when needed, establishing relationships with whānau and listening to their stories. As they will tell you, "without the relationship, nothing else is possible."

Wirihana and Speedy take pride in their work every day, although they will say, "this is just what we do" to make a difference to people on their healthcare journey.

Customer focused bookings

The Customer Focused Booking project was initiated in Sept 2015. The goal of the project is to co-design a customer focused booking system that will result in improved attendance at appointments, full clinic utility, reduced waiting times and improved levels of customer satisfaction.

The project team have made good progress with placing the customer at the heart of the booking process this year and this focus will continue into 2016/17. Some of our progress is as follows:

Consumer information – we call this "demographics". The information we hold on file is not always up to date and this affects consumers being advised of an appointment. We have completed a review of our demographics form and how we collect this information, and we're getting ready to implement changes.

Online booking system – We completed a thorough review of technology solutions to support consumers being able to book and reschedule their own clinic appointments. We have chosen software we feel is the best for our systems, and we'll be rolling out a pilot within the next few months.

Text-to-remind tool – We have worked together with consumers to find out how we best use our text reminder system to meet consumer needs (see page 14). A set of recommendations are now being implemented to make this service more effective and more valuable to our consumers.

Clinic scheduling – Work to date to support our clinics running efficiently has included a review of clinic capacity and how clinics are scheduled. We continue to look at how our outpatient clinics run and changes we can make to make them even better.

Did not attend rates – There is still inequality for Maori when it comes to not being able to attend appointments. The project group will continue to monitor the data and identify issues to support system changes to promote equity and access to healthcare.

"Mum has dementia, and it is a challenge for her to manage her own appointments. Could you please send the reminder to me as her caregiver as well?

CONSUMER EXPERIENCE

Measuring what matters most to our consumers and how you experience our services is essential in improving the way we do things.

National Inpatient Experience Survey

Feedback about the care provided in our Hospital is a good indicator of how well services are working for patients and whānau. As with other District Health Boards, we send a survey every three months to a selection of adults who spent at least one night in our hospital, inviting them to participate in the survey.

330 people responded to our surveys over the last 12 months (July 2015 to June 2016) and scored us positively across the following four domains: communication, coordination, needs and partnership (see page 15).

In addition to the scores, our reporting captures lots of comments and feedback that we share with our services. This feedback has highlighted those areas we can improve – for example pain management, privacy and discharge planning.

Real time surveys

If you have visited Nga Rau Rakau, Napier & Hastings Community Mental Health, Te Harakeke Child and Family Service (CAFS), and the Home Based Treatment Team recently you may have noticed iPads placed in reception areas and staff encouraging users of the service and their whānau to take up to three minutes of their time to "tell us what you think" in an online survey. This feedback is anonymous and captures your thoughts. We are encouraging consumers to complete the survey after each appointment or interaction as we know experiences can be different each time.

178 surveys were completed between March and July 2016 with the average rating 4.01 out of 5. We received the highest rating to the question "I would recommend this service to friends and family if they needed similar care or treatment".

Workshops

In July 2016 consumers from Wairoa to Waipukurau attended a workshop reviewing the "text to remind" tool - the method used to remind outpatients of their scheduled appointments. This workshop was useful in finding out how we can best use the tool to meet consumer needs, improve the consumer experience and increase attendance of appointments.

The ultimate aims are to ensure equitable health services for all and best use of our resources.

"Whenever I was talking with staff they showed great empathy, displayed a calming sense of humour (yet) … they were professional and competent".

Results from the 2015/16 National Patient Experience Survey

Our scores have improved on last year across all four areas and in some cases are higher than the New Zealand average.

86% Felt we communicated well, and we listened to your questions

(3% increase on last year)

87% Felt you were involved in any decisions about your care and treatment

(2% increase on last year)

88% Felt you received good care and support and we treated you with dignity and respect

(3% increase on last year)

85% Felt you were given consistent information from the teams that were treating you

(2% increase on last year)

We still have room for improvement. The survey did identify areas of concern, such as discharge planning, which we will focus on improving in the coming year.

"I wasn't given info on medications prior to discharge. I felt confused about when to take them when I got home".

Image of consumer engaging with health professional

POPULATION HEALTH

We work with people and communities to prevent disease, have a safe environment and support people to be healthy and well. Population health covers areas such as reducing harm from alcohol, drugs, tobacco and hazardous substances, water safety and sanitation, promoting physical activity and healthy eating, healthy housing, sexual health, preventing disease through on-time immunisation, managing notified communicable diseases, and cancer screening.

KEY RESULTS

- Eight drinking water suppliers signed up to the Drinking Water Assistance Programme and 96 suppliers were assisted with developing water safety plans and risk management plans
- 228 homes were insulated through DHB healthy housing programmes in the last three years
- x pregnant women were helped to give up smoking
- Plans developed to increase the activity and wellness of infants and children – Hawke's Bay Healthy Weight Strategy and Best Start: Healthy Eating and Activity

OUR FOCUS 2016/2017

- Support workplaces to have healthy workplace policies
- Support schools to have policies on drinks with no sugar
- Develop a position statement on alcohol harms and outline actions to address them
- Improve the information on pamphlets given to the public on communicable disease
- Continue to address housing issues and poor insulation

Did you know?

481 communicable disease cases notified

619 liquor licence applications received

187 tobacco retailers had compliance/ education visits

123 women supported to breast & cervical screening services


17

PRIMARY HEALTH CARE

Primary health care is the first place you go to for health services; often this is your general practice or health centre. The doctors, nurses and pharmacists working in our community provide a range of health services aimed to keep you well, from health promotion and screening to diagnosis and treatment of medical conditions.

- More people have been supported to stay at home to look after their respiratory condition (breathing). This is because general practice and hospital services have worked together to support people earlier with better understanding, tools and access.
- 2,197 four year old children have received health checks before they start school. We have exceeded the target of 90% set by the Ministry of Health.
- 344 whānau (1440 individuals) were enrolled in our first Whānau Wellness Resource Programme which is a 12 month step-up programme including support to access general practice, medicines, tests and education.
- Whāriki/Stanford, a self-management programme has supported the development of Māori community champions and 81% of whānau using the programme have completed it (see page 21)

- A review of systems that support patient safety continues within general practice
- Identify how primary and secondary care will work together to support better patient outcomes (system-level measures)
- Patient experience survey for primary care being developed by the Health Quality and Safety Commission is set to come to Hawke's Bay
- Improving Health Literacy - a new online training programme has been developed to support the people who work in general practice to understand more about the people that come to see them, their understanding of the health system and their health needs.

Did you know?

24,666 Cardiovascular Disease risk assessments were completed in general practice

(these forecast your risk of a Heart Attack or Stroke within the next 5 years)

710,857 (2% increase on last year) nurse and doctor consultations in general practice

6,276 Diabetic annual reviews were held in general practice

"Manage my Health allows me to access my general practice 24/7. I can use my tablet any time to book appointments or request repeat prescriptions, which is essential when my asthma medications run out. I can read the doctors notes from my consultation and email her if I need clarification. And there is no more waiting for ages for the receptionist to answer the phone".

Respiratory Programme

Managing your breathing issue is now easier because we have joined together general practice and hospital services to provide better service for patients with respiratory issues and concerns. This is called the Respiratory Programme. The solution has been to increase access to your doctor or nurse, for early diagnosis and to provide education enabling self-management and improved quality of life. Nurses have received education sessions to increase their skills for providing extended services for patients with respiratory conditions.

- More people (300% increase) are now using the Pulmonary Rehabilitation service.
- More people (225% increase) have been provided a spirometry (lung function) test at their health centre.
- The number of days people have not needed to be in hospital because of their breathing problems has been reduced by 740 days compared to last year.
- More people saw their doctor for breathing issues and were treated by their doctor reducing the need to see a specialist at the hospital; this reduced referrals from 658 in 2012 to 28 referrals in 2015.

"I feel I know better how to take care of the little lung capacity I have left… the programme has given me another ten years of productivity".

Supporting you to keep well

Consumer Portal

Did you know that you can access your own medical records and make your own appointments? Ask your practice about Manage My Health or Health 365. Currently ten practices in Hawke's Bay have access to this technology, and by the end of the year most general practices will have access to this technology.

Improving self-management of health issues in our community

Self-management has become a popular term for changing how people manage their own health. This is especially true for those with long term conditions, such as heart disease and diabetes. Health Hawke's Bay has developed a team of Master Trainers and Stanford / Whāriki Facilitators to provide group education sessions to people in their communities which aim to improve people's skills and confidence in managing their own health problems.

Support includes helping people understand their condition, developing the skills to empower good decision making, establishing goal setting and problem solving approaches. The programme supports patients being leaders in their own health and well-being, in close partnership with their medical practitioner. The Whāriki Stanford programme has been in place now for 12 months. During that time, 435 people have participated with 81% completion rate for Maori using the programme.

We have a targeted focus to support individuals and whānau to navigate the complex range of health services rolling out this coming year

Whāriki translates to "the woven mat". It is considered a special skill to be able to weave, taking time and concentration to complete. It allows contemplation and, once complete, is a great achievement.

ACUTE AND MEDICAL

We are responsible for providing safe and effective care across a number of services including:
Emergency Department, Intensive Care Unit, Radiology, Renal Services, Cancer Services, General Medicine, Cardiology, Respiratory and Palliative Care.

KEY RESULTS

- Continuing to reduce average length of stay for medical patients
- Refurbishment of ED front of house
- Dedicated team adding additional support to Patients at risk of deterioration within the hospital 24/7
- Medical Day Unit now well established and providing 6 beds for those admitted to the hospital for minor investigations and procedures

OUR FOCUS 2016/2017

- Continue to focus on flow of acute patients through the hospital
- In preparation for the National Bowel screening programme and to meet current needs in our community, plans are underway to commence building a standalone gastroenterology and endoscopy suite in early 2017
- With the appointment of a Clinical Nurse Specialist, Trauma and national data collection, we will review and optimise our trauma (serious injury) care
- Continue to focus on the right numbers of staff with the right skills at the right place at the right time.

? DID YOU KNOW

We provide a **24 hour** acute service 7 days per week

We manage around **45,000** emergency department presentations each year

We have **97** acute adult medical beds

13,342 people with injuries presented to E, 2,190 admitted to hospital, 79 with severe trauma

The most common cause of severe trauma is motor vehicle accidents

24/7 Stroke thrombolysis

In June 2016, the stroke team began providing 24/7 stroke thrombolysis (a treatment to dissolve the dangerous clots in blood vessels, improve blood flow and prevent damage to tissues and organs) to clinically eligible patients presenting to the Emergency Department with acute stroke.

Our Hawke's Bay stroke team are working closely with our Wellington counterparts, and video conferencing is being used to provide stroke expertise for patients presenting outside of working hours. This technology allows us to be in a position to offer therapy aimed at improving outcomes for clinically eligible stroke patients whenever they need it.

Emergency Department (ED) front of house

Last year we had lots of feedback from the community about how we could improve the ED waiting room. The front of house redesign project is finished, and the improvements are sure to help both staff and patients.

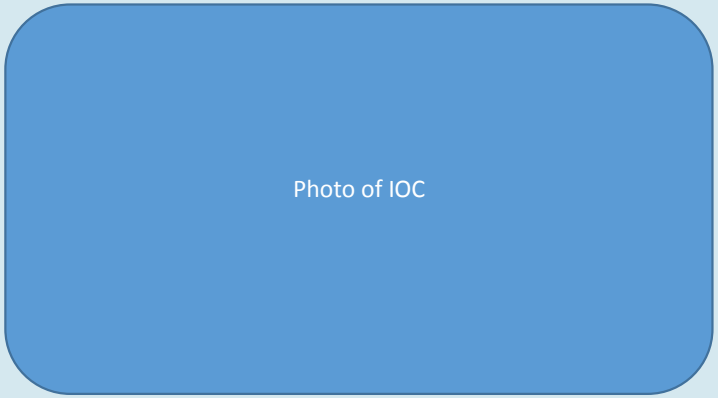
A new wall and electric doors now define ED as its own space, rather than a general thoroughfare into the hospital. This provides a clear process from the front door for patients/visitors and whanau. Increased clinical space – a new triage booth and five assessment/intervention bays – will optimise patient privacy, and commencement of interventions therefore supporting patient flow. The clear view that staff now have of patients in the waiting room will also support staff and patient safety

Integrated Operations Centre (IOC)

The Integrated Operations Centre was opened in March 2016. The main purpose of the IOC is to provide a central hub where the hospital activity is visible and patient flow across the hospital is coordinated. The IOC has become an integral part of the daily management of acute patient flow, which assists us to:

- Provide visibility of real time hospital wide activity
- Predict demand and, therefore, better manage capacity
- Alert us to areas at risk
- Manage patient flow from ED to discharge
- Support us to provide best use of our staff capacity to meet the demand

A key part of the IOC room is the three large screens, which gives us visibility of real time activity and prediction data. These screens show us at a glance what is happening and where any trouble spots are; we can then better support staff to provide high quality care and manage demand through the hospital.



"The Doctor chatted to me the day after surgery so I wasn't still foggy... and took time to answer all my questions. The Anaesthetist was calming and talked through his role and made me feel calm. The nurse kept me updated with the discharge process"

SURGICAL

We are responsible for providing surgical procedures for our consumers, whether they be elective (planned) or acute (not planned or accident) in our seven theatres, carrying out day case surgeries and caring for consumers after they have undergone surgery.

KEY RESULTS

- We exceeded the national elective health target and completed xxx surgeries, xxx more than last year
- Of these x % of people waited 4 months or less on the surgical waiting list.
- We completed xxx hip/knee joint replacements. This was {100} more than last year
- Stat about the number of breast cancer ops we did. (General statement about speed without specific number)
- Stat about average length of stay after hip/knee op – improvement on last year?
- Appointment of a Vascular Surgeon meaning consumers don't need to be sent out of the region for vascular surgery

OUR FOCUS 2016/2017

- Continue to improve the numbers of our community receiving surgery
- Updating our theatre facilities to meet the needs of the Hawke's Bay community
- Mobility Action programme – info from Dawn
- National Patient flow?
- Reduce the wait time for acute surgery by increasing our theatre opening times across the week.

? DID YOU KNOW

- X people are seen in the fracture clinic (Villa 1) weekly
- We do around **35** surgeries each day in our 7 Theatres
- **XXXX** patients are admitted to our 3 surgical wards yearly
- Around **XXX** people are seen at surgical outpatient clinics
- **XXX** gynae operations completed this year (?increase on previous years)

"The day before the procedure I had to come in for the pre-op meeting… I had to see 4 different people who all asked the same questions"

Spine Clinic

Not all people experiencing back pain require surgery. We now have advanced practitioner physiotherapists running a spine clinic providing assessment, diagnosis and physiotherapy treatment. This commenced in Hastings in February 2016 and in Napier in August 2016. These clinics were introduced to provide quicker service to our patients, and release orthopaedics surgeons to focus on surgery.

The clinics have been successful to date with 90% of patients being referred to the spine clinic not needing orthopaedic surgeon follow up.

Improving pre-surgery visits

In February 2016 we commenced the re-design of our pre-admissions process. These are the visits you have with us prior to your surgery to ensure you are safe and ready for surgery.

Our previous system of two different processes and multiple visits was creating confusion and frustration for staff and consumers. Consumers were experiencing significant delays and feeling like they were "double handled" with the same or similar information requested and recorded by different staff members.

We want a consumer centric, safe, efficient, consistent and streamlined process. Ultimately we will have you visit us prior to your surgery only if required, and then only once. In many cases you will only need to be seen by a specialist trained pre-admissions registered nurse. At times, the nurses are able to complete a telephone assessment so that you don't need to come in for a pre-admissions appointment.

So far we have concentrated on improving pre-surgery visits for our healthiest (low risk) patients and have commenced nurse led clinics for orthopaedic, gynaecology, ophthalmology and ear, nose and throat (ENT) specialties. Our next focus will be general surgery and neurology.

"The Spine clinic has provided me with a service that has been focused on rehabilitation catered to my specific needs. Before I began attending the clinic, I had been struggling with menial chores and pain management for around 5 months with no improvement. The clinic has helped me get back into everyday life with a degree of normality by achieving specific milestones. Being able to put my socks on in the morning is just one of those milestones achieved since attending the spine clinic."

WOMEN, CHILDREN AND YOUTH

Women, Children and Youth services provide services from early pregnancy through to whānau with children under the age of 15 in Napier, Hastings, Central Hawke's Bay and Wairoa. We support women, children and whānau through all aspects of their children's health journey from birth to teenagers providing acute and long term conditions assessment and care inclusive of audiology, and ongoing child development services. There is a particular focus on our most disadvantaged with a strong partnership with our violence intervention programmes.

Teenagers living with diabetes

Last year we noticed that many of our teenagers were having a tough time following their diabetic plan. It was hard for them to follow medical treatment which ultimately impacted on their diabetes and led to many coming in to ICU and children's ward with serious health issues related to their diabetes. We submitted a bid, which was approved, for funding to employ a children's outpatient social worker who could work closely with these rangatahi. The results so far have been really positive. Relationships have been built, and education and understanding has improved. Important appointments are being attended more consistently now, and engagement with the diabetes team has lifted. Since January 2016 we have engaged with eight high risk teenagers and their whānau, the majority of whom are now participating in their diabetic plan and are starting to be more positive about their future with diabetes.

KEY RESULTS

- "Waioha" primary birthing unit completed
- Established Maternity Consumer engagement Reps
- Funding to support implementation of the Foetal Alcohol Spectrum Disorder (FASD) programme secured
- Audiology (hearing clinic) waitlist reduced from 2 years to 8 weeks
- Maternity Wellbeing Child Protection coordinator appointed

OUR FOCUS 2016/2017

- Improving consumer engagement to help design and monitor services
- Review of patient management and access to non-acute
- services
- Engaging with our youth to look at ways to improve their health
- Improving Family Violence Intervention screening rates (see page 27)
- Increasing the number of births without intervention
- Continuing to improve the coordination of care for those children with complex needs
- Continuing to collaborate with children and youth agencies and providers

? DID YOU KNOW

The most common children's illness is acute bronchiolitis (a serious chest infection)

On average we have 16 children in our Paediatric (children's) ward

We gave out 626 Pepi-Pods this year

Child Development service managed 1,500 new referrals this year

"Quote from woman accessing FV services"

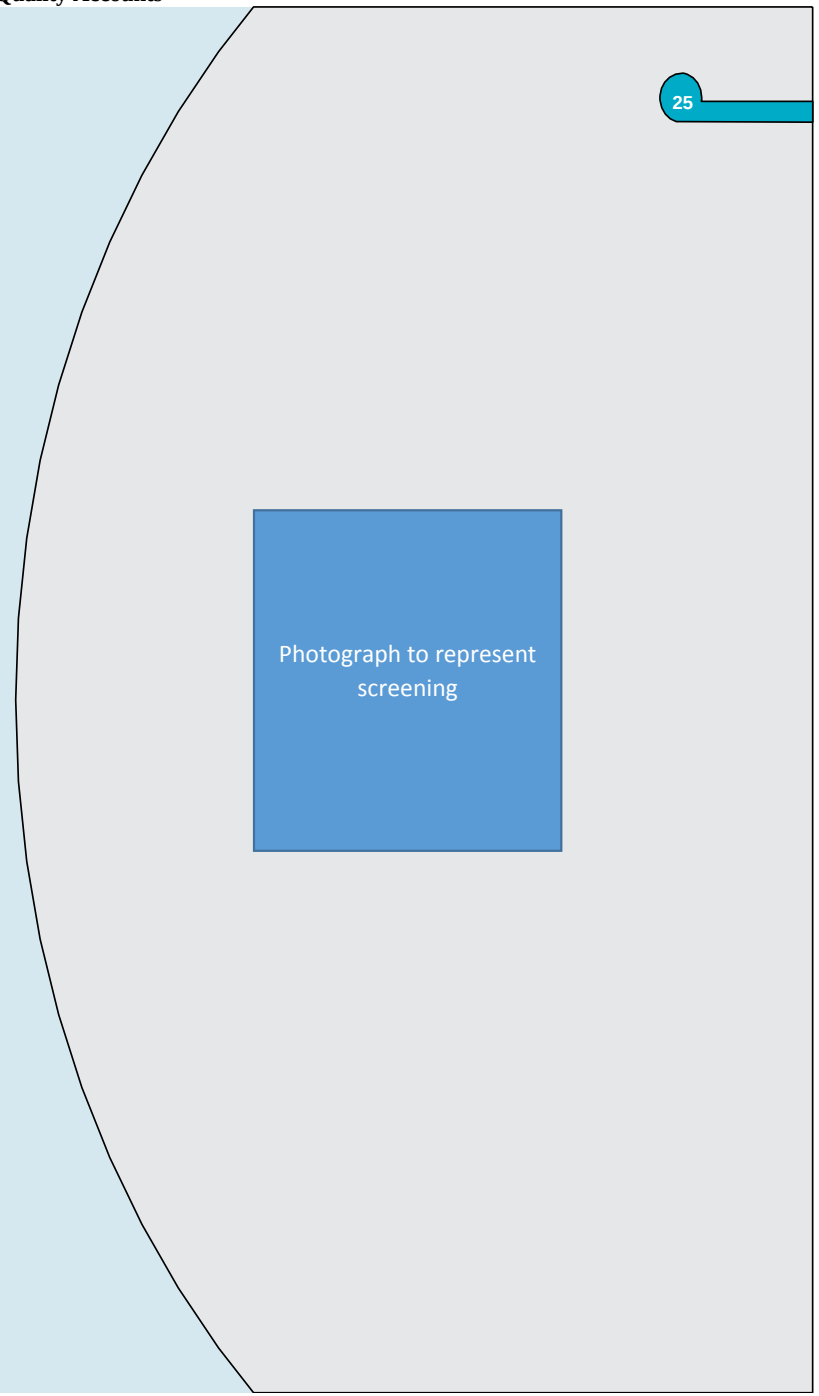
Family Violence Routine Screening

Family violence is a serious issue in Hawke's Bay. The New Zealand Police attend a family violence callout every six minutes, and on average across the country there are ten family violence incidents per 10,000 people. In Hawke's Bay we have 52 incidents per 10,000 people. That is over five times the national average!

Violence and abuse in families has damaging physical and mental health effects. The impact of witnessing violence can be devastating for children. Hawke's Bay children are exposed to more violence than any others in the country. We know that being a victim of abuse or witnessing abuse is linked to poor health outcomes such as obesity, diabetes, heart disease and depression.

Health care providers come into contact with the majority of the population regularly and are therefore in an ideal position to assist people experiencing violence and abuse.

Our Visiting Neurodevelopmental Therapists (VNT) working in the Child Development team, are well placed to incorporate routine family violence screening questions into their everyday practice. They find that women are appreciative of being asked, and it often enhances their relationship. Recently, during a consultation for a minor developmental need with her child, one mum disclosed extensive family violence in response to the routine questioning and now works with agencies to support her and her children to move away from that situation. This will have a positive impact.



"Mum has a plan in place, has talked to family and friends and is considering moving out…"

"The feedback and uptake from our staff has been nothing but positive and likely to continue to grow so we are very happy how the process is going thus far. Through this relationship we can provide our patients with a level of support and follow up care that is unprecedented both in Hawkes Bay and provincial New Zealand. "- St John's Ambulance Service Acting Territory Manager.

OLDER PERSONS HEALTH

We are responsible for providing a range of services to older people in Hawke's Bay. In the last year the engAGE service has been developed to better support frail older people who live at home to remain independent. This service has three main parts:

- engAGE team meetings are held at general practices across Hawkes Bay. These meetings allow health professionals from across the hospital and community to work more closely together and learn from each other. Team members visit older people at home and work with them to make a plan to achieve their well-being goals.
- engAGE ORBIT team works at the Emergency Department to support older people to return to their home rather than having to stay in hospital. This team is now working longer days, 7 days a week. ORBIT also take referrals from St John's Ambulance and see people in their homes to complete assessments, provide equipment and co-ordinate services for older people who need a rapid response (after a fall for instance).
- engAGE Intermediate Care Beds are beds at residential care facilities in the community where older people can stay for a short period. This service can be used by people who are unwell and cannot manage at home but do not need to be in hospital OR by people who have been in hospital and are well again but not independent enough to go home. The engAGE team works with these people to develop a plan together to get them home and back to independence.

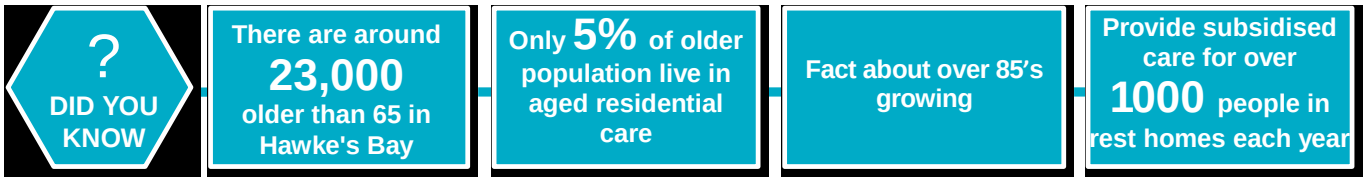
engAGE service fully functional and having a positive impact

4% increase in over 65s with no increase in hospital bed use of rest home placement

engAGE service to be developed in Wairoa and Central Hawke's Bay

engAGE ORBIT team working with Accident and Medical facilities

Evaluating the impact of the new engAGE service



"Being at home is just huge to Mum, as it is to us"

engAGE Age Well

Jessie is an 84 year old woman who lives at home alone with a supportive family.

She had three admissions to hospital in the space of a month with recurrent diarrhoea which is hard to get rid of and difficult to treat. During each hospital admission it would resolve with antibiotics but would recur when Jessie returned home.

Jessie was losing weight, becoming weak and losing confidence to be able to manage at home. Her family were extremely worried and suggested that she should move into a rest home.

Jessie was referred to engAGE for help with discharge planning and follow-up. She spent 3 weeks in an Intermediate Care Bed (ICB) located in the community with regular input from Physiotherapy and monitoring of her weight and food intake. A family meeting took place before discharge.

Jessie went home with support from engAGE and a plan in place for re-admission to an Intermediate Care Bed if she required it. Jessie has remained well and at home with no further hospital admissions.

"I'd much rather be here and have this situation in place thanks to Dr Lucy"- Jessie.

"The change in her from her last hospital release is just incredible. At home she's just Mum"- Jessie's daughter.

MENTAL HEALTH

We are responsible for delivering mental health services to people with moderate to severe mental health illness. We have community teams situated in Wairoa, Napier, Hastings and Waipukurau and a residential addiction service in Napier.

MENTAL HEALTH SERVICES
He Wāhanga Ōranga Hinengaro

KEY RESULTS

- Completion of a $22 million new building - Ngā Rau Rākau Mental Health Inpatient Unit
- Length of inpatient stay has decreased since the opening of the new inpatient unit resulting in more effective care for patients
- Ongoing implementation of a new model of care for the way services are delivered. We have established home based treatment, community resilience programmes and intensive day programmes which have decreased inpatient hospitalisations.
- Wait time for first appointment at Te Harekeke /Child and Family Service has reduced. In December 2015, 59% of people were seen within 3 weeks. In July 100% of people are seen within 3 weeks of referral

OUR FOCUS 2016/2017

- Continuing to develop and implement new services to support our consumers
- Strengthening the Community Mental Health Teams to manage and reduce the number of consumers needing acute treatment
- Recruit further staff to support our Mental Health Crisis Teams
- Continue to reduce the time children and their families wait for their first appointment with Te Harakeke/Child and Family Service

? DID YOU KNOW

X appointments with Child, Adolescent and Family Service (CAFS) per day

We have an inter-professional crisis team who are available all day, every day

We provide Maternal Mental Health specialist services for pregnant women who experience moderate to severe mental health issues

Opening of Nga Rau Rakau

On February 23, 2016, we celebrated the milestone achievement of officially opening the new mental health inpatient unit, Ngā Rau Rākau. Minister of Health, Jonathan Coleman, and Partnership Advisory Group Chair, Deborah Grace, officiated with cutting the ribbon.

The name of the new unit, Ngā Rau Rākau, means a collection of trees. By standing together, as part of the forest, Ngā Rau Rākau, the trees are protected, they are sheltered, they grow healthier, they grow stronger, they are supported and safe. And that's what developing our mental health services has been all about - growing the service, listening and transforming mental health services for Hawke's Bay people.

Home Based Treatment intervention prevents admission

Waekura Home Based Treatment prevents inpatient admissions and makes a positive difference in the life of consumers and their whānau.

A powerful case study: A young adult presented to the ED. The impression gained from the notes was that the client was recommended to be admitted to the inpatient unit.

The mental health assessment indicated moderate risk and the Home Based Team (HBT) thought this was a situation that could be managed effectively in the home setting.

The client was not keen on being admitted to the inpatient unit but needed support to cope with the impact of an upcoming significant event. Staff used multiple strengths-based, evidence-based counselling approaches which gave the family and client confidence to deal with the situation.

The client engaged well with HBT, stayed at home, was monitored at a relative's house, was visited daily by whānau, and received regular HBT clinician interventions.

The client also re-engaged with friends, built confidence, became much more resilient, and developed more positive thinking.

RURAL, ORAL AND COMMUNITY

The Rural, Oral and Community Directorate (ROC) has services located in Wairoa, Central Hawke's Bay, Napier and Hastings. Most of our services support people staying well in their community with a focus on integration and collaboration of services with primary care, Māori providers and other providers. ROC services provide a diverse range of care including: community nursing, pulmonary long term management, continence services, ostomy. Napier Health, outpatients, public health nursing, integrated sexual health services, Health Care Centre – Wairoa (HCC) – a general practice, Central Hawke's Bay Health Centre, diabetes service, endocrinology, hospital dental and community dental service (school dental service).

KEY RESULTS

- Community Nurses working alongside general practices in both Napier and Hastings.
- Increase in pulmonary long term conditions group sessions for patients with breathing issues. 10 groups increased to 22 and are more accessible in the community. For the first time, the programme was implemented in Wairoa.
- Networking with health providers in the community is progressing in Central Hawke's Bay and Wairoa

OUR FOCUS 2016/2017

- Implementing the District Nurses more closely with General Practice into Wairoa and Central Hawke's Bay.
- Involving other health providers in improving access for Māori children and whānau to dental care.
- More healthy warm homes
- Reducing hospital admissions for children.

? DID YOU KNOW

X patients enrolled in general practice in Wairoa

X people attended pulmonary long term management sessions

28692 children enrolled with community dental

X outpatient clinics in Napier Health per day

Development of the Pulmonary Long Term Management Service

During 2014/2105 the Pulmonary Rehabilitation Service experienced a large increase in referrals to attend the Pulmonary Rehabilitation courses which at the time were offered four times a year in Napier, Hastings and twice yearly in Central Hawke's Bay. The increase in referrals was due to improved access to spirometer (lung function) services in the primary care setting.

The Pulmonary Rehabilitation Specialty Clinical Nurse identified the service could not accommodate this level of referrals and a business case was developed to alter the service model and allow for increased service provision throughout Hawke's Bay.

This resulted in the development of the Pulmonary Long Term Management Service and implementation of a new model which commenced in January 2016. This has doubled the availability of Pulmonary Rehabilitation courses in the community, and allowed the service to be offered in Wairoa as well as Central Hawke's Bay.

The programme outcomes for this patient group have demonstrated reduced presentations to the emergency department, reduced hospitalisations, improved quality of life and fitness. Patients and families have an increased understanding of their condition and improved confidence with self-management.

E Tu Wairoa – Violence Free Whānau

In 2015 Wairoa leaders decided to establish an intersectoral network with the purpose of creating a tikanga based approach to eliminating violence in our homes and community.

The network is chaired by the Wairoa Health Centre manager and to date have launched the E Tu Whānau charter with a commitment from many community members and leaders including Wairoa Mayor, Craig Little.

A programme of action has been developed and recruitment of a network coordinator is underway. The network has also secured funding to develop and deliver tikanga based programmes to address family violence.

This is an exciting collaboration of providers and community members who believe in a common goal and have worked across structures and barriers to establish a family violence intervention model that is locally grown and delivered.

NATIONAL HEALTH TARGETS

Our results

✓ TBC surgeries delivered. That's TBC more than the target/last year.

✗ TBC% of people referred with a high suspicion of cancer received their first treatment within 62 days

✓ TBC% of eight-month olds had their immunisations on time.

✓ TBC% of the eligible population had their Cardiovascular Disease risk assessed in the last five years.

✗ 93% of people spent less than six hours in the Emergency Department.

✓ 99% of hospitalised smokers were offered advice to quit.

✗ TBC% of those consumers who are smokers and have a family doctor were offered advice to quit.

NATIONAL HEALTH TARGETS - AT A GLANCE

HEALTH TARGET	TARGET	OUR RESULT	TREND (since last year)	COMMENT
Shorter stays in Emergency Department	95%	Not Achieved	↓	…
Improved access to elective surgery	100%	Exceeded	↑	This year we have continued to focus on 'Operation Productivity' and increasing Hip and Knee surgeries (pg22) to increase the number of people receiving surgery.
Faster Cancer Treatment	85%	Not achieved	N/A	…
Increased Immunisation	95%	Exceeded	↑	Hawkes' Bay DHB remains one of the top performers in this Health Target
Better help for smokers to quit (Hospitals)	95%	Exceeded	-	Hawke's Bay DHB has achieved this target for the last three years.
Better help for smokers to quit (Primary Care)	90%	Not achieved	↓	General Practice continues to have a strong focus on helping smokers to quit.
More heart and diabetes checks	90%	TBC	↑	We have maintained our performance in this area and continue to focus on priority groups who are most at risk of heart disease and diabetes.

KEY:

↑ Improved our performance against the health target.

↓ Our performance against the health target has

– Our performance against the health target has stayed the same.

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TRADE
Photo courtesy of HB Today

SERIOUS ADVERSE EVENTS

In hospital

A serious adverse event is an event which has led to significant additional treatment, is life-threatening or has led to an unexpected death or major loss of function.

These events are uncommon; however with 38,715 hospital admissions in 2015/2016, we continue to focus on improving the quality and safety of the care that we provide to all our consumers so that we can prevent these events in the future.

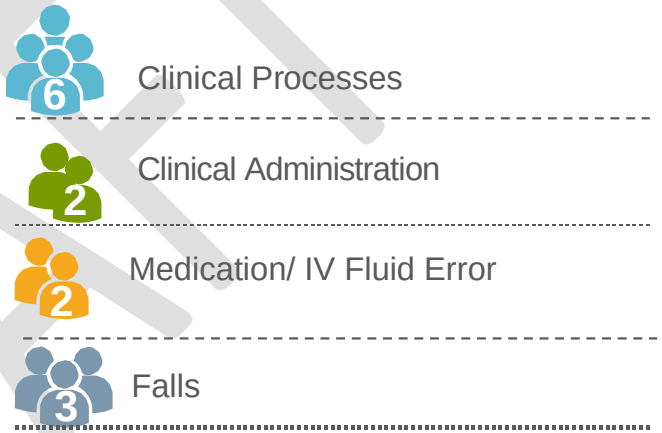
In 2015/2016 Hawke's Bay DHB had 13 serious adverse events which is an increase by two from last year.

When a serious adverse event occurs, we review our processes to try to determine the major cause, or causes that led to the event. When these causes are known, interventions are recommended to try to prevent the recurrence of the same or similar adverse event in the future. The aim is to enhance patient safety by learning from adverse events when they occur.

Did you know?

- Incidents indicate where we need improvement
- The more we report the better we will get through learning and improving
- We reported 4,168 incidents last year
- 13 of these were classified as serious adverse events
- Serious Adverse Event reviews focus on what happened? Why did it happen? What can be done to prevent it happening again?

Serious events 2015/2016



Our focus 2016-2017

- Distribute key patient safety learnings across the sector
- Develop an education programme to train reviewers of serious adverse events
- Work with PHO, GPs and aged care facilities to establish a reporting and learning programme/culture
- Upgrade our electronic risk management system

The Health Quality and Safety Commission releases an annual report titled 'Making our health and disability services safer', which is due to be released later this year. In this report we will provide more detail surrounding these events.

NATIONAL PATIENT SAFETY PRIORITIES

In hospital

The Health Quality & Safety Commission is driving improvement in the safety and quality of New Zealand's health care through the national patient safety campaign 'Open for Better Care'. All of New Zealand's District Health Boards need to report on how well they are doing against key targets. These targets are about making sure consumers are not harmed from a fall when in our care, that we reduce the number of infections and that we make sure that when consumers have surgery that they receive the necessary medicines, and that we work as part of a team.

This is how we are doing (results for Jan-Apr 2016 unless otherwise specified):

✓ 97%

Falls prevention 1: older consumers assessed for risk. Target 90%

✗ 86%

Falls prevention 2: percentage of older patients assessed as at risk of falling who receive an individualized care plan addressing these risks. Target 90%

✓ 90%

Hand hygiene: percentage of health professionals who clean their hands before and after having contact with a patient. Target 70%

Surgical site infection targets (Oct-Dec 2015):

✗ 98%

Antibiotic administered in the hour before surgery. Target 100% (Achieved 100% in the three quarters prior)

✗ 94%

Right antibiotic in the right dose.

Target 95%

✓ 100%

Appropriate skin antisepsis in surgery.

Target 100%

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Preventing harm from medicines in hospital

In the hospital we commonly use a group of pain killer medicines called 'opioids' (e.g. 'morphine', 'oxycodone', 'codeine'). Unfortunately these medicines can cause serious side effects like constipation. Constipation is when you haven't had a bowel motion ('poo') for three days or more. It can be painful and delay your recovery.

We introduced three things to reduce the number of patients having constipation while on opioids:

1) A patient leaflet and poster to help patients and staff describe bowel motions using the 'Bristol Stool Chart'.
2) A stamp for the patient's health record, to improve how we record each patient's bowel activity - giving us a clearer view of which patients are constipated or at risk of becoming so.
3) A 'laxative ladder' to describe the best laxatives to prevent and treat constipation.

Preventing harm from surgery in hospital

The 'Safe Surgery Program' aims to improve quality and safety of health care services provided to patients having surgery through the use of a 'surgical safety checklist'. The checklist is used to ensure patients receive the right surgery with the right preparation.

This year, a 'paperless' checklist (a poster with prompts) was introduced in our operating theatres. Theatre staff (nurses, doctors and anaesthetists) from Hawke's Bay and Royston Hospitals worked together to ensure they use the checklist in the same way. This enables staff to speak up and ask questions without fear.

Preventing harm from falls in hospital and the community

Last year we planned to take a 'wrap-around' approach to preventing falls and we've made some good progress on this since then. Representatives from HBDHB, Health Hawke's Bay (PHO), Sport Hawke's Bay, St John's Ambulance, ACC, and local Aged Care Facilities meet regularly to actively coordinate falls prevention activities across the region.

During the national 'April Falls' campaign (run in April), the group chose to highlight the falls risk associated with poor vision with 'eyes on falls', offering free eye checks.

An 8-week program called 'Upright and Active' (funded by Age Concern) introduces Tai Chi to improve flexibility and strength. Green Prescription offers individual support programmes and Kori Tinana Mo Nga Kaumatua Taster programmes is offered to kaumatua, based in marae.

We've looked into why people fall in hospital and have found poor lighting at the bedside to be a key factor. We now have an upgrade of the over-bed lighting included in the facilities' maintenance plan.

Preventing Harm from Infection

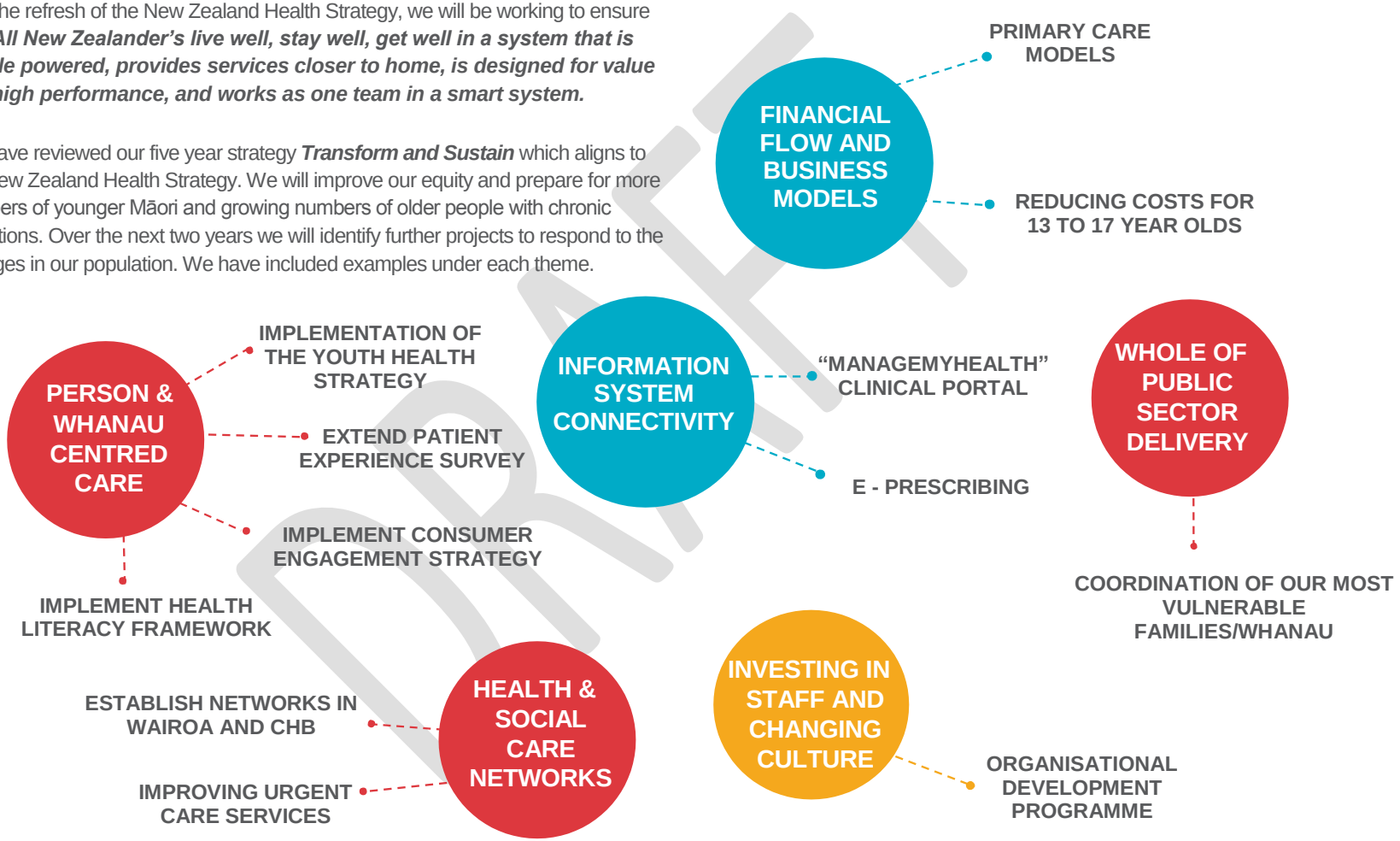
Hand hygiene is recognised as the single most effective way to prevent the spread of infection. As at June 2016 Hawkes Bay District Health Board has achieved 87.5% in the national hand hygiene programme and continues to rank amongst the top performers in NZ.

This year our focus will be the promotion of appropriate usage of antibiotics. We see this as an important patient safety issue to prevent the overuse of antibiotic and the development of multi resistant organisms. Our aim is to improve patient outcomes.

OUR FUTURE FOCUS

With the refresh of the New Zealand Health Strategy, we will be working to ensure that: ***All New Zealander's live well, stay well, get well in a system that is people powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system.***

We have reviewed our five year strategy ***Transform and Sustain*** which aligns to the New Zealand Health Strategy. We will improve our equity and prepare for more numbers of younger Māori and growing numbers of older people with chronic conditions. Over the next two years we will identify further projects to respond to the changes in our population. We have included examples under each theme.



OUR QUALITY PICTURE 2016

YOUR FEEDBACK

Consumer feedback

We welcome and appreciate receiving feedback. To improve our services we need to hear your story. Whether compliments, comments, questions or suggestions, complaints or a mixture, your feedback is valuable. It helps us see where we are performing well and where we could improve.

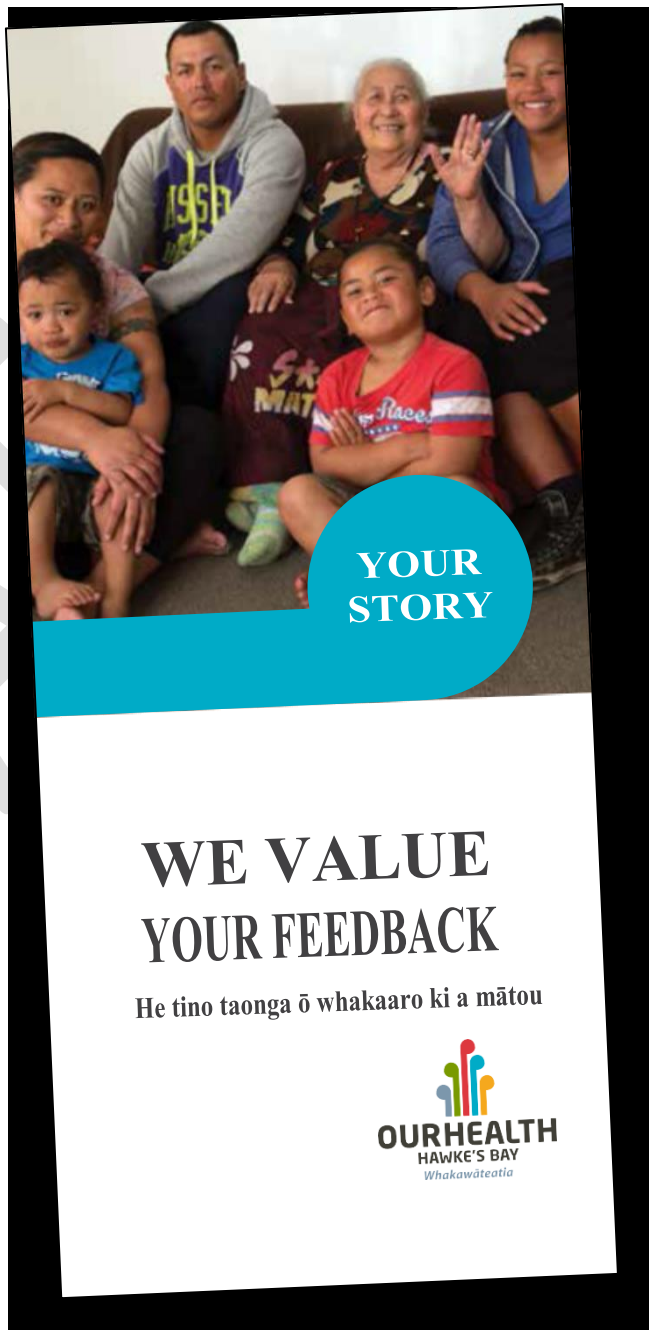
You can give feedback in a number of ways:

- email us: feedback@hbdhb.govt.nz
- complete an online feedback form: www.ourhealthhb.nz
- phone us: 0800 000 443
- complete a freepost feedback form which may be given to you when you visit, or which can be found in many areas across the DHB's sites.

You may receive a phone call or receive a request to complete a survey based on your experience. It is your choice to take part or not.

Then what happens?

Your feedback will be passed to the manager of the area you are providing feedback on. We will acknowledge your feedback, and if your feedback is a complaint an investigation will take place. We will let you know what we have found out and this may include what we have done to make things better, or what we are planning on doing to ensure things improve.



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OUR HEALTH
HAWKE'S BAY

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Māori Health Plan Q4 (Apr-Jun 2016)** **Non-Financial Exceptions Report**
	For the attention of: **Māori Relationship Board, HB Clinical Council, HB Health Consumer Council and the HBDHB Board**
Document Owners:	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:	Executive Management Team
Month:	August 2016
Consideration:	For Monitoring

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RECOMMENDATION

MRB, Clinical and Consumer Council and HBDHB Board:

Note the contents of this report.

OVERVIEW

The purpose of this paper is to provide MRB, HB Clinical Council, HB Consumer Council and the HBDHB Board with exception report for Quarter 4 on the implementation of Annual Māori Health plan. A quick reference summary dashboard will be supplied prior to the meeting and shows our position as at the end of Quarter 4 for all indicators. The dashboard uses traffic light methodology with detailed information and symbols for all indictors. For example, in a situation where the performance of the indicator for the current quarter is higher than the previous quarter this symbol '▲' will be used to show an upward trend while an opposite symbol '▼' will be used to shown a downward trend. In cases where the variance to the annual target for the indicator is greater than 0.5% this symbol **'U'** *(indicated on the dashboard in red)* will be used to indicate unfavourable trend and 'F' for favourable trend *(indicated on the dashboard in green colour)* toward the annual target *(see the table below).*

KEY FOR DETAILED REPORT AND DASHBOARD

Baseline	Latest available data for planning purpose
Target 2015/16	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

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2015-2016 ANNUAL MĀORI HEALTH PLAN PERFORMANCE HIGHLIGHTS

Achievements

1. Cervical Screening for 25-69 year old Māori women (73.2%) for this quarter is slightly lower than the 74.4% in the first quarter but still puts HBDHB on the top list on Cervical Screening performance in New Zealand. This performance also narrows the disparity gap between Māori and European by 4%. The performance is attributed to the HBDHB integrated service approach where all service providers (i.e. HBDHB Population Health, Health HB PHO (HHB PHO), general practices and Hauora Providers etc.) across the screening pathways are joined up and working together towards a common goal of attaining the national target for Māori women and addressing inequity. Furthermore, Māori women have access to free cervical smear tests and support services across the district.

   In an effort to further improve our services there has, over the years been a strong focus on continued service quality improvement e.g. improving systems and processes within primary care, improving National Cervical Screening Programme (NSCP) participant data quality on patient management systems (PMS) and the NCSP Register, compliance with NCSP policies and standards, offering client incentives, and improving access via clinical and outreach settings and support services.

2. Immunisation rates for 8 month old Māori have remained above or very near the target of ≥ 95% throughout the year with a 95.6% result in Quarter 1 and a 94.6% result in Quarter 4. Similarly, immunised rates for 2 year old Māori remained above or very near the annual target of ≥ 95% with 95.9% in Quarter 1 and 94.7% in Quarter 4. Immunisation results for 4 year olds remains above the expected target of ≥ 90% with 94% immunised in Quarter 4.

   This success is attributable to a number of factors. These range from having a champion in the executive management team; a committed, appropriate, experienced workforce; an action plan focused on bridging any gaps in service delivery; a very experienced NIR (National Immunisation Register) team; good collaboration across all immunisation providers and partners; a budget with a little leeway to try new initiatives; a service that can easily be delivered within the home; and a very effective outreach service team.

3. Ambulatory Sensitive Hospitalisation (ASH) rates overall declined from 82% in Quarter 1 to 79% in Quarter 4 following concerted work in the area of skin management through Public Holiday in early Childhood centres, Kōhanga reo and Primary Schools.. This Quarter has seen a continued focus on strengthening systems and relationships across Oral health services and providers. Resources to support self-care and management of skin have been translated in Te reo and English to support this work. To reduce DNA's at Community oral health clinics WCTO provider relationships with whānau will be strengthened coupled with funding to Tamariki ora and Plunket for advocacy and facilitation role in initiating oral health appointments and attendance. A joint analysis and review of currently contracted respiratory support services is being carried out to extend the Primary Care respiratory Pilot services to cover the 0-4 year age group.

4. Quick Access to Angiograms for Māori exceeded the expected target of ≥70% with 84.6% in Quarter 4 up from 38.5% in Quarter 1. This success is attributed to Locum Cardiologist who completed full Friday angiogram sessions for the time he was here.

Areas of progress

1. Staff completed cultural training is making good progress from 64% in Quarter 1 to 77.5% in Quarter 4. Medical staff had the largest increase of all occupational groupings from 14% in Quarter 1 to 39.6% in Quarter 4 (page 13). This progress is attributed to the growing push from EMT coupled with access to the electronic training reports by Managers and Heads of Service which enable them to keep track of their staff training.

2. Māori Breastfeeding rates at 6 weeks are 67% a 9% increase in comparison to the previous reporting period and Breastfeeding rates at 6 months shows a 2% increase.

Areas of focus

The above achievements notwithstanding, we are challenged to put more efforts in the following areas to gain traction towards targets:

1. Access to Care – Increase Patients Enrolment to the HHB PHO

The number of Māori enrolled in the HHB PHO decreased slightly by 0.3% from 95.9% in Quarter 1 to 95.6% in Quarter 4 and remains below the expected performance target of 97% (page 5). These trends are attributed to the limited availability and capacity of GPs to enrol new patients. Only 5/28 practices are enrolling new patients; 14/28 practices are enrolling new patients with conditions i.e. family member is already a patient, moved into the district from another district etc.; and 9/28 practices are not enrolling new patients at all. Furthermore, some patients are using Emergency Department (ED) for General Practice (GP) services instead of enrolling with a general practice; limited access to affordable general practice services for low income patients; and some patients moving outside of HB.

HHB PHO has been working with GPs to consider models of care that include provision of services to walk in appointments. HHB PHO has also been looking into availability of High Need Enrolment Programme via NGOs, ED, DHB and GPs with initial GP and Nurse Consultations at no cost to patients. HHB PHO feels that efforts to address health inequalities may include: support to practices to recruit general practice clinicians and staff; continue to offer the High Need Enrolment Programme; and supporting general practice to consider and implement walk in appointments.

2. Child Health - Breastfeeding

Breastfeeding rates at 3 months show a decrease of 7% from 46% in the previous reporting period to 39% this quarter. Multiple pieces of work are underway across Well Child and LMC/Midwife workforce to improve these rates. These include promotion of early engagement with services; consistent appropriate breastfeeding messages across sectors and the community; and the development of a responsive breastfeeding support service for Māori (a joint approach between the DHB Māori and Women, Child and Youth portfolios).

5. Oral Health

Pre-school oral health enrolments for Māori under 5 years of age increased from 65.3% in 2014 to 74.1% in 2015 (page 11). There is still some work to do to reach the expected target of ≥90%. We plan to update the data at the end of the calendar year.

8. Cancer Screening - Breast Screening

There has been a slight decrease from 68.4% in Quarter 1 to 67.9% in Quarter 4 and remains just below the expected target of ≥70% (page 9). This can be attributed to a number of factors including a slight increase of 25 women on the Breast Screening Aotearoa (BSA) Māori population which forms the denominator for the coverage data; increased seasonal fluctuations; and access to appointments due to holidays and availability of seasonal work. Efforts will be made on identify unscreened and under- screened women along with other approaches tailored to improve access and encourage women to participate in the BSA programme.

9. Smokefree

Māori women who are smoke free at 2 weeks post natal increased from 62% in Quarter 1 to 65.6% in Quarter 4. However, overall performance remains well below the expected target of ≥ 86% (page 7). In an effort to up these rates, HBDHB is collaborating with Choices Heretaunga in the implementation of Increasing Smoke-free Pregnancy Programme (ISPP) which is currently being used by HB midwives and LMCs to refer pregnant mothers who smoke. Acknowledging the

importance of whānau support for mothers to be smoke-free the programme has expanded its support to whānau members to live with pregnant and post-partum women.

The report also noted that advice to quit smoking for Māori pregnant women at hospital setting declined from 87.7% in Quarter 1 to 86.25 in Quarter 4 and remains below expected target of ≥90%. This is attributed to the high smoking rates among pregnant Māori women ages 20 to 29 years. We also know that most of these women either come from high deprivation areas or transient whānau so our efforts are focused on encouraging HB midwives and LMCs to refer pregnant women who smoke to ISPP, up to six months post-partum.

10. Mental Health

Māori under Mental Health Act Compulsory Treatment Orders has risen from 189.3 per 100,000 population in Quarter 1 to 201.6 per 100,000 population in Quarter 4. There remains a significant inequality between Māori and non-Māori of 104.9 per 100,000 population up from 97.7 per 100,000 population in Quarter 1 (page 12). . An audit has been carried out to better understand the issues around these rates and develop better strategies to lower them.

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13. Workforce Development

Māori Workforce only grew 0.2% from 12.3% in Quarter 1 to 12.5% in Quarter 4 and did not reach the 2015-2016 expected target of 14.3% (page 13). The targeted areas for increasing the retention and recruitment of Māori of Nursing and Allied Health increased only marginally over the year. Nursing went from 10.1% to 10.8% and Allied Health from 13.1% to 13.2%. Since these are our two biggest workforce the impact of this trend is reflected across the overall performance figure for the period.

Following a significant rethink of our strategy to increase Māori staff representation we have identified actions that will make this happen. These include increasing the number of Māori applying for positions; number shortlisted and recruited for our roles and actions for better retention of our Māori staff.

An overarching Māori staff recruitment campaign is being developed with targeted actions by workforce grouping also. Focus groups discussions of current Māori staff are to be held to better understand what can be done to improve the work environment for Māori staff.

QUARTERLY PERFORMANCE AND PROGRESS UPDATE

1. Access to Care

Outcome: Increase enrolment in the HHB PHO

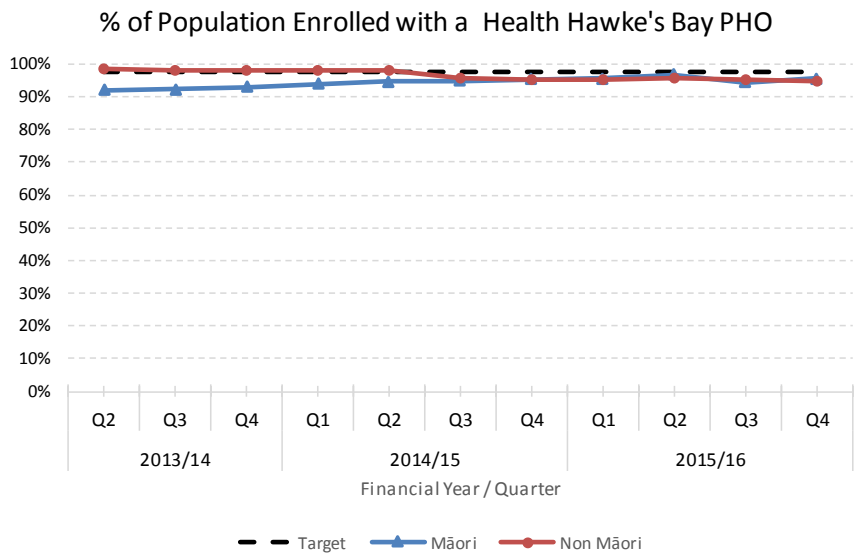
Key Performance Measures	Baseline [1]	Previous result[2]	Actual to Date[3]	Target 15-16	Trend direction
Māori	94.7%	94.5% (U)	95.6% (U)	≥97%	▲
Pacific	99.3%	86.5% (U)	88.4% (U)	≥97%	▲
Other	98.2%	96.0% (U)	96.5% (F)	≥97%	▲
Total	97.3%	95.2% (U)	95.9% (U)	≥97%	▲

Comment:

Limited availability and capacity of general practice to enrol new patients

- 5/28 practices are enrolling new patients
- 14/28 practices are enrolling new patients with conditions i.e. family member is already a patient, moved into the district from another district
- 9/28 practices are not enrolling new patients
  - Patients utilising ED for General Practice services instead of enrolling with a general practice
  - Limited access to affordable general practice services for low income patients
  - Patients moving outside of HB
  - Plan to work with General Practices to consider and review models of care

Time series



1 October 2014 to December 2014

2 October to December 2015

3 January to March 2016

2. Child Health						
Outcome: Breastfeeding of pepi improved						
Key Performance Measures	Baseline[4]	Previous result	Actual to Date	Target 15-16	Trend direction	
Infants are exclusively or fully breastfed at 6 weeks						
Māori	-	58% (U)	67% (U) [5]	≥75%	▲	**Comments:**
Pacific	-	74% (U)	82% (F)	≥75%	▲	With the combined Plunket and WCTO Breastfeeding data now being collected by the MOH more accurate breastfeeding data will be available, the new KPI card will over time show this new combined data as a trend line giving an improved picture of Breastfeeding performance for HB.
Total	-	68% (U)	73% (U)	≥75%	▲	
Infants are exclusively or fully breastfed at 3 months of age						The most recent Quarterly HB Breastfeeding data shows a 5% increase in Māori Breastfeeding rates at 6 weeks, with 3 month data showing a decline of 6% and 6 months remaining the same.
Māori	-	46% (U)	39% (U)[6]	≥60%	▼	
Pacific	-	62% (F)	63% (F)	≥60%	▲	
Total	-	54% (U)	53% (U)	≥60%	▼	Work continues on the development of a model of service provision that effectively supports Māori particularly, to sustain Breastfeeding, this is a joint approach between Māori Health and Women, Child and Youth (further details are included below)
Infants are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)						
Māori	-	46% (U)	48% (U) [7]	≥65%	▲	
Pacific	-	57% (U)	66% (F)	≥65%	▲	
Total	-	56% (U)	58.% (U)	≥65%	▼	

4 No baseline data available

5 6 months to June 2015

6 6 months to December 2015

7 6 months to December 2015

5. Oral Health

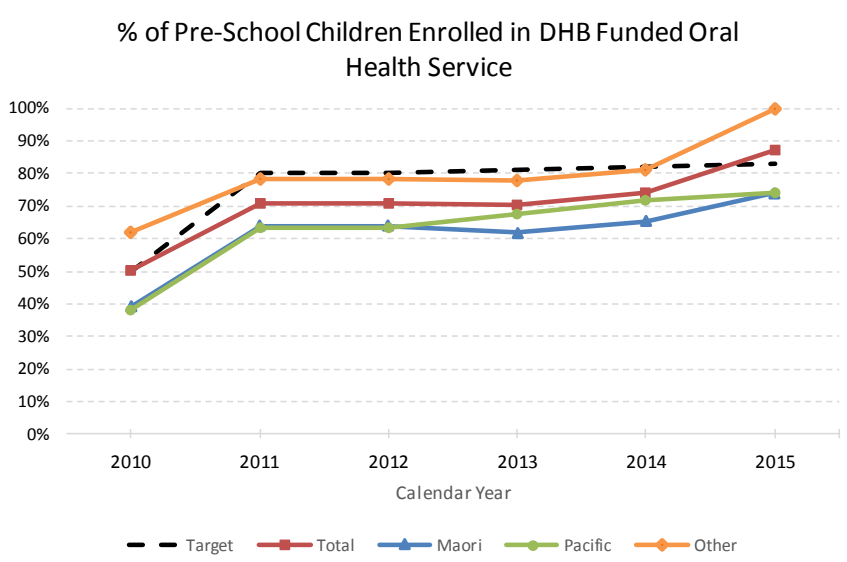
Outcome: More pre-school enrolments in the community oral health service (COHS) - 90% children under 5 years of age enrolled in community oral health services

Key Performance Measures	Baseline [8]	Previous result[9]	Actual to Date[10]	Target 15-16	Trend direction
Māori:	65.3%	74.1% (U)	-	≥90%	—
Pacific:	71.7%	74.2% (U)	-	≥90%	—
Other:	81.3%	99.8% (F)	-	≥90%	—
Total	73.9%	87.1% (U)	-	≥90%	—

Comments

This is an annual indicator which is only reported in Q3 every financial year. Health Intelligence discussing with services about the capability of reporting more frequently.

Time series



8 2013 calendar year

9 2014 calendar year

10

8. Cancer Screening

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

Key Performance Measures	Baseline[11]	Previous result[12]	Actual to Date[13]	Target 15-16	Trend direction
Māori	73.8%	73.2% (U)	73.2% (U)	≥80%	—
Pacific	72.8%	70.4% (U)	71.4% (U)	≥80%	▲
Other	78.0%	77.2% (U)	77.8% (U)	≥80%	▲
Total	76.9%	76.1% (U)	76.6% (U)	≥80%	▲

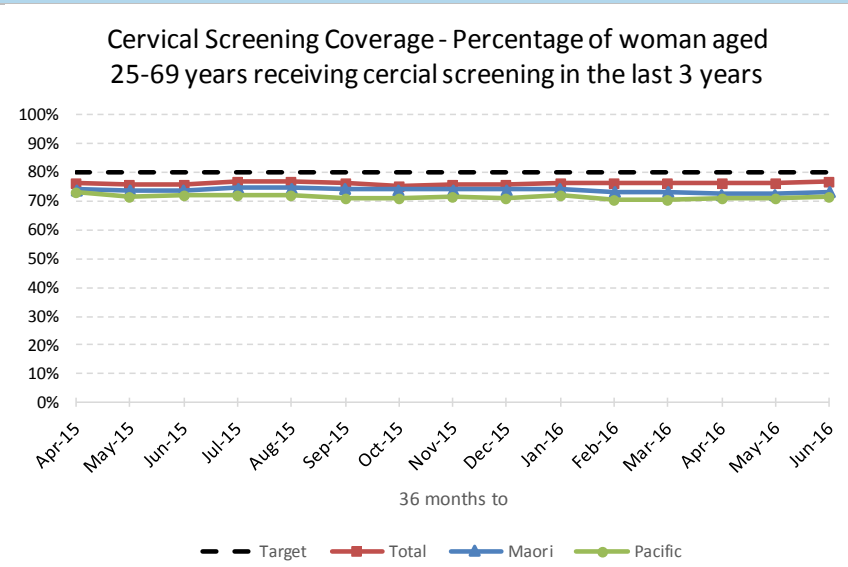
Comments:

Continuing to work with GP practices to improve participation of NCSP priority group women in screening e.g. Best Practice in Primary Care project and data-matching. In addition, contacting Māori and Pacific women who have never had a cervical smear or have not had one for over five years by phone or home visits, and offering outreach smears. The uptake has been positive.

Continuing to ensure accuracy of participant ethnicity data held on National Cervical Screening Programme Register.

Recent population projections released by the National Screening Unit show that in the next five years (2016-2021) Hawke's Bay's NCSP eligible Māori and Pacific populations will increase by 7% and the Asian population will increase by 16%. A challenge to the sector.

Time series



Source: National Screening Unit

11 3 years to December 2014

12 3 years to December 2015

13 3 years to March 2016

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

Key Performance Measures	Baseline [14]	Previous result[15]	Actual to Date[16]	Target 15-16	Trend direction
Māori	67.2%	68.4% (U)	67.9% (U)	≥70%	▼
Pacific	79.0%	66.5% (U)	67.2% (U)	≥70%	▲
Other	77.2%	79% (F)	74.5% (F)	≥70%	▼
Total	75.8%	74.7% (F)	73.4% (F)	≥70%	▼

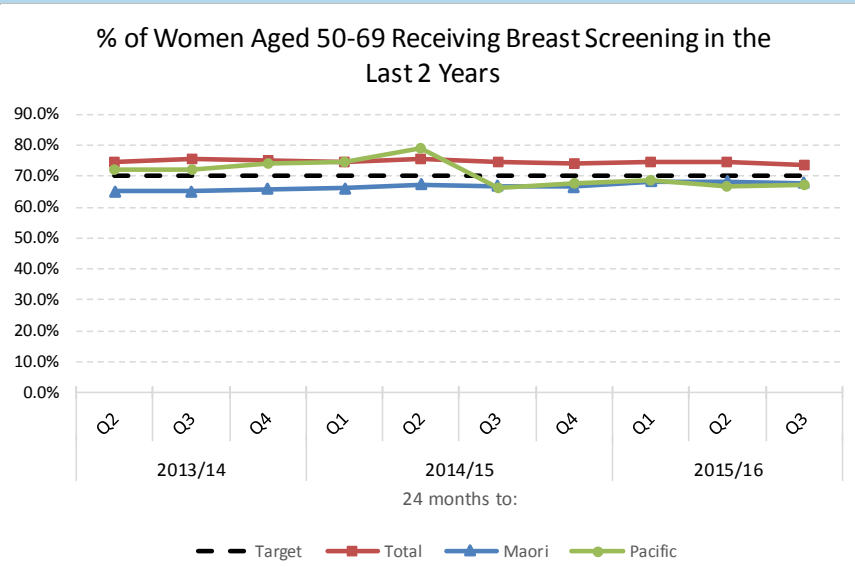
Comments:

Preparation has begun for the next mobile screening unit visit at the Cook Island Community Centre at Flaxmere on 13-27 September. BreastScreen Coast to Coast is working with Hastings-based GP practices to datamatch Flaxmere-resident clients for the upcoming visit. Invitation and recall letters will be sent out to priority group women offering an appointment for a screening mammogram. The DHB Population Screening, HHB PHO and Māori providers are working together to promote the mobile visit and offering support services to priority women.

HHB PHO and TRG Imaging facilitated an education session for GPs focused on pathology, diagnostics and treatment for breast disease.

Recent population projections released by the National Screening Unit show that in the next four years (2016-2020) Hawke's Bay's BSA eligible Māori population will increase by 8% and the Pacific population by 13%. This will be a challenge to the sector to achieve and maintain targets.

Time series



Source: National Screening Unit

14 24 months to December 2014

15 24 months to December 2015

16 24 months to March 2016

9. Smokefree							
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[17]	Previous result[18]	Actual to Date[19]	Target 15-16	Trend direction		
Māori	100.0%	95.2% (F)	86.2% (U)	≥90%	▼	**Comments**	
Total	98.1%	96.5% (F)	88.6% (U)	≥90%	▼	HBDHB in collaboration with Choices Heretaunga have successfully implemented the Increasing Smokefree Pregnancy Programme (ISPP). HB midwives and LMCs refer pregnant mama who smoke, to this programme. On post-partum up to six months of age, woman who are still smoking can be referred to ISPP. ISPP supports pregnant and post-partum women to be smokefree at 1, 4, 8 and 12 weeks with a supply of nappies, if they have a validated CO monitor reading. Since 1 July, the programme has expanded to support whānau members who live with pregnant mama and post-partum women and pepi to be smokefree at 1, 4, 8, 12 weeks with grocery vouchers, if they too have a validated CO monitor reading.	

13

17 October to December 2014

18 October to December 2015

19 January to March 2016

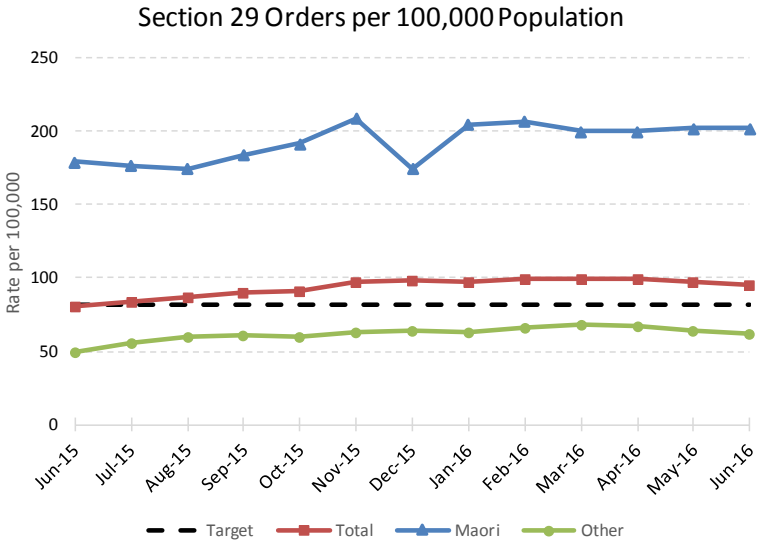
10. Mental Health

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

Key Performance Measures	Baseline [20]	Previous result[21]	Actual to Date[22]	Target 15-16	Trend direction
Māori (per 100,000)	-	204.0 (U)	201.6 (U)	≤81.5	▲
Other (per 100,000)	-	98.9 (U)	96.7 (U)	≤81.5	▲
Total (per 100,000)	-	99.0 (U)	97.3 (U)	≤81.5	▲

Comments

We are still undertaking audits to understand the reason for the rate. First audit completed and further audit is now being undertaken.



20

21 *January to March 2016*

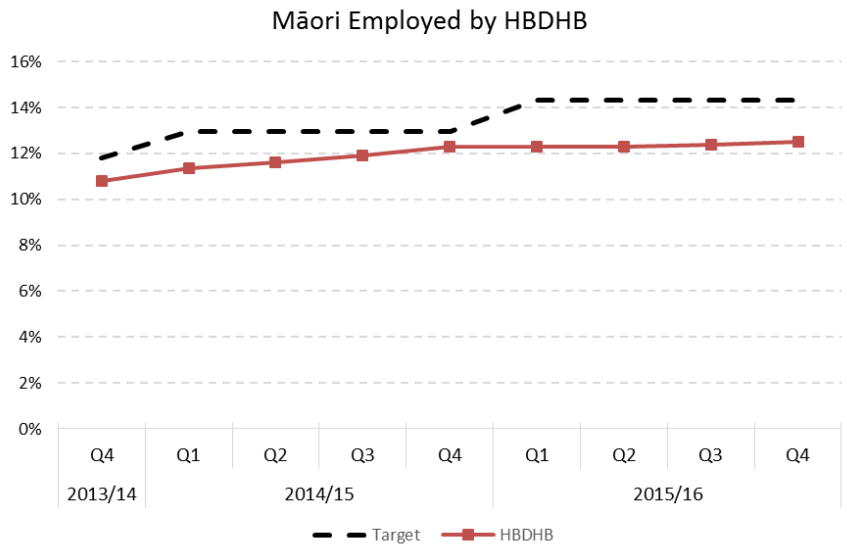
22 *April to June 2016*

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[23]	Previous result[24]	Actual to Date[25]	Target 15-16	Trend Direction
Medical	2.7%	3.2%	3.2%	-	—
Management & Administration	15.7%	16.1%	16.0%	-	▼
Nursing	10.1%	10.7%	10.8%	-	▲
Allied Health	11.9%	12.4%	13.2%	-	▲
Support Staff	26.7%	30.2%	29.3%	-	▼
HBDHB	11.6%	12.4% (U)	12.5% (U)	≥14.3%	▲

Time series



Comments:

The targeted areas for increasing the retention and recruitment of Māori of Nursing and Allied Health increased only marginally over the year. Nursing went from 10.1% to 10.8% and Allied Health from 13.1% to 13.2%. Because these are our two biggest workforce the impact is going to flow through to the overall figure.

As a result of a significant rethink or our strategy for increasing Māori staff representation we have identified actions to increase the number of Māori applying, being shortlisted and recruited for our roles and actions for better retaining our Māori staff.

An overarching Māori staff recruitment campaign is being developed and targeted actions by workforce grouping also. Focus groups of current Māori staff are to be held to better understand what can be done to improve the work environment for Māori staff.

13

23 December 2014

24 March 2016

25 June 2016

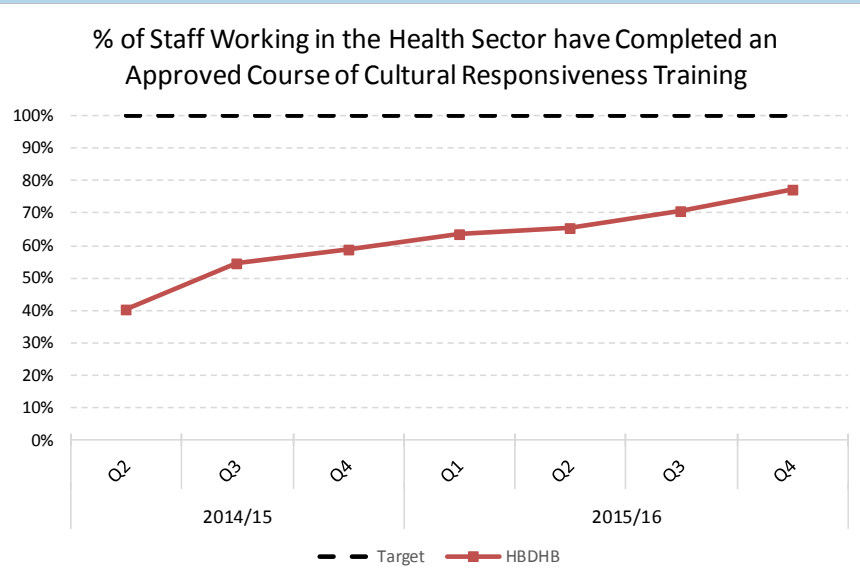
Outcome: All staff working in the health sector have completed an approved course of cultural responsiveness training.

Key Performance Measures	Baseline [26]	Previous result[27]	Actual to Date[28]	Target 15-16	Trend direction
Medical	9.0%	32.4%	39.6%	-	▲
Management & Administration	43.0%	82.1%	85.6%	-	▲
Nursing	41.0%	74.7%	81.4%	-	▲
Allied Health	59.0%	80.4%	85.2%	-	▲
Support Staff	12.0%	38.6%	60.1%	-	▲
HBDHB	40.0%	70.6%	77.5% (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.
- The current Engaging Effectively with Māori (EEM) training sessions run to the beginning of September. There is a mandatory training report that all managers have access to and this now enables managers to follow-up on staff who have not attended EEM. This training has been rolled across the HHB PHO and NGOs.

Time series



26 December 2014

27 March 2016

28 June 2016

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Māori Health Plan Q4 (Apr-Jun 2016) DASHBOARD**
	For the attention of: **Māori Relationship Board (MRB), HB Clinical Council and HB Consumer Council and HBDHB Board**
Document Owners:	Tim Evans, General Manager Planning, Informatics and Finance Tracee Te Huia, General Manager Māori Health
Document Author(s):	Patrick LeGeyt, Programme Manager Māori Health Justin Nguma, Senior Health & Social Policy Advisor Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Executive Management Team (EMT)
Month:	August 2016
Consideration:	For Monitoring

13.1

RECOMMENDATION

That MRB, Clinical and Consumer Council and HBDHB Board:

Note the contents of this report.

CONTENTS OF THE REPORT

This is a report on:

- The Māori health indicators agreed as part of the development of 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 June 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

2015-2016 ANNUAL MAORI HEALTH PLAN 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 have remained above or very near the target of ≥ 95% throughout 2015-2016 with a 95.6% result in Quarter 1 and a 94.6% result in Quarter 4. Similarly, immunised rates for Māori 2-year olds remained above or very near the target of ≥ 95% throughout 2015-2016 with a 95.9% result in Quarter 1 and a 94.7% result in Quarter 4. Immunisation results for 4-year olds remains above the expected target of ≥ 90% with 94% immunised in Quarter 4.
3. ASH Rates overall have declined from 82% in Quarter 1 to 79% in Quarter 4 and present a significant narrowing of disparity gap for 0-4 year old group between Māori and Other. Similarly, ASH Rates for 45-64 year old group have declined from 193% in Quarter 1 to 170% in Quarter 4 and present a significant narrowing of disparity gap between Māori and Other.
4. Quick Access to Angiograms for Māori exceeded the expected target of ≥70% with 84.6% in Quarter 4 up from 38.5% in Quarter 1.

Areas of progress

1. Staff Completed Cultural Training is making good progress from 64% in Quarter 1 to 77.5% in Quarter 4. Medical staff had the largest increase of all occupational groupings from 14% in Quarter 1 to 39.6% in Quarter 4.

Challenges

1. Breastfeeding rates at 3 months show a decrease of 7% from 46% in the previous reporting period to 39% this quarter. All breastfeeding rates at 6 weeks (67%), 3 months (39%) and at 6 months (48%) for Maori fell below the target rates of 75%, 60% and 65% for the period.
2. Māori under Mental Health Act Compulsory Treatment Orders has risen 189.3 per 100,000 population in Quarter 1 to 201.6 per 100,000 population. There remains a significant inequality between Māori and non-Māori of 104.9 per 100,000 population up from 97.7 per 100,000 population in Quarter 1.
3. Māori women who are smokefree at 2-weeks post natal increased by 3.6% from 62% in Quarter 1 to 65.6% in Quarter 4. However, overall performance remains well below the expected performance target of ≥ 86%.
4. Advice to Māori smokers in hospital who are pregnant to quit declined by 7.5% from 87.7% in Quarter 1 to 86.25 in Quarter 4 and remains below expected target of ≥90%.
5. Breast Screening has decreased slightly from 68.4% in Quarter 1 to 67.9% in Quarter 4 and remains just below the expected target of ≥70%.
6. Māori Workforce only grew 0.2% from 12.3% in Quarter 1 to 12.5% in Quarter 4 and did not reach the 2015-2016 expected target of 14.3%.
7. The number of Māori enrolled in the Health Hawke's Bay PHO decreased slightly by 0.3% from 95.9% in Quarter 1 to 95.6% in Quarter 4 and remains below the expected performance target of 97%.
8. Pre-school Oral Health Enrolments for Māori under 5-years of age increased from 65.3% in 2014 to 74.1% in 2015. There is still some work to do to reach the expected target of ≥90%.

Please note:

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

ANNUAL MĀORI HEALTH PLAN, QUARTER 4 APRIL - JUNE 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%	94.5%	95.6%	96.5%	≥ 97.0%	-595		↑
0-4 years (6m)	82.0%	82.0%	79.0%	70.0%	≤ -			↓
45-64 years (6m)	100.0%	172.0%	170.0%	94.0%	≤ -			↓

Child Health
Breastfeeding rates (3m)

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Total	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
QIF Data								
At 6 Weeks	68.0%	58.0%	67.0%	73.0%	≥ 75%	-		↑
At 3 months	54.0%	46.0%	39.0%	53.0%	≥ 60%	-		↑
At 6 months	59.0%	46.0%	48.0%	58.0%	≥ 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%	97.7%	94.6%	95.4%	≥ 95%	-1		↑
Immunisation (2 years)	95.0%	94.8%	95.1%	94.9%	≥ 95%	0		↑
Immunisation (4 years)	-	93.2%	94.0%	92.1%	≥ 90%	11		↑
65+ Influenza (3m)	68.0%	56.5%	-	-	≥ 75%	-		

Rheumatic Fever

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Total	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Hospitalisation rate (6m)	4.3	2.48	7.33	1.87	≤ 2.0	-2		↓

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%	74.1%	-	-	≥ 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%	-	-	≥ 90%			↑
Quick access to angiograms	66.7%	81.8%	84.6%	77.6%	≥ 70%	1.9		↑
Completion of registry data	12.5%	100.0%	90.0%	96.6%	≥ 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%	73.2%	73.2%	77.8%	≥ 80%	-614		↑
Breast screening (50-69 yrs)	67.2%	68.4%	67.9%	74.5%	≥ 70%	-74		↑

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%	53.0%	65.6%	79.9%	≥ 86.0%	-		↑
Pregnant smokers Brief Advice to Quit	100.0%	86.2%	81.1%	89.0%	≥ 90.0%	-5		↑

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)	-	212.7	201.6	96.7	≤ 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%	3.2%	3.2%	-	≥ -			
Management & Administration	15.7%	16.1%	16.0%	-	≥ -			
Nursing	10.1%	10.7%	10.8%	-	≥ -			
Allied Health	11.9%	12.4%	13.2%	-	≥ -			
Support Staff	26.7%	30.2%	29.3%	-	≥ -			
Māori staff - HBDHB	11.6%	12.4%	12.5%	-	≥ 14.3%	-54		↑

Cultural Responsiveness

Indicator	Baseline	Prior period result	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	9.0%	32.0%	39.6%	-	≥ -		
Management & Administration	43%	82.1%	85.6%	-	≥ -		
Nursing	41%	74.7%	81.4%	-	≥ -		
Allied Health	59%	80.4%	85.2%	-	≥ -		
Support Staff	12%	38.6%	60.1%	-	≥ -		
HBDHB	40%	70.6%	77.5%	-	≥ 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)	75%	67.0%	61%	69%	≥ 75%	-62.75		↑
DNA's	16.2%	18.2%	15.20%	4.70%	≤ 7.50%	-98		↓
Oral Health (% Caries Free at 5yrs)	38.7%	36.0%	-	-	≥ 65%			↑
Bariatric Surgery	7.00	-	3.0	5.0	-	-		-

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora / Culturally Competent Workforce**
	For the attention of: **Maori Relationship Board, HB Clinical Council, HB Health Consumer Council and HBDHB Board**
Document Owner: Document Author(s):	Chris McKenna, Chief Nursing Officer Andrew Phillips, Director of Allied Health John McKeefry, General Manager, Human Resources
Reviewed by:	Executive Management Team
Month:	August 2016
Consideration:	For Information

14

RECOMMENDATION:

That MRB, Clinical and Consumer Council and HBDHB Board

Note the contents of this report.

OVERVIEW

The national General Managers Māori (Tumu Whakarae) raised concerns about the slow pace of progress on some of the Māori health indicators. In September 2013, the executive management team (EMT) considered a paper from Tumu Whakarae about an approach to accelerating Māori health plan indicator performance. As a result, individual EMT members agreed to provide a championship role for the Māori Health Plan across areas of key concern. Part of that role is to provide the Board with a report each month from one of the champions. This report is from John McKeefry, Chris McKenna and Andrew Phillips, Champions for the Culturally Competent Workforce Indicators.

THIS REPORT COVERS

Priority	Indicator	Champion	Reporting Month
Culturally Competent Workforce	▪ Increase % of HBDHB staff who are Māori ▪ 100% of HBDHB staff have completed Treaty on line training ▪ 100% of HBDHB staff have completed "Effective Engagement with Māori" (EEWM) training ▪ 100% of HBDHB staff have KPI's to accelerate the improvement of Māori health	John McKeefry, Chris McKenna, and Andrew Phillips	July 2016

MRB at its June 2016 meeting identified a number of actions for consideration by EMT as below. These were discussed with MRB at its meeting of 13 August 2016 and have been considered as part of the development of this report.

a) Raise the target to Increase Māori Staff from 10% year-on-year to 25% over a five year period.
b) Present the strategy to Increase Māori staff to MRB before going to the Finance, Risk and Audit Committee (FRAC).
c) Review the current HBDHB hiring protocols and processes
d) Review the conviction policy for the HBDHB and whether a conviction that is old, is relevant now
e) Broaden the scope to the target to all disciplines, not just medical, nursing and allied health
f) Shift the responsibility of achieving the target to Hiring Managers setting KPIs for monitoring
g) Senior Management monitor the progress of the target and provide monthly updates identifying why the target was achieved, or not achieved.
h) Train Hiring Managers efficiently and effectively use the Managers Toolkit
i) Māori Health Service involved in the recruitment process form the development of position profiles, shortlisting and interview stages with a member of the team becoming a compulsory member of all hiring/selection panels.

At the July 2016 MRB meeting, MRB also identified further actions for consideration as below.

- Would like to see the midwifery workforce as part of the strategy as Māori midwifery representation is less than 2% in DHBs. Action: The General Manager, Human Resources will look into this with the Chief Nursing Officer
- MRB raised almost two years ago the issues and the need for Māori nursing students to receive formal coaching, pastoral care and Tuakana/Teina support. While EIT are still working on these student services and the DHB are partnering with EIT to develop these services, MRB were somewhat disappointed that these issues have still not been addressed
- There seems to be a gap in the Hiring/ Selection process. Recruitment panels needs strengthening to ensure they understand the need to employ more Māori and why
- Introduction Relationship Based Management Skills training is being led by Andrew Phillips (Director Allied Health HBDHB). Suggest utilising a Māori to support the training to add more value because of their first-hand knowledge and experience
- There is a lot of comprehensive work around having Māori review recruitment processes to ensure Māori priorities and realities are implemented. We should be identifying what is ***not*** attractive about the DHB rather than trying to make the DHB look attractive. The recruitment process needs to be driven by Māori. Structural issues will impinge on Māori recruitment. The barriers of the recruitment process need to be identified through forensic audits.

MĀORI HEALTH PLAN INDICATOR: Culturally Competent Workforce

% of HBDHB Staff who are Māori

Current Performance

At 30 June 2015 our Māori staff representation figure increased to 12.3% of our workforce from 8.7% in June 2012. This is off the back of increases from June 2012 (8.7%) to June 2013 (9.9%) to June 2014 (10.8%).

Unfortunately our performance has plateaued with our performance at 30 June 2016 sitting at 12.5% against a target of 14.3%. The position for all workforce groupings at 30 June 2016 is set out in Table A below. This shows for all workforce groupings the percentage of Māori staff has increased. Pleasingly there have been significant percentage increases of Māori staff representation from 2012 to 2016 in our two biggest workforces – Nursing 7.0% to 10.8% and Allied Health, 9.4% to 13.2%.
Note: Nursing workforce data is unable to be broken down into Midwifery workforce data.

Table A

Report as at 30 June last 5 years

	30-Jun-16					30-Jun-15					30-Jun-14				
	Staff	Target 14.3%	Actual	Actual %	Gap	Staff	Target 12.97%	Actual	Actual %	Gap	Staff	Target 11.78%	Actual	Actual %	Gap
Medical - SMO	142	20	2	1.4%	18	140	18	3	2.1%	15	127	15	2	1.6%	13
Medical - RMO	138	20	7	5.1%	13	119	15	4	3.4%	11	123	14	2	1.6%	12
Nursing	1,504	215	162	10.8%	53	1,453	188	147	10.1%	41	1,386	163	129	9.3%	34
Allied Health	553	79	73	13.2%	6	528	68	69	13.1%	-1	525	62	55	10.5%	7
Support	188	27	55	29.3%	-28	181	23	50	27.6%	-27	174	20	49	28.2%	-29
Management & Admin	457	65	73	16.0%	-8	440	57	78	17.7%	-21	426	50	62	14.6%	-12
Total	**2,982**	**426**	**372**	**12.5%**	**54**	**2,861**	**371**	**351**	**12.3%**	**20**	**2,761**	**325**	**299**	**10.8%**	**26**

	30-Jun-13					30-Jun-12				
	Staff	Target 10.71%	Actual	Actual %	Gap	Staff	Target 9.73%	Actual	Actual %	Gap
Medical - SMO	132	14	1	0.8%	13	128	12	1	0.8%	11
Medical - RMO	122	13	4	3.3%	9	113	11	3	2.7%	8
Nursing	1,393	149	113	8.1%	36	1,313	128	92	7.0%	36
Allied Health	527	56	53	10.1%	3	521	51	49	9.4%	2
Support	182	19	49	26.9%	-30	186	18	46	24.7%	-28
Management & Admin	420	45	56	13.3%	-11	435	42	43	9.9%	-1
Total	**2,776**	**297**	**276**	**9.9%**	**21**	**2,696**	**262**	**234**	**8.7%**	**28**

When we look at Health Services where the majority of our staff work as can be seen in Table B below, the largest gaps are in Acute and Medical and Surgical Services.

Table B

Gap by Service	Nursing	Allied Health
Acute & Medical Services	30	7
Director of Nursing (Hospital)		
Surgical Services	20	3
Facilities & Operational Support	4	1
Laboratory		8
Older Persons & Mental Health	(5)	6
Oral Rural & Community		(6)
Woman Children & Youth Service	6	1
Subtotal Health Services	**53**	**10**

Māori candidates – application shortlisting, interview appointment

Proposed Target

It is proposed by MRB that we increase the target to 25% by 2021 to mirror the population demographic for Hawke's Bay. This would see the percentage increases and gap for the next five years as below in Table C.

A 10% increase for each year would see gaps for each year through to 2021 also set out in Table C.

Table C

Increase year on year 11.82%							Increase year on year 10.00%						
Target	% Target	Emps	Target Maori	Actual	% Maori	Gap	Target	% Target	Emps	Target Maori	Actual	% Maori	Gap
2015/16	14.30%	2,970	425	366	12.32%	59	2015/16	14.30%	2,970	425	366	12.32%	59
2016/17	15.99%	2,970	475	366	12.32%	109	2016/17	15.73%	2,970	467	366	12.32%	101
2017/18	17.88%	2,970	531	366	12.32%	165	2017/18	17.30%	2,970	514	366	12.32%	148
2018/19	19.99%	2,970	594	366	12.32%	228	2018/19	19.03%	2,970	565	366	12.32%	199
2019/20	22.36%	2,970	664	366	12.32%	298	2019/20	20.94%	2,970	622	366	12.32%	256
2020/21	25.00%	2,970	742	366	12.32%	376	2020/21	23.03%	2,970	684	366	12.32%	318

This suggests that increasing the target to 25% by 30 June 2021 will be too high a target because of the sheer number of staff to be recruited and even increasing the target year on year by 10% each year will make the target harder and harder to achieve each year. A target for 2016/17 will be discussed at the FRAC meeting.

Table D

Table D below shows by workforce grouping the recruitment of Māori into the HBDHB, the turnover of Māori leaving the organisation and the total number and percent of Māori staff.

Report as at (or year end) 30 June 2016

	RECRUITMENT				TURNOVER		ACTUAL STAFFING 30 JUNE 2016				
	% Maori applied	% Maori Interviewed	% Maori Appointed	% Maori Appointed v Maori Interviewed	Maori	Total DHB	Staff	Target 14.3%	Actual	Actual %	Gap
Medical - SMO	0.0%	0.0%	0.0%	0.0%	0.0%	4.9%	142	20	2	1.4%	18
Medical - RMO	0.4%	2.0%	2.1%	100.0%	0.0%	0.0%	138	20	7	5.1%	13
Nursing	5.5%	12.3%	13.4%	58.6%	11.0%	9.2%	1,504	215	162	10.8%	53
Allied Health	11.7%	15.7%	13.8%	42.5%	5.3%	8.9%	553	79	73	13.2%	6
Support	29.3%	32.7%	24.0%	35.3%	12.2%	12.3%	188	27	55	29.3%	-28
Management & Admin	13.3%	17.0%	14.3%	29.5%	13.2%	10.2%	457	65	73	16.0%	-8
Total	**9.3%**	**14.5%**	**12.8%**	**44.4%**	**10.4%**	**9.3%**	**2,982**	**426**	**372**	12.5%	**54**

Table D shows that:
For nursing 5.5% of all applicants, 12.3% of interviewees and 13.4% of candidates appointed are Māori, 58.6% of Māori interviewed are appointed.

For Allied Health 11.7% of all applicants 15.7% of interviewees and 13.8% of candidates appointed are Māori. 42.5% of Māori interviewed are appointed.

For Support, 29.3% of all applicants, 32.7% of interviewees and 24% of appointees are Māori. 35.3% of Māori interviewed.

For Management and Administration 13.3% of applicants, 17 of interviewees and 14.3% of appointees are Māori. 29.5% of Māori interviewed and appointed.

This shows we need to increase the number of Māori applying and being interviewed for Nursing, Allied and Management and Administration roles and increase the number of Māori being interviewed and appointed for Support and Management and Administration roles.

As for turnover, Management and Administration and Nursing turnover is higher than the DHB turnover figure. This means we need to do better at reducing turnover in these areas particularly for Nursing as our biggest workforce.

Māori Staff Representation

The DHB wants to achieve Māori staff representation levels equal to the Hawke's Bay population Māori ethnicity of 25%. We want to do this to ensure we can better engage effectively with our communities and provide more jobs (and well paid jobs for Māori).

Overall we have increased Māori staff representation to 12.5% at June 2016. This has largely been achieved through our focus on increasing Māori staff representation in Nursing, increasing from 7.0% at June 2012 to 10.8% at June 2016. Increasing the target form 12.97% at June 2015 to 14.3% at June 2016 did not see a continued lift in performance. Performance at June 2015 was 12.3% only increasing to 12.5% at June 2016. We started the year with a gap of 59 closing to 54 at 30 June 2016. MRB have asked that the DHB commit to a target of 25% by 30 June 2021. This wouldrequire net increases of 109, 165, 228, 298 and 376 additional Māori staff through to 30 June 2021. Increasing the target by 10% each year through to 2021 would require net increases in Māori staff representation of 101, 148, 199, 256 and 318 each year to 30 June 2016.

EMT has considered each of these approaches at their meetings of 12 and 26 July 2016. EMT believes that it is better to commit to a realistic and achievable target for July 2017 and work with Medical, Nursing, Allied and other workforce leaders to confirm the targeted actions that need to be taken workforce grouping by workforce grouping to improve performance against the target. EMT believes a target of 30 June 2017 of 10% increase on the actual percentage achieved to 30 June 2016 of 12.5%. This would mean a new target by 30 June 2017 of 13.75%. A new target for the years' after June 2017 can be set once the targetted actions for each workforce grouping have been identified.

100% of HBDHB staff has completed Treaty on line training & 100% of HBDHB staff has completed the "Engaging Effectively with Māori" (EEWM) training.

Current Performance

We launched the newly developed package EEWM in August 2014 and it has been a success. Current training stats as at 30 June 2016 are attached as Appendix A.

To date 1925 current staff members (65.6%) have completed the EEWM training. A total of 86.3% managers have attended.

Feedback from staff attending has been positive and almost all staff feeding back through formal course feedback sheets state that they would recommend the course. We now automatically enrol all new staff onto the EEWM course and are following up with staff enrolled to make sure they attend.

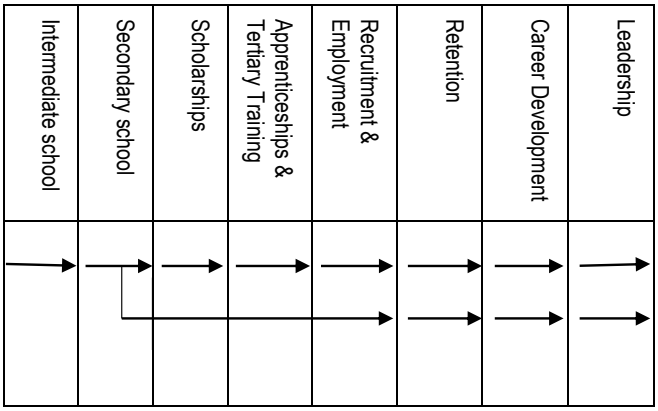
This training is under review and will be modified for internal delivery from within Māori Health Services (MHS) from July 2016 onwards.

Programme Incubator
Our Programme Incubator has been running since 2007. In the 2016 uptake, 19 schools are participating with 352 year 12 and 13 total students of which 89 (28%) are Māori. Our Earn and Learn programme targets year 11, 12 and 13 students that may not have an academic interest but are still interested in working in health. However, once employed into the DHB roles such as Orderlies, Care Associates, Laboratory Technician etc., there is an opportunity to further their career pathway through workplace training to gain national qualifications. This programme has a total of 37 students participating of which 20 (54%) are Māori.

We run our annual Health Careers Expo targeting year 10 and 11 students to get these students interested in health careers and the sciences. Most recently run in June 2016, 492 students in total attended. Ethnicity is not recorded for this.

Turuki
For Turuki we offer Health Workforce New Zealand (HWNZ) funded and other scholarships which have had a total of 79 scholarships taken up over the last three years and promote health careers to Hastings Intermediate students.

Increasing Māori Staff representation
The pipeline for Māori staff out of intermediate and secondary school into employment in the HBDHB is described below:



Students can go from secondary schooling straight into employment or into employment via tertiary training and apprenticeships.

Recruitment and Employment
We need to move our hiring managers to taking on board the challenge of recruiting more Māori staff members from understanding it in their heads to taking it into their HeARTs. We propose to introduce a number of significant new interventions including:

1. Putting in place KPI targets for Māori staff representation into hiring managers' performance plans.
2. Train up all hiring managers to EEWM and live our Values/behaviours.
3. Develop a community engagement campaign targeting local Māori through social media and events in conjunction with Communications.
4. Develop a recruitment campaign to map Māori health workers in New Zealand and Australia and target those workers to work in Hawke's Bay.
5. Understand how MHS is able to recruit high numbers of Māori and share learnings with other hiring managers.
6. Re-balance the membership of interview panels to include the hiring manager, professional lead, Māori staff member/consumer AND a community representative.

The current and proposed new actions for the tertiary training and apprenticeships and for the recruitment and employment parts of the pipeline are set out in Table E. Of the new actions identified some have been completed, others progressed and others only recently identified.

Table E

Intermediate school and secondary school student				Status
Current	Turuki – promoting health careers Incubator – promoting health careers in 19 secondary schools - targets year 12, 13 students Earn and Learn – targets 11, 12, 13 year students Health Careers Expo – targets year 10,11 students	New	Community engagement campaign to be developed including targeting Māori through social media and community events (local and national) held in Hawke's Bay).	Under development
		New	Promote new and innovative models of care that better meet community need /achieve equity e.g. EngAGE.	New
Current	Turuki – scholarships 79 Scholarships offered over last 3 years	New	KPI targets for Māori staff representation into hiring managers' performance plans.	New
Current	Tertiary Training Facebook contact with Incubator students	New	Campaign to promote HBDHB at Tertiary institutions Kanohi ki te Kanohi and on-line.	New

Recruitment and Employment				
Current	Focus on nursing with initial focus on Nurse Entry to Practice (NEtP) nursing and valuing locally trained and Māori applicants by weighting of two.	New	Work with Kia Ora Hauora to identify Māori candidates who are keen to work in the Hawke's Bay and develop ongoing relationships through their course of study.	Underway
Current	Using assessment centres to assess candidates demonstrate relationship management, EEWN skills.	New	Position profiles to be updated (key competencies and essential criteria) to include EEWM.	Completed
Current	Broadened focus to Allied Health and other roles systematically reviewing recruitment processes to audit where Māori applicants aren't recruited.	New	Update interview question template to ensure EEWM is Q2 or Q3 and also it is weighted two or higher for assessment.	Completed
Current	Job adverts include statements in Te Reo for some roles e.g. Community Health. Extend for all roles.	New	Ensure all HBDHB hiring managers complete EEWM course and can effectively assess for the competence EEWM	Ongoing (currently 86.3%)
		New	Ensure all members of an interview panel have completed EEWM and for this eventually to be a mandatory requirement before they can be involved in selection and assessment and complete Values and behaviours online training currently being developed.	Ongoing
		New	Include a Māori consumer representative on interview panel in the interim utilise Māori staff members. For targeted areas re-balance the membership of interview panels to include the hiring manager, professional lead, a Māori staff member/consumer AND a community representative.	In place for Māori staff
		New	Develop "Day in the Life" video of current Māori staff.	First video developed, five more to come

		New	Briefing of CNMs, nurse leaders, allied health leaders, other hiring managers and Union bipartite forum to confirm focus on recruiting Māori staff.	All briefings held
		New	Understand what MHS are doing well to attract Māori staff to work for their teams, "bottle" it" and extend to other DHB hiring managers and teams. Then work with these teams to develop initiatives to improve Māori staff representation in their areas.	New
		New	Provide monthly reports to hiring managers (in addition to the Māori staff representation and advise KPI performance to date) - Total no. of Māori applicants / total applicants - Total no. of Māori shortlisted / total shortlisted - Total no. of Māori appointed / total shortlisted EMT to receive monthly report.	Requires system development. Almost complete.
		New	Include question in proposal to appoint to ask "Have you appointed a Māori applicant and if not why not."	Requires system development. Almost complete.
		New	Identify unsuccessful Māori applicants and refer to other hiring managers and MHS for other potential opportunities.	Requires system development. To commence
		New	Systematic debriefing of unsuccessful Māori candidates	To commence
		New	Revise the Request to Recruit form to ask hiring managers to confirm that there is a Maori staff member or consumer on interview panels	Underway
		New	Develop a recruitment campaign to attract Māori staff to the Hawke's Bay Health Sector. Focussed on: - Mapping the talent pool of Māori Health talent in New Zealand and Australia - Developing a talent and recruitment strategy to attract Māori Health talent to work in Hawke's Bay. DHB recruitment team to provide proactive for NEtP candidates	Underway
		New	Improve EIT support for training and for application for nursing roles (tie into contract).	New
		New	Use assessment centres for other roles other than NEtP.	New
		New	Recruitment on Marae?	New
		New	Develop mid-career RN recruitment strategy	New
		New	Develop Allied Health recruitment strategy	New
		New	Work nationally to develop Allied Health career progression framework and remuneration to make Allied Health profession more attractive.	New

Retention
For retention Māori turnover has for the 12 months to 30 June 2016 been 10.4% versus the whole of DHB turnover figure of 9.3%. In previous years Māori staff turnover has been below or the same as DHB turnover.

Staff Turnover 12 months ended 30 June 2016 and reasons given by Māori staff for voluntary resignations for each workforce grouping are set out in Table F. Turnover for RMOs is 0% as all RMOs are fixed term and therefore not included in the calculation for voluntary turnover.

Table F

	DHB Turnover	Māori Staff Turnover	Number of Māori resignations	Reasons
Medical - SMO - RMO	4.9% 0.0%	0.0%	0	
Nursing	9.2%	11.0%	10	4 move to alternative position 3 not returning from maternity leave 1 retired 2 other reasons
Allied Health	8.9%	5.3%	3	1 move to alternative position 1 personal reasons 1 retired
Support	12.3%	12.2%	5	1 retired 1 relocating outside HB 1 not returning maternity leave 1 personal reasons 1 other reasons
Management & Admin	10.2%	13.2%	9	4 move to alternative position 2 relocating outside HB 1 retired 2 other reasons
Total	**9.3%**	**10.4%**	**27**	

Staff completion of exit interviews is low internationally and in New Zealand as staff feel it is too late and wonder what is the point. It is the same for the HBDHB with only a small percentage of all staff resigning for the 12 months to 30 June 2016 having completed an exit interview. Retention interviews with focus groups of Māori staff would work better and is proposed as a new retention initiative. For the HBDHB by holding focus groups with groups of Māori staff to understand what they like about working for the DHB, what they don't like and what needs to change. The feedback from these focus groups will be used to change practice within the DHB. Changing practice will lead to increased Māori staff retention.

In respect of additional retention initiatives addition we need to:
1. Revitalise the Tuakana / Teina groups in place and where this is not in place set these up by workforce grouping. This can be done post the focus groups.
2. In order to grow more Māori managers, identify aspirant Māori managers and leaders and enrol into the Basic Management and potentially Transformation Leadership programmes.
3. In rolling out our Values and behaviours team by team ensure out team leaders lead at out on our relationship based management and our Values and behaviours to ensure a supportive team environment is created.
4. Our managers to adopt flexible work practices that are family friendly and supportive and therefore better retain our Māori staff.
5. A new staff engagement survey has been selected (IBM Kenexa) and this provides an opportunity for Māori staff to feedback on a range of questions including questions based on each of our Values and new Behaviours. This survey will be run in October 2016.

Supply of Māori health workers

For each occupational group the 2016 supply of Māori Health Workforce is set out in Table G below: This shows that there will be a higher percentage of medical graduates who are Māori in five years' time but not in the interim. Nursing students across all years at 16.5% Māori which is slightly ahead of our 30 June 3016 target. For occupational therapy and physiotherapy indications are that the percentage of Māori students' graduates is low at 8% and 5%. Overall the supply of Māori health workers is not especially high and provides a challenge when wanting to increase the number of Māori applying for Nursing and Allied Health roles.

Table G

	Total Māori %
Medical	20% 2016 intake only
Nursing	16.35% for all employees
Occupational Therapy	8% (estimated)
Physiotherapy	5% (estimated)

Appendix One

Cultural Training at 30 June 2016 *By percentage*

	Total Employees	Engaging effectively with Maori	Treaty of Waitangi
Frequency		3 yearly	Once
Medical - SMO	140	61	14
Medical - RMO	137	10	33
Nursing	1480	993	694
Allied Health	540	405	282
Support	187	96	65
Management & Admin	452	360	278
DHB Total - June 2016	**2936**	**1925**	**1366**

	Total Employees	Engaging effectively with Maori	Treaty of Waitangi
Frequency		3 yearly	Once
Medical - SMO	140	43.6%	10.0%
Medical - RMO	137	7.3%	24.1%
Nursing	1480	67.1%	46.9%
Allied Health	540	75.0%	52.2%
Support	187	51.3%	34.8%
Management & Admin	452	79.6%	61.5%
DHB Total - June 2016	**2936**	**65.6%**	**46.5%**

In addition to the specific recruitment initiatives above, add in the Māori staff representation KPI into all managers and team leaders performance plans and reviews.

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora – Mental Health**
	For the attention of: **Māori Relationship Board, HB Clinical Council, HB Health Consumer Council and HBDHB Board**
Document Owner: Document Author(s):	Sharon Mason – Chief Operating Office (Champion) Allison Stevenson, Service Director & Simon Shaw, Medical Director
Reviewed by:	Paul Malan – Strategic Service Manager; Health Services Leadership Team; Executive Management Team
Month:	August 2016
Consideration:	For monitoring

15

RECOMMENDATION

That MRB, Clinial and Consumer Council and HBDHB Board:

Note the contents of this report.

OVERVIEW

Te Ara Whakawairoa (TAW) is a report drawn from the Māori Health Plan and is reported on quarterly with champions to oversee that monitoring and reporting.

Non-performing indicators are identified by the Māori Relationship Board which require special reporting through a channel of committees and then onto the HBDHB Board.

This report is from Sharon Mason, Champion of Mental Health Services Indicators. It focuses on key indicators to improve Mental Health Services for Māori.

UPCOMING REPORTS

The following are the indicators of concern; allocated Executive Management Team (EMT) Champion and reporting month in 2015 / 2016.

Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
Mental Health	Rate of section 29 Compulsory Treatment Orders	81.5% (per 100,000)	Sharon Mason	Allison Stevenson	August 2016
	Percentage of clients discharged from Child, Adolescent and Family Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) Services with a transition (discharge) plan	95%	Sharon Mason	Allison Stevenson	August 2016
	PP8 mental health wait times for non-urgent mental health or addiction services seen within three weeks (mental health provider arm), 0 to 19 years	80%	Sharon Mason	Allison Stevenson	August 2016

WHY ARE THESE INDICATORS IMPORTANT?

Use of Section 29, Compulsory Treatment Orders (CTO) is symptomatic of system-wide and socioeconomic issues. Monitoring rates is important in order to provide data for teams to understand their preparedness for clients under CTO and for them to respond appropriately to need. Māori are over represented in these statistics, showing that just less than half the consumers on CTO are Māori.

Monitoring the percentage of clients discharged from Child, Adolescent and Family Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) Services with a transition (discharge) plan showing the discharge to primary care with a plan in place. Showing the partnership between primary and secondary services. Consumers must have had three face-to-face contacts for a discharge plan to be generated (MoH KPI). HBDHB count all consumers discharged from CAFS Service as having a discharge / transition plan in place.

Ministry of Health monitoring of mental health wait times for non-urgent Mental Health or Addiction Services seen within three weeks, (mental health provider arm), 0 to 19 years, showing people are receiving services within acceptable timeframes of referral to face-to-face appointment. Consumers are not waiting for appointments and the services have been timely and effective in their care.

Inequality in Outcomes in Mental Health Status for Māori

- Māori have a high rate of access to Mental Health Services than non-Māori.
- Māori have 3 – 4 times higher rates of use of Section 29 compared to non-Māori on average.
- Estimated twelve month prevalence of schizophrenia for Māori (0.97%) is significantly higher than for non-Māori (0.32%[i]).
- Hospitalisation rate and readmission rate is higher for Māori (17%).

Rate of Section 29 Compulsory Treatment Orders

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

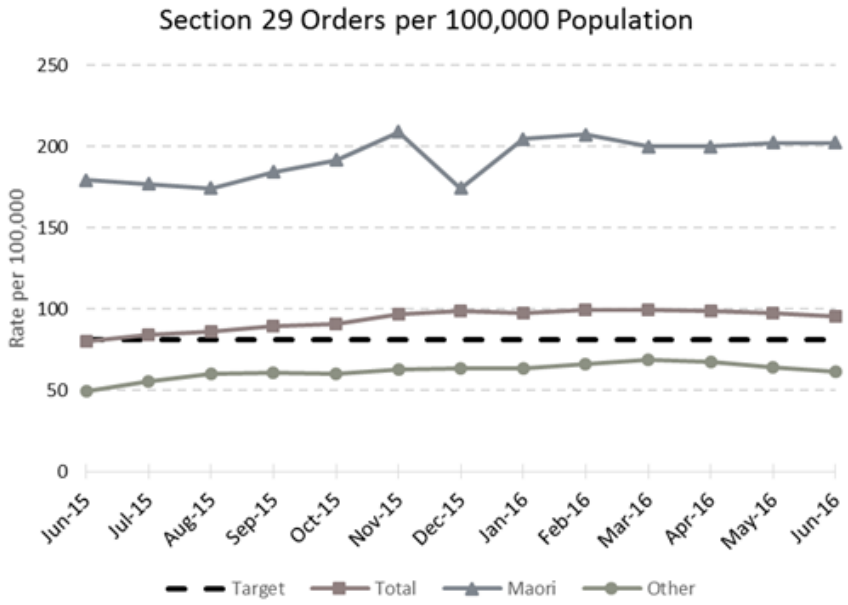
Compulsory Treatment Order (CTO) rates are symptomatic of system-wide and socioeconomic issues. Monitoring rates is important in order to provide data for teams to understand their preparedness for clients under CTO and for them to respond appropriately to need.

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

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

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

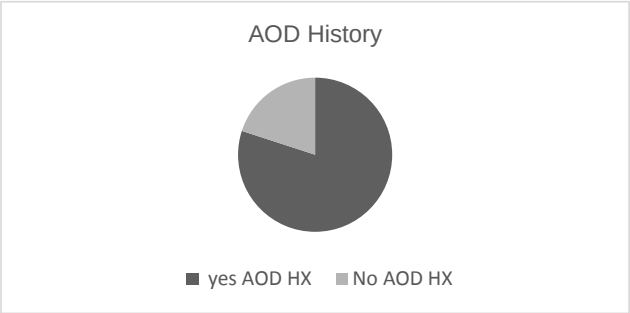
HBDHB Section 29 Orders – June 2015 to June 2016

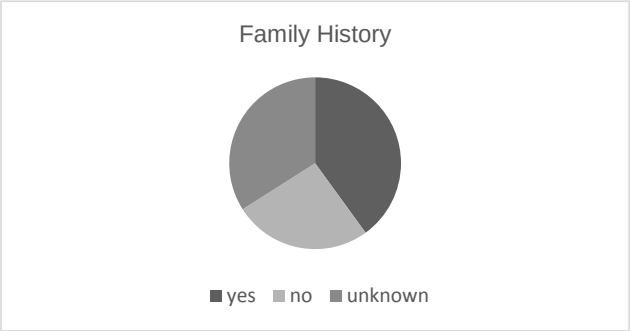


			Target	Total	Māori	Other
2015/16	Q1	≤	81.5	86.7	178.6	59.0
	Q2	≤	81.5	95.6	191.7	62.2
	Q3	≤	81.5	99.0	204.0	65.9
	Q4	≤	81.5	97.3	201.6	64.5

Audit of Fifty Random Consumer Files That Were Placed on the Community Treatment Order (CTO)

In the 2015 / 2016 Annual Plan, we signalled that we would undertake an audit of patients subject to CTO to determine factors associated with treatment under the Mental Health Act. The Mental Health Service completed the audit of fifty random files under the Mental Health Act over the past year showing the socioeconomic factors that are part of a person being place on a CTO. Some key factors examined were:

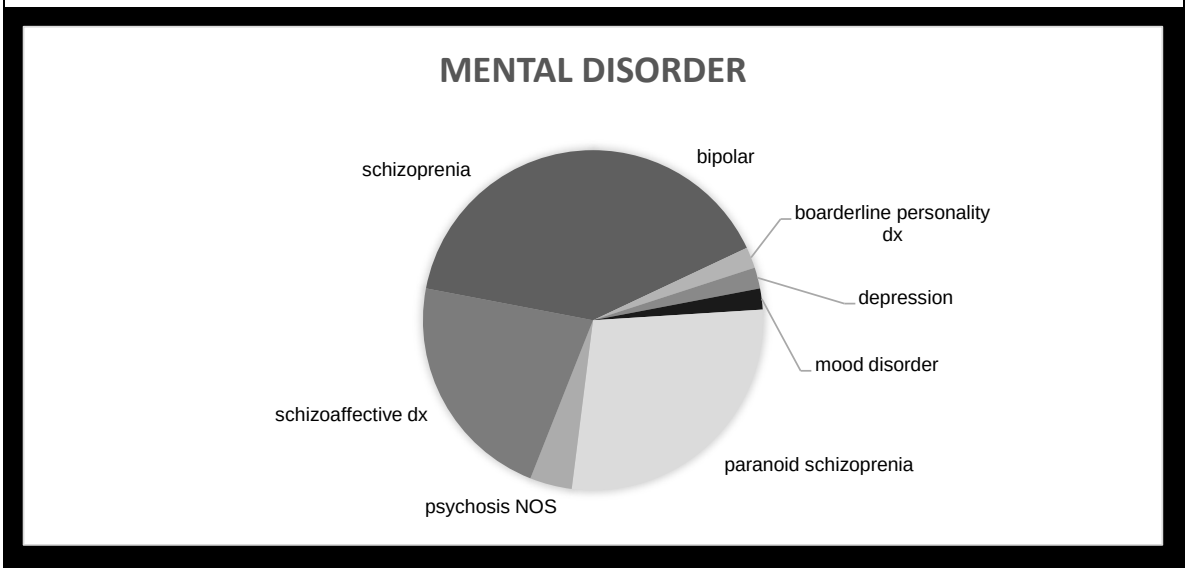
Addictions History Were addictions part of the person's history? 20% had no addictions history. 80% had an addictions history.	

Family History of Mental Illness Was there a history of mental illness within the family? 40% had a mental illness history. 26 % did not have a history of mental illness. 34 % were unknown**.**	

Work Status Was the person employed at the time of the CTO? 92% of people on CTO were unemployed. 8% were is some type of employment.	

What type of mental illness did people have who were placed under CTO?

People who were under CTO suffered from; schizophrenia 22%, bi-polar 18%, schizoaffective disorder 22% and paranoid schizophrenia 28%



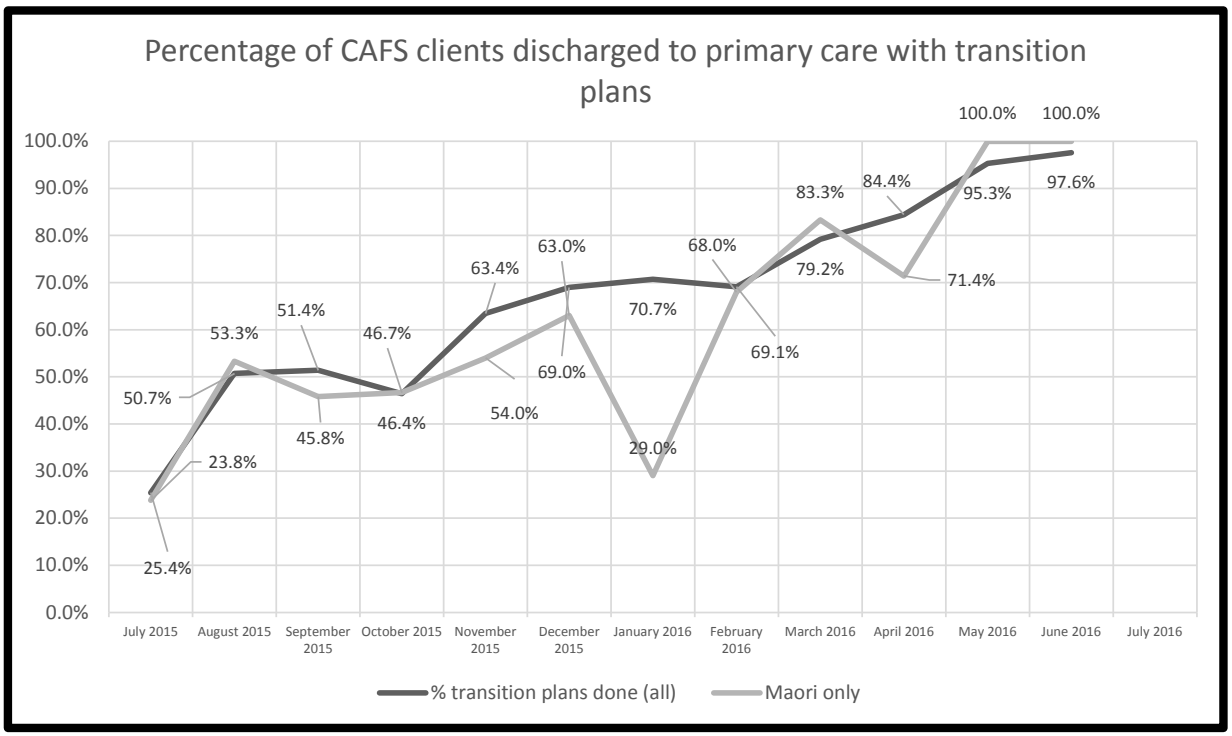
The audit shows that being placed under the CTO is not just about mental health but a complexity of social, family and health factors. In addition, differences in the population rates of these underlying factors may be a significant driver of compulsory treatment and is an important component of any attempt to reduce the rate. Currently we are analyzing the data for Māori vs non-Māori for the same content.

NUMBER 2 INDICATOR

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

This ministry measurement is after three face-to-face meetings with the child and family, a transition or discharge plan must be generated and sent to family and referrer. HBDHB counts all children and family appointment regardless of how many face-to-face contacts have been held.

The below table shows that from July 2015 to July 2016 we have increased from 23.8% to 100%.



NUMBER 3 INDICATOR

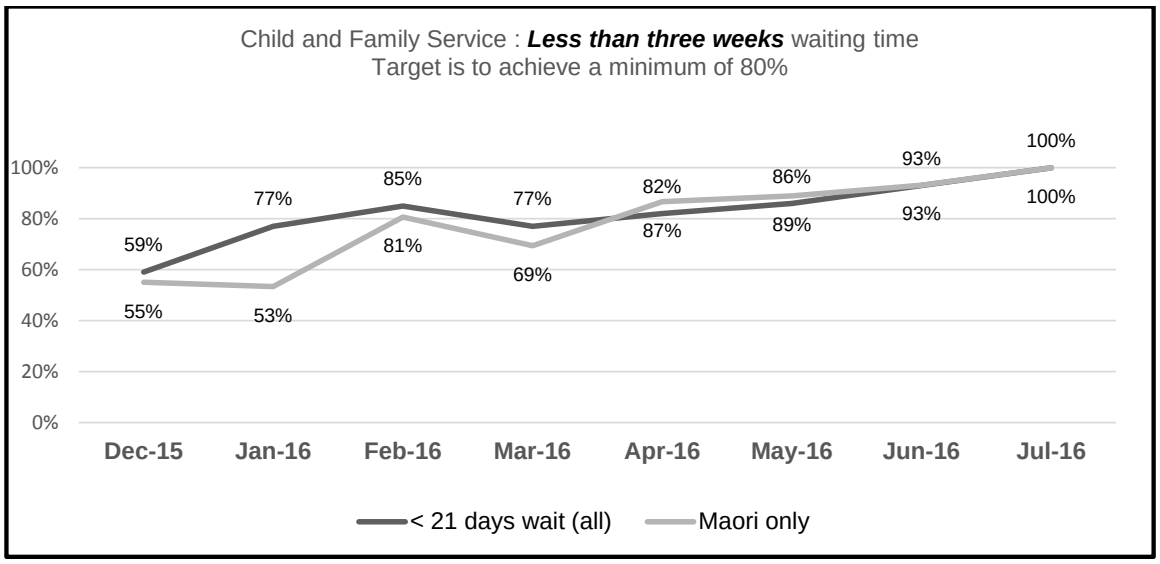
Mental Health Wait Times for Non-Urgent Mental Health or Addiction Services Seen within Three Weeks (provider arm) 0 – 19 years

This indicator shows from the time of receiving the referral from the referrer to the time the child / family are seen by a health practitioner. December 2015 at 59% to July 2016 100%.

Note: the table below is for quarter reporting and only is reported to March 2016.

	Mental Health Provider Arm									
	<3 weeks					**<8 weeks**				
12 months to	Target	Provider Arm Total	Māori	Pacific	Other	Target	Provider Arm Total	Māori	Pacific	Other
Mar-16	80.0%	67.4%	66.4%	71.4%	68.0%	95.0%	90.2%	91.4%	95.2%	89.0%

During the first six months of 2016 (i.e. Q3 and Q4), the CAFS team completed extensive work to improve the waiting time between referral and appointment. A consistent improvement from January 2016 is shown in the graph below, and the service is achieving 100% within three weeks as of July 2016.



The second component of this measure is the proportion of CAFS clients seen within eight weeks, with a national target of 95%. In December 2015 we were at 90% and in March 2016, 91.4% for Māori children and adolescents.

As explained above, the CAFS team have completed extensive work on waiting times and we are now (July 2016) achieving 100% of referrals seen within three weeks. We have been achieving 100% for Māori since April 2016 but the eight week indicator has now become irrelevant as no one is waiting longer than three weeks.

CHAMPIONS REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THIS INDICATOR

Compulsory Treatment Orders
In line with Annual Plan 2015 / 2016[iii], Mental Health and Addiction Services began an audit of CTO in quarter three. That audit has given us some baseline understanding of the population under CTO. Whilst there is still work to do on further investigation of those factors, the services we are already putting in place, are a new model of care for acute and community services. This includes a shift in focus to a recovery approach that builds resilience for people with low-prevalence conditions and / or high needs and is more responsive to the wider socioeconomic factors that drive the need for intensive mental health treatment. These changes enhance access by integrating hospital and community services, strengthening collaboration with kaupapa services, and developing better primary care responses.

Transition and Discharge Planning
Over the last year we have developed a standard transition plan document / template that covers secondary mental health and addiction services. Every clinician who has primary responsibility for a case now completes the core transition document and we ensure that the primary care provider or primary referrer is prompted to make a follow-up appointment within three weeks. The completed transition plans are communicated to the primary referrer.

Reducing Waiting Times
The work that was planned to support this indicator was mostly procedural and administrative i.e. establishing prompts with appropriate policies and procedures to ensure proactive management of referrals. This was enhanced with good monitoring of results and attention to DNAs.

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

From the HBDHB Annual Plan 2016 / 2017[iv], the table below shows the activity that is planned to support the CTO indicator.

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

From the HBDHB Annual Plan 2016 / 2017[v], the table below shows the activity that is planned to support transition planning:

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

From the HBDHB Annual Plan 2016 / 2017[vi], the table below shows the activity that is planned to support maintaining waiting times:

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

PRIMARY AND SECONDAY SERVICES INEGRATION OF MENTAL HEALTH SERVICES

In March 2015, Primary Health Organisation (PHO) commissioned a review of primary mental health services and this was reviewed and completed with recommendations from the Chiplin group. The recommendations are clear about strengthening the relationships between secondary and primary care to improve and support access for clients. If availability of clinical pathways, provision of advice, joint consultations and case discussions were implemented this may reduce the increasing burden on secondary care and provide better outcomes for mental health clients in primary care.

RECOMMENDATIONS FROM TARGET CHAMPION

Activity to support these three indicators is well underway and should continue. The complexity around CTO will be better understood by further analysis of the audit results and, by sharing this information, the services will be better placed to ensure the most appropriate use of compulsory treatment. I support the intentions to increase family involvement, integrate services and service providers, and develop staff capability and to build networks.

Targets in respect of transition planning and waiting times are now all being met. This is commendable and must be maintained. The intentions in the Annual Plan will all help with ongoing

improvement but it is also recommended that the service ensure robust operational performance monitoring of these aspects of service quality in order to capture the gains.

I support the recommendations within the Chiplin report and encourage primary and secondary mental health services to implement mechanisms to allow for further integration.

CONCLUSION

Our changing models of care are designed to increase access to services, including earlier access for all people across the spectrum of need. Mental Health and Addiction Services have come a long way in the last year and it will be good to maintain that momentum and to keep improving on these and other markers of service quality.

REFERENCES

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

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

[iii] Hawke's Bay District Health Board, Annual Plan 2015/16. HBDHB.

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

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
AOD	Alcohol & Other Drugs
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
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
DQIPS	Director Quality Improvement & Patient Safety
ED	Emergency Department

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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
GM PIF	General Manager Planning Informatics & Finance
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
HPL	Health Partnerships Limited
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	Māori Development Organisation
MECA	Multi Employment Collective Agreement
MHI	Mental Health Initiative (PHO)
MHS	Māori 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
RHIP	Regional Health Informatics Programme
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
TAW	Te Ara Whakawaiora
TOR	Terms of Reference
UCA	Urgent Care Alliance
WBS	Work Breakdown Structure
YTD	Year to Date