Hawke's Bay Clinical Council Meeting

Combining with Hawke's Bay Health Consumer Council

Date: **Wednesday, 11 May 2016**

Lunch 12.30pm Meeting: 1.00 pm to 6.00 pm

Venue: **"Takarangi" Conference Room**
Te Taiwhenua o Heretaunga, 821 Orchard Road, Hastings

Council Members:

Chris McKenna (co-Chair)
Dr Mark Peterson (co-Chair)
Dr Caroline McElnay
David Warrington
Dr John Gommans
Billy Allan
Dr Robin Whyman
Jules Arthur
Robyn O'Dwyer
Dr Kiri Bird
Dr Tae Richardson
Dr Malcolm Arnold
Dr Andy Phillips
Dr David Rodgers
Debs Higgins
Anne McLeod

Apologies:

Dr John Gommans and Dr Andy Phillips

In Attendance:

Kevin Snee, Chief Executive Officer
Ken Foote, Company Secretary
Kate Coley, Director of Quality Improvement & Patient Safety
Tracy Fricker, Council Administrator
Graeme Norton, Chair HB Health Consumer Council

PUBLIC EXCLUDED

Item	Section 1 – For Discussion / Decision	Time(pm)
2.	Investment / Disinvestment Prioritisation *(Peter Kennedy)*	1.00 pm
	Section 2 – Routine	
3.	Minutes of Previous Meeting (public excluded)	3.00 pm
4.	Matters Arising – Review Actions (public excluded)	

PUBLIC MEETING

Item	Section 3 – Routine	Time(pm)
5.	Apologies	3.10 pm
6.	Interests Register	
7.	Minutes of Previous Meeting	
8.	Matters Arising – Review Actions	
9.	Clinical Council Workplan	
	Section 4 – Presentations	
10.	Clinical Governance Structures / Committees Review *(Kate Coley)*	3.20 pm
11.	Quality Improvement Programme *(Kate Coley)*	3.30 pm
	Section 5 – Committee Reports	
12.	Urgent Care Report *(Graeme Norton)*	3.40 pm
13.	CAG Report – Meeting on 3 May *(Dr Tae Richardson)*	
	Combined Clinical and Consumer Council Meeting • Welcome / Introductions and afternoon tea	3.45 pm
	Section 6 – For Endorsement	
14.	Best Start Healthy Eating Plan (final) *(Shari Tidswell)*	4.00 pm
	Section 7 – For Information	
15.	Customer Focused Booking Programme Update *(Carleine Receiveur)*	4.05 pm
16.	Quality Accounts – Overview of plan & content *(Kate Coley)*	4.10 pm
17.	Endoscopy Service Transition Update	4.15 pm
18.	Travel Plan – verbal update *(Andrea Beattie)*	4.20 pm
19.	Youth Health Strategy (draft) *(Nicky Skerman)*	4.25 pm
20.	Te Ara Whakawaiora / Cardiovascular – for info only, no presenter	-
21.	Annual Maori Health Plan Q3 Jan-Mar16 Dashboard – for info only, no presenter	-

PUBLIC EXCLUDED

Item	Section 8 – For Discussion	Time(pm)
22.	13-17 Year Old Primary Care Zero Rated Subsidy- verbal *(Patrick Le Geyte)*	4.40 pm
	Section 9 – Combined Workshop	
23.	Person and Whanau Centred Care *(Kate Coley)*	4.50 pm

The meeting will conclude around 6.00pm

Next meeting:

Wednesday, 8 June 2016 commencing at 3.00 pm in the HBDHB Boardroom, Hastings

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

2. Investment / Disinvestment Prioritisation
- Public Excluded

3. Minutes of Previous Meeting
- Public Excluded

4. Matters Arising – Review of Actions
- Public Excluded

22. 13-17 Year Old Primary Care zero Rated Subsidy (verbal)
- Public Excluded

23. Person and Whanau Centred Care (Workshop)
- Public Excluded

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

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.
- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.
- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).

Interests Register

13 April 2016

Hawke's Bay Clinical Council

Name Clinical Council Member	Interest eg Organisation / Close Family Member	Nature of Interest eg Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to
Chris McKenna (Director of Nursing)	Hawke's Bay DHB - Susan Brown	Sister	Registered Nurse	Yes	Low - Personal - family member
	Hawke's Bay DHB - Lauren McKenna	Daughter	Registered Nurse	Yes	Low - Personal - family member
	Health Hawke's Bay (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
Dr Mark Peterson (Chief Medical Officer - Primary	Taradale Medical Centre	Shareholder and Director	General Practice - now 20% owned by Southern Cross Primary Care (a subsidiary of	Yes	Low
	Royal New Zealand College of General Practitioners	Board member	GP training and standards	Yes	Low
	City Medical Napier	Shareholder	Accident and Medical Clinic	Yes	Contract with HBDHB
	Daughter employed by HBDHB from November 2015	Post Graduate Year One	Will not participate in discussions regarding Post Graduates in Community Care	Yes	Low
	PHO Services Agreement Amendment Protocol (PSAAP)	"Contracted Provider" representative	The PHO services Agreement is the contract between the DHB and PHO. PSAAP is the negotiating group that agrees the contract.	Yes	Representative on the negotiating group
	Health Hawke's Bay Limited (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
Dr John Gommans (Chief Medical Officer - Hospital)	Stroke Foundation Ltd	Chairman of the Board of Directors	Provides information and support to people with a stroke. Has some contracts to the MOH	Yes	Low
	Internal Medicine Society of Australia and New Zealand (IMSANZ)	Immediate Past President and a current Director of IMSANZ	The IMSANZ represents the interests of specialist General Internal Medicine physicians throughout Australia and New Zealand	Yes	Low
	Royal Australasian College of Physicians (RACP), Adult Medicine Division Committee (AMDC)	Member and Chair elect of NZ Committee	RACP represents Physicians in all Adult Medicine specialties across Australasia; the NZ AMD representing those based in NZ	Yes	Low
Dr Caroline McElnay (Director Population Health & Health Equity Champion)	NZ College of Public Health Medicine	President until October 2017	NZCPHM represents the interests of Public Health Medicine specialsits in NZ, provides training of registrars, ongoing accrediation of specialists and advocacy on public health matters.	*No*	
	RNZ Plunket Society	National Board member	Provision of heath and social services to children under 5 years, advocacy for children	*No*	
William Allan (Chief Pharmacist)	Pharmaceutical Society of New Zealand	Executive member	Pharmacy advocacy, professional standards and training	Yes	Low
	Pharmaceutical Management Agency (PHARMAC)	Member, Tender Medical Subcommittee of PTAC (Pharmacology & Therapeutics Advisory Committee)	Provide advice to PHARMAC on the clinical suitability of tenders for subsidised medicines for inclusion in the Pharmaceutical Schedule and Hospital Medicines List (HML)	Yes	Low. Influences the cost of subsidised medicines to the DHB's combined pharmaceutical budget
	Executive User Group for eMedicines programme (ITHB/HQSC)	Member (Central Region's representative)	Provide leadership and guidance to the HITB and HQSC on the eMedicines (Hospital) programme (electronic prescribing & administration; eMedicines Reconciliation)	Yes	Low

Name Clinical Council Member	Interest eg Organisation / Close Family Member	Nature of Interest eg Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to
	Pharmacy Steering Group (MoH)	Member	Provide advice to the Ministry on the utilisation of pharmacists within the health workforce	Yes	Low
Jules Arthur (Midwifery Director)	National Midwifery Leaders group	Member	Forum for national midwifery and maternity issues	No	
	Central Region Midwifery Leaders report to TAS	Member	Regional approach to services	No	
	National Maternal Wellbeing and Child Protection group	Co Chair	To strengthen families by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner.	No	
Dr Kiri Bird (General Practitioner)	Te Timatanga Ararau Trust (Iron Maori)	Partner is a Trustee	Health and Wellbeing	Yes	Low - Contract with HBDHB
	Te Taiwhenua o Heretaunga	General Practitioner	General Practice	Yes	Low - TToH contract with HBDHB
	Royal NZ College of General Practitioners	Board Member	Health and Wellbeing	No	
	Te Ora Board (Maori Doctors)	Deputy Chair	Health and Wellbeing	No	
	Te Akoranga a Maui (Maori chapter for RNZCGP	Chairperson	Health and Wellbeing	No	
Robyn O'Dwyer (Nurse Practioner Whanau Ora)	Wairoa Health Care Center	Nurse Practitioner	General Practice	No	
	The College of Primary Care Nurses	Member	National submissions/member of nursing leadership	No	
	The College of Maori Nurses	Member		No	
	New Zealand Scientific Society of Diabetes	Member		No	
Dr Malcolm Arnold (Medical Director / HOD)	NZ Society of Gastroenterology	Executive member	Provision of Gastroenteorlogy expertise throughout NZ, study of relevant conditions	No	
	NEQIP (National Endoscopy Quality Improvement Programme)	Clincal Support Lead	Standardising and improving quality of endoscopy services and training throughout the countrv	No	
	Endoscopy Users Group, HBDHB	Chairman	Assessing and improving provision of Endoscopy services in HB	Yes	Potential to influence budget/spending/provision of services
	Hawke's Bay Medical Research Foundation	Member of Scientific Advisory Group	Advising HBMRF on use of funds for research projects	No	
	NZ Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy (since June 2015)	Chairman		No	
David Warrington (Nurse Director - Older Persons)	Havelock North Chiropractic	Wife is Practitioner and Co-owner	Chriopractic care and treatment, primary and preventative	Yes	Low
	Pilates Works	Wife is CE and Co-owner	Rehabilitation, Primary and preventative.	Yes	Low
	National Directors of Mental Health Nursing	Member		No	Low
Dr Tae Richardson (GP and Chair of Clinical Quality Advisory Committee)	Loco Ltd	Shareholding Director	Private business	No	
	Dr Bryn Jones employee of MoH	Husband	Role with Ministry of Health as Chief Advisor in Sector Capability and Implementation	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Report on CQAC meetings to Council	No	

Name Clinical Council Member	Interest eg Organisation / Close Family Member	Nature of Interest eg Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Life Education Trust Hawke's Bay	Trustee		No	
Andrew Phillips (Director Allied Health HBDHB)	Nil	Not Applicable	Not Applicable	No	Nil
Dr David Rodgers (GP)	Tamatea Medical Centre	General Practitioner	Private business	Yes	Low. Provides services in primary care
	Tamatea Medical Centre	Wife Beth McElrea, also a GP (we job share)	Private business	Yes	Low. Provides services in primary care
	Directions Youth Health	Wife Beth involved	Assisting youth in HB	No	
	City Medical	Director and Shareholder	Medical Centre	Yes	Low. Provides services in primary care
	NZ Police	Medical Officer for Hawke's Bay	Provider of services for the NZ Police	No	
	Health Hawke's Bay (PHO) initially - from 1 July 2015 under HB District Health Board	Collaborative Clinical Pathways development	Was the Champion for the initial work, however on 1 July this moved under the HBDHB umbrella (with a community focus).	No	
	Advanced Care Planning	Steering Group member	Health and Wellbeing	No	
	Urgent Care Alliance	Group member	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues around the development of urgent care services.
	National Advisory Committee of the RNZCGPs	Member	Health and Wellbeing	No	
	Health Hawke's Bay (PHO)	Medical Advisor - Sector Development	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues in this area relating to the PHO.
Debs Higgins (Senior Nurse)	The Hastings Heatlh Centre	Practice Nurse Family Violence Intervention Coordinator	Delivery of primary health care - General Practice and training of Clinicians in family violence intervention.	No	
	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
	LIVE (Local Initiative for Violence Elimination)	Member of management Committee	Network of agencies that provide family violence intervention services.	No	
Anne McLeod (Senior Allied Health Professional)	Aeotearoa NZ Association of Social Workers	Member		Yes	Low
	HB DHB Employee Heather Charteris	Sister-in-law	Registered Nurse Diabetic Educator	Yes	Low
	Directions Coaching	Coach and Trainer	Private Business	Yes	Low: Contracts in the past with HBDHB and Hauora Tairawhiti.
Dr Robin Whyman (Clinical Director Oral Health)	NZ Institute of Directors	Member	Continuing professional development for company directors	No	
	Australian - NZ Society of Paediatric Dentists	Member	Continuing professional development for dentists providing care to children and advocacy for child oral health.	No	

MINUTES OF THE HAWKE'S BAY CLINICAL COUNCIL MEETING
HELD IN THE HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE
ON WEDNESDAY, 13 APRIL 2016 AT 3.00 PM

PUBLIC

Present:
Dr Mark Peterson (Co-Chair)
Chris McKenna (Co-Chair)
Dr John Gommans
Dr Tae Richardson
Dr Andy Phillips
Dr David Rodgers
Debs Higgins
Dr Malcolm Arnold
Dr Robin Whyman
Dr Caroline McElnay
Robyn O'Dwyer (from 3.30 pm)
Billy Allan
Jules Arthur (from 3.15 pm)
Anne McLeod

In Attendance:
Dr Kevin Snee (Chief Executive Officer)
Ken Foote (Company Secretary)
Kate Coley (Director – Quality Improvement & Patient Safety)
Graeme Norton (Chair HB Health Consumer Council)
Tracy Fricker (PA to Director QIPS / Clinical Council Secretary)

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Mark Peterson (Chair) welcomed everyone to the meeting. Apologies received from Dr Robin Whyman and Dr Kiri Bird.

2. INTERESTS REGISTER

No conflicts of interests for agenda items.

Mark Peterson advised that he is now a member of the Board of Health Hawke's Bay Limited (PHO) and he has another interest as a contracted provider (GP) on the negotiating group for the PHO Services Agreement Amendment Protocol (PSAAP).

Chris McKenna (Co-Chair) is also a member of the Board of Health Hawke's Bay Limited (PHO).

3. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the meeting held on 9 March 2016, were confirmed as a correct record of the meeting.

Moved and carried.

John Gommans advised that following the visit from the Hutt Valley DHB Clinical Council members last month, that they have had their first Clinical Council meeting. Informal feedback received is that it went well.

Andy Phillips thanked colleagues for their feedback on the mobility action plan work and advised that it is their intention to submit a bid to the Ministry following the comments. He thanked Tae Richardson for her help with transforming our bid, and he is hopeful they will be successful.

4. MATTERS ARISING, ACTIONS AND PROGRESS

Item 1: Alternative Health Provider
The Complementary Therapies policy is still in draft. Andy Phillips commented that any further feedback would be helpful. Andy requested a copy of the Rongoa Māori policy from William Allan and he will make reference to it in the new Complementary Therapies policy.

Item 2: Changes to Interest Register
Actioned.

Item 3: Customer Service Training
We have received a proposal from Business Training for Receptionist/Administration training around customer services. They can run workshops for x20 per workshop at around $250 per person. Kate Coley will send out information with the two dates currently available. Further dates can be arranged in the future if there is a need. We had good feedback from the staff who attended the training.

Kate Coley will go back to Business Training and confirm that we are comfortable with the proposal and request another date for later in the year.

Action: Kate Coley to place information about the training sessions on the PHO Portal.

Item 4: Clinical Council Member Portfolios
Areas of interest to be provided to Ken Foote (Company Secretary).

Item 5: Annual Maori Health Plan Q2
Training is mandatory for all DHB staff. The Engaging with Maori training has been socialised with primary care to get their doctors, nurses and receptionists to attend. Mark Peterson will talk to Tracee Te Huia about the possibility of also running some sessions in the evening, which has worked well in the past.

5. CLINICAL COUNCIL WORK PLAN

The Chair reminded everyone that the May meeting is the quarterly meeting starting at 12.30 pm, with a two hour session on Investment/Disinvestment Prioritisation. Peter Kennedy, Finance Manager is coming to the meeting today to give Clinical Council members background information to prepare for the process. Each member will need to do their prioritisation scoring and send their information back to Peter prior to the meeting on 11 May.

The Chair advised that if members of the Clinical Council have any other items they wish to add to the work plan please advise him or Chris McKenna (Co-Chair).

Reminder that the Health Sector Leadership forum is being held on 17 May.

SECTION 2: DECISION

6. DETAILED BUSINESS CASES FOR 15/16 INVESTMENTS

The Chair advised that at the time of prioritisation last year the three proposals below were approved subject to them coming back to the Clinical Council with an appropriate business case.

Chris McKenna advised that the reports have been written by the Directorate Teams who are responsible for these services.

A: Palliative

Palliative Care Medical Registrar Trainee

We do have an advanced trainee in palliative care and we need to cover this off with a business case, and sustainability around palliative care training. Note that this position is part time and compliments our hospital palliative care service and the palliative care service going across the sector. The post is for two years. John Gommans added that palliative care is one of the at risk specialties with Health Workforce NZ, and there is only a small pool of specialists in New Zealand. The palliative care physician training requires a period of both hospital-based palliative care as well as training in the community. There are limited palliative care training runs in hospitals across the country which is why Health Workforce NZ is keen to assist with the funding of this post.

The funding allocation matches what was signed off last year.

Palliative Care Clinical Nurse Specialist Cover

Originally there was funding for 1.5fte Clinical Nurse Specialists (CNS) for the hospital, which has resulted with increased demand when a CNS is on leave as we do not have cover. The business case is so we can provide this cover and a continuous service. Ongoing budget of $47k.

Villa 6 Registered Nursing Posts

We are a satellite unit to Mid Central and have Mid Central Senior Medical Officers working here in Hawke's Bay and are now increasing the modalities/therapies we are giving. There is an increased demand around cancer and cancer co-ordination, so this is to meet that demand. The registered nurses will be coming in at a lower level and will need to be trained up.

In the third business case there is also provision for some limited therapies to be offered at the Napier Health Centre which is new, as we have not currently done that due to the breadth of staff, so this is a new innovation with this investment.

We are currently working on an integrated model and strategy for a continuous service in. palliative care for Hawke's Bay. Chris McKenna advised that the CNSs are working closely with the PCCs at Cranford with case loading and the sharing of information and skills.

Business case endorsed by the Clinical Council.

B: Cardiac

Chris McKenna advised there are an increasing group of cardiac patients who have pacemakers and implantable cardiac defibrillators. Our patients go for their check-ups to either Auckland or Wellington. We want to bring this service back locally to reduce on travel and that we have a system in place so they can be followed up and monitored at a local level.

John Gommans commented on the importance of having a CNS liaising with an out of district Specialist Cardiologist to interface with patients. We will see more and more of this in the future, bring services back locally and using nurse skills to deliver care to patients in their own community.

Business case endorsed by the Clinical Council.

C: Patient at Risk

John Gommans advised this was another proposal which was approved in principle, this was part of transform and sustain out of hours inpatient mortality of care. A lot of work is going on nationally, with the Health Quality Safety Commission (HQSC) making this a specific work stream. The proposal is for an an in hours specialist nurse led service, previously called the outreach. This is about the better identification of people who are at risk and ensuring they have plans in place to reduce the possibility of deterioration. In the hospital we have a rapid response system so when people do deteriorate we have a more sophisticated response for "rescuing" them, this is about getting to them before they deteriorate.

Discussion regarding the language used "patient at risk" and "deteriorating patient". There is a lot of debate about the name. This is the international language which is currently being used.

Question was raised as to whether in putting this service in are we adding a further tier and potentially deskilling our nurses. John Gommans advised that a component of this role will be about up skilling and educating our nurses and working with the teams. At present we are unable to establish this team to work 24/7 and therefore the up skilling of staff will be vital. The aim is to reduce the rapid responses and make sure that in the middle of the night when these situations occur there is enough support for those teams. We can't to 24/7 but the big problem is at 2 am in the morning with the ward nurse and house officer, this will reduce the number of those incidents. There is still other work to be done. Within the money that was allocated this was the best use of it for training/set up in the day time.

Chris McKenna advised this is a good investment based on international literature and we have done a pilot with Aim 24/7 which has proved the outcome for a small amount of investment.

Comment regarding the measures on page 54, and challenged that the equity measures we have in place are equity measures and if they are, are they the equity measures we should have? They need to be worked on and if they are kept, need to be aggregated by ethnicity.

Business case endorsed by Clinical Council.

SECTION 3: REVIEW

7. BEST START HEALTHY EATING (DRAFT)

Caroline McElnay welcomed Shari Tidwell and Kim Williams to the meeting.

Caroline McElnay advised they came to the Clinical Council a year ago with a high level strategic obesity plan. The recommendation of that plan was to focus on children. The Board accepted that recommendation but wanted more detail on the implementation of that strategy. Feedback also received from the Consumer Council and Maori Relationship Board around better understanding of engagement and consultation in the community. Shari and Kim have worked on the plan with more detail and are hoping they have the balance right on what will be happening.

Shari advised that they have been engaging with communities and schools and the Consumer Council to get a feel for what the best approaches would be and a summary of the evidence which is around that has been included and the plan has been divided into four areas to focus on:

1. Increase healthy eating environments
2. Develop and deliver prevention programmes via food literacy, maternal nutrition, physical activity and implementing policy
3. Intervention – support people to have healthy weight
4. Provide leadership in healthy eating

General discussion held and feedback from Clinical Council:

Feedback:

- Environment and supermarkets, that's where most people do their shopping, this is a significant part of the problem – is there something we can do to influence? Also tackling the food labelling system in NZ to enable better understanding so that they can make a more informed choice.

- Is there a place for something like "my food bag"? It can cut down on what you spend in the supermarket, planned recipes etc. Is that something we can support or look at doing, having healthy menus plus the food provided at a lower cost? We would like to design these programmes with the communities and also supporting existing programmes.

- This is an excellent document and captures a lot of the complex research. Is there room to include specific interventions around sugar? We should consider doing something around the hidden sugar in foods. Most people don't actually know how much sugar they are consuming.

- Would it help if we aligned our plan to the World Health Organisation (WHO) recommendations for ending childhood obesity and the six domains of that, even using the same pictorial graphics will make things simpler? It has been very well researched and evidenced based, we don't need to reinvent the wheel. They are strong on the environment part as well. If we aligned with the WHO document it will strengthen our work here.

- Education of health providers e.g. GPs, Midwives, Nurse Practitioners, Plunkett Nurses the document lacks some specifics on how we may go about it. We need to be better in educating our providers on nutritional aims. The literacy of some of our health providers needs to be improved.

- The document name - should it be healthy lifestyle rather than healthy eating, it is about activity as well as eating? Caroline McElnay advised Northland have a programme called fit for life which we can't copy.

- Tom Rath's book "are you fully charged" comes to mind and other books like it looking at the psychology behind having people focus on having full energy for the course of their day rather than focusing on am I getting less fat.

The next step is the plan will go through to the other committees for feedback then it will come back to Clinical Council for endorsement before going to the Board in May.

SECTION 4: REPORTING COMMITTEES

8. URGENT CARE ALLIANCE QUARTERLY UPDATE

Graeme Norton advised a significant part of this work is in progress, going through EMT and is subject to strict control around what is happening. The RFP is being developed now and will go out by the end of April.

Suggestion that it would be helpful in the Advanced Practitioner Workforce to see some allied health people involved as well as nursing. Also, it was discussed at EMT yesterday that whatever the concept model, the key to its success will be providing an option for consumers that is at least as attractive as the current ED option and how that is being built into the discussions. The Chair advised that is an ongoing process and because of a potential conflict of interest he has stepped down and Liz Stockley is the owner of this process.

9. RADIOLOGY SERVICES COMMITTEE

The Chair advised there has been no feedback from ACC regarding the out of area investigations.

Radiology ultrasound guidelines is on the primary care education programme and there will be an education session in July to update people about rational use of ultrasound. One of the issues for the radiology department are the number of referrals for ultrasound.

Malcolm Arnold queried if there has been much of an impact with CT colonoscopy, as he is now vetting every request. The standard of referral is abysmal e.g. one line referrals. The electronification of referrals will make things better in many respects and clinical judgement actually has to be stated on the basis of facts rather than supposition.

Question whether there had been any discussion in the committee about the national maternity monitoring group who have put specific requests around the use of ultrasound in pregnancy and the volumes which have quadrupled. Some consultants are working on the template, equally the level of referral in terms of information is poor.

10. LABORATORY SERVICE COMMITTEE

Kiri Bird not at the meeting to talk to the report. Report taken as read.

There is an ongoing issue of clinicians getting inappropriate feedback in their in-boxes. This is an issue that Information Services is trying to fix. Privacy and patient risk issues of results not going to the right clinician.

Various quality groups based in the laboratory need to report up through the Laboratory Committee through to the Clinical Council. The most pressing issue is the IANZ recommendations with the 16 corrective action requests. We are working through all of the corrective action requests, there are two which we will need to continue to report to IANZ. Major work to histology and the histology department - the DHB has agreed additional funding for histology to make that happen; and the other outstanding issue is making sure we have appropriate medical microbiology support for the microbiology function.

As we evolve our clinical governance structure we will accept more from the committee in terms of monitoring the quality of what is going on in radiology and laboratory because ultimately we are the governance body that is responsible for keeping tabs on issues across the sector in terms of quality, effectiveness and access. They need to be coming to us via those committees.

11. CLINICAL ADVISORY GOVERNANCE GROUP

Reports for February and March taken as read.

No feedback from members.

12. CLINICAL PATHWAYS COMMITTEE UPDATE

The Chair commented that two items are in amber and two are green. The ones we have good control over and the process of developing the guidelines are green. The ones that require more technology and regional support etc are amber. The key concern with the pathways is to ensure they make clinical sense and ensure that they are being utilised appropriately.

SECTION 5: FOR INFORMATION / DISCUSSION

13 AIM 24/7 QUARTERLY UPDATE

The AIM 24/7 is currently in stage 2. The current focus is in four core areas:

1. Integrated Operations Centre
2. Management of the deteriorating inpatient – establishment of a hospital wide nurse lead "patient at risk service"
3. AAU Model of care – addressing the recommendations of the TAS AAU review
4. Matching workforce to demand

A query was raised whether primary care was part of the process in the review of AAU? John Gommans confirmed that the reviewer met with Mark Peterson. One of the big problems was the model was flawed, how we implemented it and the resourcing to do that, the governance of it and the governance structure needs to bring in ED and primary care.

The Chair queried what is happening with the TAS report? John Gommans advised that it is with the directorate team to turn the recommendations into reality.

14. TRANSFORM AND SUSTAIN REFRESH (DRAFT)

Report taken as read. Mark Peterson advised there are only two or three projects which are yet to commence. There are still lots to finish.

15. PRIORITISATION PROCESS PRELIMINARY DISCUSSION

The Chair welcomed Peter Kennedy to the meeting to discuss the prioritisation process for investment bids which will take place next month. This is a piece of work that allows the Clinical Council to have a say on where our new money goes.

For 2016/17 there is $2M available for new investment. Currently there is a list of 33 requests totalling around $8M. The task of Clinical Council is taking the list of requests and coming up with a recommendation to the Board on where that money is best invested. Peter Kennedy spent time taking the Clinical Council members through the scoring criteria and the process that needed to be completed prior to the meeting in May.

John Gommans commented that the discussion on the day around the table makes the difference and the collective wisdom on how it was achieved. It is important to remember that you are not there to represent your area, but a group of collective wise heads. It is important to keep that in mind otherwise you are disadvantaging people who are not around the table. That is where the tool and the collective scoring of the group comes into play.

The Clinical Council members must complete independent grading of proposals and send them back to Peter Kennedy by Monday, 2 May.

Any issues with using the tool contact Peter Kennedy.

SECTION 6: RECOMMENDATION TO EXCLUDE THE PUBLIC

16. RECOMMENDATION TO EXCLUDE THE PUBLIC

Recommendation by The Chair to move to the public excluded section of the meeting.

Approved.

The meeting closed at 4.50 pm

Confirmed: _____
Chair

Date: _____

HAWKE'S BAY CLINICAL COUNCIL
Matters Arising – Review of Actions
(PUBLIC)

Action No	Date issue raised	Action to be Taken	By Whom	By When	Status
1	10/2/16	***Clinical Council Member Portfolios*** Members to email Ken/Brenda with areas of interest to be added to the plan.	All	Apr	
2	9/3/16	***Alternative Health Provider*** (**Complementary Therapies Policy)** New draft Policy reviewed under item 8 "Draft Complementary Therapies Policy". Revised version considering feedback to be provided for sign off.	A Phillips	?	Timing to be advised
3	13/4/16	***Customer Service Training*** Contact to be made with Jeff Petrie re: information on sessions to be placed on PHO Portal.	M Peterson	May	

HB CLINICAL COUNCIL WORKPLAN 2016-2017

Title of the Paper	Council meeting date	EMT Member
HB Health Sector Leadership Forum	**17 MAY Venue: Waipatu Marae 8.30am-3.00pm**	
Youth Health Strategy (FINAL)	**8-Jun-16**	Caroline
Suicide Prevention Plan Update prior to MOH CFA website	8-Jun-16	Caroline
NEW Patient Safety and Experience Dashboard Q3 Jan-Mar 16)	8-Jun-16	Kate
Health and Social Care Networks Update (Mar-Jun-Sept-Dec-Mar 17)	8-Jun-16	Liz
Te Ara Whakawaiora / Oral Health	8-Jun-16	Sharon
Food Services Internal Review - FINAL	8-Jun-16	Sharon
IS Review/Restructure Update Qtly Update - June + Sept + Dec 16	8-Jun-16	Tim
Final Annual Plan and COI	8-Jun-16	Tim
Infection Prevention Control Committee - Quarterly / reporting from June 2016	8-Jun-16	Chris
HB Nursing Midwifery Leadership Council Update (June-Oct))	8-Jun-16	Chris
Urgent Care Monthly Project Report (provided to PMO)	8-Jun-16	Liz
Endoscopy/Gasto Build - Project Build Update (FRAC request 30/3/16)	8-Jun-16	Sharon
Alcohol (DISCUSSION)	**13-Jul-16**	Caroline
DRAFT Developing a Person Whanau Centred Culture	13-Jul-16	Kate
AIM 24/7 Update (Quarterly -Apr/July/Oct/Feb17 /Apr17)	13-Jul-16	John G
Quality Annual Plan (same time as "Governing for Quality")	13-Jul-16	Kate
Governing for Quality (same time as "Quality Annual Plan")	13-Jul-16	Kate
Transform and Sustain Refresh (Final)	13-Jul-16	Tim
HB Integrated Palliative Care (discussion draft)	13-Jul-16	Tim / Mary
Urgent Care Alliance Update Quarterly (Apr/Jul/Oct/Feb 17)	13-Jul-16	Liz
Radiology Services Committee	13-Jul-16	Mark
Laboratory Service Committee (March July November, March 17)	13-Jul-16	Mark
CAG Report (meeting on 14 June 2016) – written due 4 July	13-Jul-16	Mark / Chris
Renal Stage 4 - seeking guidance	13-Jul-16	Sharon
DRAFT Quality Accounts (annual) - coordinate for issue same time as Annual Report	**10-Aug-16**	Kate
ICU Learnings	10-Aug-16	Kate
Event / Complaint / Hazard / Risk Management System	10-Aug-16	Kate
Travel Plan - verbal	10-Aug-16	Sharon
Annual Maori Plan Q4 Apr-Jun 16 Dashboard	10-Aug-16	Tim / Tracee

Urgent Care Monthly Project Report (provided to PMO)	10-Aug-16	Liz
Clinical Pathways Committee (4 monthly Apr-Aug-Dec-Apr 17)	10-Aug-16	Mark
CAG report (meeting on 26th July 2016) – no report this month - combined aug/sept	10-Aug-16	Mark / Chris
Operation Productivity Update	10-Aug-16	Sharon
Orthopaedic Review - phase 2 DRAFT	**14-Sep-16**	Andy
Family Violence - Strategy Effectiveness - for noting	14-Sep-16	Caroline
Alcohol (DRAFT)	14-Sep-16	Caroline
FINAL Developing a Person Whanau Centred Culture	14-Sep-16	Kate
FINAL Quality Accounts (annual) -	14-Sep-16	Kate
NEW Patient Safety and Experience Dashboard Q4 (Apr-Jun 16)	14-Sep-16	Kate
Health and Social Care Networks Update (Mar-Jun-Sept-Dec-Mar 17) Board6monthly	14-Sep-16	Liz
HB Integrated Palliative Care (Final)	14-Sep-16	Tim
IS Review/Restructure Update Qtly Update - June + Sept + Dec 16	14-Sep-16	Tim
Falls Minimisation Committee Update (Mar-Sept)	14-Sep-16	Chris
Maternity Clinical Governance Group Update (Mar-Sept	14-Sep-16	Chris
Infection Prevention Control Committee (Sept-Dec-Mar-Jun)	14-Sep-16	Chris
DRAFT Serious Adverse Events (annually)	14-Sep-16	Kate
Urgent Care Monthly Project Report (provided to PMO)	14-Sep-16	Liz
CAG Report (meeting on 6 September 2016) – tabled/verbal	14-Sep-16	Mark / Chris
Alcohol (FINAL)	**12-Oct-16**	Caroline
HB Nursing Midwifery Leadership Council Update (June-Oct))	12-Oct-16	Chris
AIM 24/7 Update (Quarterly -Apr/July/Oct/Feb17 /Apr17)	12-Oct-16	John G
FINAL Serious Adverse Events (annually)	12-Oct-16	Kate
Urgent Care Alliance Update Quarterly (Apr/Jul/Oct/Feb 17)	12-Oct-16	Liz
Radiology Services Committee	12-Oct-16	Mark
Te Ara Whakawaiora / Smoking (national indicator) - same dates as Tobacco Plan	**9-Nov-16**	Caroline
Tobacco - Annual Update on Progress against the Plan (for noting) - same as TAW	9-Nov-16	Caroline
Travel Plan (Quarterly updates from May 16 - May/Aug/Nov/Mar17) VERBAL	9-Nov-16	Sharon
Annual Maori Plan Q1 Jul-Sept 16 Dashboard	9-Nov-16	Tim / Tracee
Allied Health Professions Forum	9-Nov-16	Andy
HB Clinical Research Committee Update (May-Nov)	9-Nov-16	John G
Urgent Care Monthly Project Report (provided to PMO)	9-Nov-16	Liz
Laboratory Service Committee (March July November, March 17)	9-Nov-16	Mark
CAG Report (meeting on 11 October 2016) - written due mon 31 OCT	9-Nov-16	Mark / Chris
Endoscopy/Gasto Build - Project Build Update (FRAC request 30/3/16)	9-Nov-16	Sharon

HBDHB Workforce Plan - Discussion Document (Dec 16 - final in March 17)	**7-Dec-16**	John McK
NEW Patient Safety and Experience Dashboard Q1 (July-Sept 16)	7-Dec-16	Kate
Health and Social Care Networks Update (Mar-Jun-Sept-Dec-Mar 17)	7-Dec-16	Liz
IS Review/Restructure Update Qtly Update - June + Sept + Dec 16	7-Dec-16	Tim
Infection Prevention Control Committee (Sept-Dec-Mar-Jun)	7-Dec-16	Chris
Urgent Care Monthly Project Report (provided to PMO)	7-Dec-16	Liz
Clinical Pathways Committee (4 monthly Apr-Aug-Dec-Apr 17)	7-Dec-16	Mark
CAG Report (meeting on 29 November 2016) – tabled/verbal Rpt DUE 30 NOV	7-Dec-16	Mark / Chris
Renal Stage 4 FINAL FOR ENDORSEMENT	7-Dec-16	Sharon
Orthopaedic Review - phase 3 DRAFT	**8-Feb-17**	Andy
Annual Maori Plan Q2 Oct-Dec 16 EMT version goes into committee papers	8-Feb-17	Tim / Tracee
AIM 24/7 Update (Quarterly -Apr/July/Oct/Feb17 /Apr17)	8-Feb-17	John G
Radiology Services Committee	8-Feb-17	Mark
Urgent Care Alliance Update Quarterly (/Feb -May 17)	8-Feb-17	Liz
NEW Patient Safety and Experience Dashboard Q2 (Sept-Dec 16)	**8-Mar-17**	Kate
Health and Social Care Networks Update (Mar-Jun-Sept-Dec-Mar 17) Board6monthly	8-Mar-17	Liz
Travel Plan (Quarterly updates from May 16 - May/Aug/Nov/Mar17) VERBAL	8-Mar-17	Sharon
Falls Minimisation Committee Update (Mar-Sept)	8-Mar-17	Chris
Maternity Clinical Governance Group Update (Mar-Sept)	8-Mar-17	Chris
Infection Prevention Control Committee (Sept-Dec-Mar-Jun)	8-Mar-17	Chris
Urgent Care Monthly Project Report (provided to PMO)	8-Mar-17	Liz
Laboratory Service Committee (March July November, March 17)	8-Mar-17	Mark
AIM 24/7 Update (Quarterly -Apr/July/Oct/Feb17 /Apr17)	**12-Apr-17**	John G
Urgent Care Monthly Project Report (provided to PMO)	12-Apr-17	Liz
Clinical Pathways Committee (4 monthly Apr-Aug-Dec-Apr 17)	12-Apr-17	Mark
HB Clinical Research Committee Update (May-Nov)	**10-May-17**	John G
Urgent Care Alliance Update Quarterly (/Feb -May 17)	10-May-17	Mark
Orthopaedic Review - closure of phase 2	**8-Jun-17**	Andy
Orthopaedic Review - closure of phase 3	8-Jun-17	Andy
NEW Patient Safety and Experience Dashboard Q3 (Jan-Mar 17) MAY	8-Jun-17	Kate
Infection Prevention Control Committee (Sept-Dec-Mar-Jun)	8-Jun-17	Chris
HB Nursing Midwifery Leadership Council Update (June-Oct))	8-Jun-17	Chris

OURHEALTH HAWKE'S BAY Whakawateatia	**Urgent Care Alliance Update**
	For the attention of: **HB Clinical Council**
Document Owners:	Liz Stockley Project Sponsor and Graeme Norton, Chair
Document Author:	Jonathan Amos (Project Manager)
Reviewed by:	n/a
Month:	May, 2016
Consideration:	For Information

12

RECOMMENDATION

That Clinical Council:

Note the contents of this report.

Attached is the latest Project Progress Report for the Urgent Care Alliance

Key highlights of this report include:

Following approval by board an Urgent Care Services Change Request for Proposals is now live. The registration of interest (ROI) process for providers closed on the 21st March and we are happy to report that we had enough providers registered to proceed with an RFP on the 29th April 2016.

RFP timeline

Provisional date of supplier briefing session	6pm	23/05/16
Deadline for Proposals:	Noon	29/07/16
Respondents' presentations		15/08/16
Provisional date of Evaluation panel recommendation		05/09/16
Provisional date of Panel recommendation approved		13/10/16
Anticipated Contract start date (subject to negotiations)		01/03/17

See overleaf for planned activities for remaining and new work streams:

- Oral Health
- Advanced Practitioner Workforce
- Aged Residential Care
- Greater Treatment in Pharmacies

HAWKE'S BAY District Health Board

Project Status Report

Project Name:	Urgent Care – Implementing change in Hawke's Bay
Project Manager:	Jonathan Amos
Sen Res Owner **Project Sponsor**	Mark Peterson Graeme Norton

Date of Progress Report	May 2016
Project Start date	March 2015
Planned Finish Date	December 2016

STATUS SUMMARY

Project Performance Dimensions Key	***Traffic Light Status Key***	**Time Status**	**Financial Status**	**Overall Status**
Time: *Meeting milestones on time as planned* ***Financial:*** *and/or Project Budget Expenditure Savings is on track* ***Overall:*** *Expect to achieve the goal and benefits*	***Red = R:*** *Off Track* ***Amber = A :*** *Generally on track _ minor issues* ***Green = G****: On track*	**G**	**G**	**G**

Summary Comment	Following approval by board an Urgent Care Services Change Request for Proposals is now live. The registration of interest (ROI) process for providers closed on the 21st March and we are happy to report that we had enough providers registered to proceed with an RFP on the 29th April 2016. **RFP timeline** Provisional date of supplier briefing session 6pm 23/05/16 Deadline for Proposals: **Noon 29/07/16** Respondents' presentations 15/08/16 **Provisional date of Evaluation panel recommendation 05/09/16** **Provisional date of Panel recommendation approved 13/10/16** Anticipated Contract start date (subject to negotiations) 01/03/17 Other Urgent Care work streams progress is shown on timeline below

Planned Activities next period	Urgent Care RFP briefing session for registered providers is provisionally being held on the 23rd May. Ongoing communication updates for progress of RFP and effects for stakeholders. See below for planned activities for remaining and new work streams: • Oral Health • Advanced Practitioner Workforce • Aged Residential Care • Greater Treatment in Pharmacies

	Urgent Care Project - Outline timeline for UCA consideration												
		January	February	March	April	May	June	July	August	September	October	November	December
1	**Urgent Care Health services Change Proposal**	ROI / Feedback underway	Face to Face Meetings	RFP developed / Feedback ends / Registration ends	RFP finalised / RFP Evaluation Group formed / RFP issued	RFP out with providers / RFP Briefing Session held with registered providers	RFP out with providers	RFP ends	RFP Evaluation Group meets to consider proposals	RFP Evaluation Group makes recommendations	Decision Paper on recommendations	Negotiation and contracting / Plan for implementation	Negotiation and contracting / Plan for implementation
2	**Oral Health**		Oral Health Group met review options	Cost options narrowed / Pathway work / MSD work	Onoging - Pathway work / MSD work	Business Case preparation	Decision on Business Case - UCA / Next years budget bids	Handover to group	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Completion Report			
3	**Public Communication**	Monitor website usage	Review success of campaign	Handover ongoing responsibility for Choose Well / Agree KPI / UCA Monitoring	Ongoing budget agreed	Completion Report							
4	**St John service provision**	UCA reviewed the progress to date on this work stream and made a decision to suspend unitl further notice from St John											
5	**Transport Assistance**	UCA Handover / DHB decision taken to support strategic review	UCA to support review	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Handed over to Strategic Services								
6	**Support Pathways**	UCA Handover to engAGE working group	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Handed over to engAGE Steering Group									
7	**Timely Access to Data**	UCA Handover to Information services	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Handed over to Information Services									
8	**Advanced Practitioner Workforce**		Met with Nurse Midwife Leaders Council and asked them to help recruit more nursing staff to form a sustainable workstream		Stakeholder Group established / Set Principles	Develop Options	Develop Options	Decision paper drafted / Establish if a business case is required	Decision paper	UCA Handover to Nursing and Midwifery Leadership Council	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Completion report	
9	**Aged Care Residential**				Review Aged Care Residential priority with UCA	Explore progress made against priority with Aged Residential Care stakeholders / Potentially Set Principles	Develop Options	Decision paper drafted / Establish if a business case is required	Decision paper	UCA Handover to UNKNOWN	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Completion report	
10	**Greater Treatment in Pharmacies**		Attended Pharmacy forum / Establishing Work Stream Group		UCA agreed to postpone progress of work stream until after Pharmacy contract signing in June		Set up group / Set Principles	Develop Options	Decision paper drafted / Establish if a business case is required	Decision paper	UCA Handover to Proposed Pharmcy Leadership group	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Completion report
11	**Affordable Access**			Review evidence of priority area so far	UCA decision to build into RFP weighting and criteria alongside recommendation that affordability be considered in all future major health sector programmes								

HAWKE'S BAY District Health Board

Project Status Report

MILESTONE UPDATE

Agreed Milestone Plan as per TOR	Planned Finish Date	% Complete	Key Achievements this period
Project start up and planning • Project TOR signed off • Urgent Care Alliance TOR signed off • Work Breakdown Structure / Timeline drafted • Stakeholder analysis and Comms Plan/ Website • Risk Plan • Benefits Plan • Project Budget • Project Plan acceptance	April 2015	100%	• Project TOR signed off • Key documents are live and being updated. o Risk Plan o Timeline o Stakeholder Analysis • It was agreed by UCA Chair that Comms Plan would be developed alongside work streams • Project Budget bid approved in principle. Each work stream to produce a costed proposal against budget for final approval by UCA/EMT/Clinical Council. • It was agreed with Project Assurance that Benefits Plan would be ongoing
Staged work plan development • Establish UCA Stakeholder Group • Produce UCA Principles document • Produce criteria to be mapped in co-design of service solutions • Review previous solutions • **Workshop with UCA and other stakeholders to develop a staged work plan including stage 1 and 2 solutions that will inform project plan over length of project** • Develop a consultation model for co-design of solutions. • Deliverables acceptance	May 2015	100%	• Staged work plan completed and endorsed by EMT/Clinical Council
Stage 1 – Planning and implementation • Staged implementation of service and community focused solutions o Resources engaged for stage one o Refine stage one implementation plan o Acceptance of stage one implementation plan o Stage one implementation	December 2015	100%	▪ Staged work plan completed and endorsed by EMT/Clinical Council ▪ First Work Streams up and running ▪ Year End Report completed – Work Streams being handed over to business as usual or brought forward into Stage 2 (see chart)
Stage 1 Completion and Stage 2 Design and approval • Review stage one implementation and approve stage two	December 2015	100%	• Year-end report approved by governance process
Stage 2 – Planning and Implementation • Staged implementation of service and community focused solutions o Resources engaged for stage two o Refine stage two implementation plan o Acceptance of stage two implementation plan • Stage two implementation	December 2016	20%	• Staged work plan completed and endorsed by EMT/Clinical Council • Stage 2 Work Streams being started February 2016
Communication • Communication plan to be developed, followed and updated throughout the lifecycle of this project (Effective/Appropriate/Timely).	Ongoing - December 2016	40%	• It was agreed by UCA Chair that Comms Plan would be developed alongside work streams
Project closure • Project completion evaluation sign off.	December 2016		•

HAWKE'S BAY District Health Board

Project Status Report

RISK MANAGEMENT: *up to date each month including your action plan to minimise these risks and issues.*

Current Risks or Issues of Note	Planned Actions to reduce the Impact or Likelihood
Public consultation does not support the level of change	Communication planning and testing of material Use of UCA Stakeholder Group to enable positive change with Service Providers Use of Expert Panel to support delivery of key messages at community forums
Hawke's Bay Communities will potentially have concerns due to perception that they are losing services	Communication plan with agreed response including: • focus on patient concerns • supplementary meetings with key stakeholders • expert panel to be involved in discussions UCA/Project Manager to jointly develop solutions with consumers and services directly invested in these areas and ensure high levels of communication and seek guidance from Clinical Council / HB Alliance. May involve the development of separate projects / business cases where appropriate
Urgent Care Alliance Membership Changes	Project Manager ensures that there is a process supported by the UCA to select new members and Project Manager/Chair of UCA is responsible for bringing any new members up to speed.
Project deliverables deadlines missed	Due to the complex first time nature of some of the deliverables it may be that some are delayed. Robust project monitoring in place. Alongside project escalation of any issues/problems incurred to Project Board and beyond for resolution.
DHB/PHO Health Alliance break up	Alliance principles stated in signed Health Alliance agreement. This is not a binding contract and can be dissolved by either party.
Communication plan doesn't have a desired effect as specified in plan itself	Project board and Stakeholder group sign off of the Communications plan. Latest techniques (where evidenced) in world-wide medicine copied and utilised where appropriate. Active monthly review to ensure all stakeholders are engaged
Insufficient budgetary provision	Robust business case/s produced for solutions. A number UCA solutions will produce recommendations of reallocation of funding to fund further solutions elsewhere.
Insufficient link to HBDHB EMT	Allocation of EMT member to Senior Responsible Owner to ensure that reporting links to EMT maintained
Lack of visibility of proposed initiatives that have been removed	Project Manager to maintain database recording source and activity status of proposed initiatives
Lack of engagement from Primary Health Care providers	UCA Stakeholder Team formed to influence the design and implementation of the project initiatives Clinical Council / UCA Leadership Team and UCA Stakeholder Team member to encourage cross sector involvement of colleagues Communications plan to raise profile of Urgent Care Project and update all health sectors on monthly progress of initiative that affect them
Potential changes to the delivery of Urgent Care to the different models of primary service provision and subsequently the PHO and its board	The UCA Leadership has a senior PHO staff member and two GP's on the group who were chosen to represent these issues with any future decisions. We are ensuring that our papers are considered by the PHO EMT and Board.

HAWKE'S BAY District Health Board

Project Status Report

RISK MANAGEMENT: *up to date each month including your action plan to minimise these risks and issues.*

Current Risks or Issues of Note	Planned Actions to reduce the Impact or Likelihood
Engagement with Project SRO not sufficient to help him support the project at Governance levels	HBDHB EMT selected a new Senior Responsible Owner - Mark Peterson - Chief Medical Officer - Primary. He is actively involved in the project Project manager and Project Sponsor to ensure that the new SRO is kept involved and informed of all progress to ensure that he is confident and can represent the project at the governance level

CHANGE CONTROL HISTORY *Note any formal requests for change to the agreed project TOR or Charter:*

Date of Request	Request Number	Description of Change	Status

Clinical Council Report

Clinical Advisory and Governance Committee

Date:	3 May 2016	Time:	5.30pm
Item	**Summary**		
1. Minutes and action register 1.2 Action register	Verbal update provided on the transferring of patients on Reandron from secondary care to primary care after process began in 2015. It was acknowledged that as PHARMAC fund a medicine on the Community Schedule and the patient is transferred from secondary care (free of charge) to general practice (charges incurred) there is an inequity risk with potential for further increase with proposed changes to the pharmacy contract for expensive medicines. Request from CAG to write a paper to Clinical Council for sector wide discussion.		
3. Correspondence **3.1 Correspondance In** 3.1.1 Medication Safety Watch April 16	Methotrexate - HQSC guidance is that only 2.5mg strength is prescribed; however there is prescribing of 10mg methotrexate in Hawke's Bay including local specialists. Request from CAG to raise at Pharmacy and Therapeutics Committee meeting. Suggestion was that Chair write to specialist prescribing 10mg for clarification as to why HQSC recommendation is not being followed.		
4. Decision papers 4.1 Clozapine 4.2 Specimen Labelling Issues Report (SCL) 2015 4.3 Brief Update	Endorsed a change in contract to reflect Medsafe change that GPs no longer required to be vocational registered. Dr Simon Shaw provided questions he had and which CAG provided guidance on answers to these. CAG stressed importance of annual GP education and audit. Endorsed paper and acknowledged quality improvement activity planned for 2016/7 around specimen labelling. Acknowledged that samples identified as being from General Practice could have been labelled by general practice staff, the patient or staff from Age Related Residential Care facilities. Endorsed sharing individual practice information with practice managers. Endorsed for sharing with Clinical Council and general practice teams. **FOLLOWS**		
5. Discussion papers 5.1 Significant Events Sharing-GP - failure to follow up abnormal blood results 5.2 System Level Measures	Presentation provided by Kaye Lafferty stimulated much discussion. Request from CAG that a letter be sent to the Chair of Clinical Council requesting sector wide discussion on the issues of test follow up. Discussion occurred around challenges when tests requested in secondary care. Request to share HDC case and references provided by Kaye to general practice via Practice managers and local GP peer groups, via RNZCGP. Request to obtain information from practices regarding current processes around test follow up for reporting back to CAG / Board. Request for guidance on sector wide discussion was provided suggesting discussion include: General Practice leadership, Nurse leadership, Clinical Council, Consumer Council, DHB – group coordinated by Wietske Cloo and DHB – Belinda: Health and Social Care Network.		
7. Information papers 7.2 HB Clinical Council 13 April 2016 – Clinical Pathways Update	Invitation from Dr Mark Peterson for ideas and guidance making Clinical Pathways more valuable in general practice.		

Agenda Item 4.3

Health Hawke's Bay – Te Oranga Hawke's Bay
Clinical Advisory and Governance Committee
Health Hawke's Bay Brief Updates
For Information

	Content/Comments	Management Lead
Transformation		
engAGE	ORBIT- Rapid response Allied Health team (PT, OT, SW) at ED/ AAU has been expanded from 3.0 to 6.0 FTE. This team are now covering 7.00am-7.00pm, 7 days a week (previously 8.00am-4.30pm, Mon-fri). Focus is on preventing unnecessary admissions to hospital for frail older people presenting to ED but not medically requiring admission. High utilisation rates during extended hours of service. First 4 months of service allowed 289 extra patients to be seen in the extended hours (after 4.30pm on weekdays and all day at weekends). Approximately 50% of these patients were discharged home following assessment with equipment, carer supports, follow up plan etc. ORBIT have also opened up to taking referrals from City Medical in order to negate the need for some older people to be transferred to ED. Initial referral rated low but good outcomes for patients eg. 85 year old male with fractured wrist who received ORBIT in-put at home in Napier, was provided with equipment and had carer supports arranged. Previously this patient would have been sent to ED as City Medical uncertain if he would cope at home following his injury. Plan in place to open up to referrals from St John from 18th April. It is envisaged that this will negate the need for some frail older people to be transported to ED and have ORBIT in-put in their home instead. Community MDTs- 6 MDTs now operating across Napier, Hastings, Taradale and Havelock North. Comprehensive MDT with representation from many disciplines and agencies. Engagement with most of the larger practices though variable per area. Work now needs to be done to engage with some of the smaller practices or look at how they can best be linked with the service. Work on-going to refine referral and triage processes and meeting structure to ensure best use of time. Monthly cross sector education sessions on health of older people to be provided. engAGE in ARRC- contract to provide both short and intermediate stay residential care services has been taken up by all 13 facilities that provide both hospital and residential care. Service rolled out to these facilities from 29th February with high rates of utilisation to date. Concern that number of facilities with the contract for short stay (previously CPO) now reduced but only one case of this causing an issue fed back to engAGE team leader since roll out. Paperwork developed. Plan to provide education to facilities on restorative model of care. Operational guidelines (manuals) for the service written for ARRC facilities, primary care and acute ward MDTs. Work on-going to refine referral processes for this services.	Sarah Shanahan
Quality		
Data Quality	MOH/DHBSS have recently stopped providing practice level CX and Imms data. The Health Intelligence team are working with Karo, NSU and NIR to obtain methodologies to report at practice level on these metrics.	Adrian Rasmussen
Clinical Programmes and Team updates		
Mental Health	HHB has contracted Chiplin Consultants to review the Primary Mental Health Services Programme. We are expecting the final report and recommendation for consideration – mid April 2016. The overarching objective of this review was to improve access and equity to mental health services in primary care; increasing scope of services; availability / effectiveness of resources; workforce development requirements; culturally safe and appropriate; consideration of needs for population age groups	Trish Freer
Diabetes	Health Intelligence Team has implemented an upgrade to the PMS Dashboard which has an increased focus on the quality management of	Trish Freer

	diabetes patients. This will move the emphasis from Diabetes Annual Reviews to the quality clinical indicators for the proactive management of patients with diabetes.	
Whānau Wellness	Health Hawke's Bay facilitated the first quarterly information session for Whānau from 6th – 8th April 2016. Day sessions were facilitated in Napier, Hastings and Wairoa. Although disappointed with the low number of whānau participants those who did attend found all sessions relevant and useful. All quarterly sessions were planned around Whānau identified needs via a Te Whare Tapa Whā Self-Assessment form that Whānau completed during Welcomes Sessions. The theme for this session was called Preparing for Winter. Presentations included: - Health Hawke's Bay's Healthy Homes (Insulation) Programme - HBDHB Rheumatic Fever Keeping and Maintaining a Health Home - The NZ Red Cross Curtain Bank - HBDHB Respiratory Clinical Nurse Specialist Sue Ward –Asthma management and common colds/flu prevention and step by step demonstrations on how to use an asthma inhaler correctly - HHB Promotion of Flu Vaccination, free to all WWRP Whānau over the age of 6 months - Patu Up – Exercise and Nutrition conversation with a Patu Up participant/trainer - The NZ Red Cross Community Resilience Based Programme	Lillian Ward
Health Literacy	6/6 online training modules are complete, and up loaded. HHB test the training programme prior to the online training programme being made available to general practice teams.	Lillian Ward
Social Workers in VLCA practices	Te Wahanga Māori Social Worker continues to work alongside of three of the four VLCA practices. No referrals have been received from one general practice however the provider continues to engage with this provider to encourage referrals. Wairoa VLCA practices are still to recruit A 0.5 Social Work position One Hastings and one Napier (non-VLCA) practice has advertised a 0.5 Social Work position Health Hawke's Bay are also in discussions to allocate another fulltime social worker for 4 other Napier (non-VLCA) practices One other Hastings VLCA practice has a dedicated 0.5 Social Worker and an additional VLCA practice has social work/navigation resource that equates to 0.8 FTE.	Lillian Ward
Steering Group Feedback		
Long-term Conditions	HBDHB Portfolio Manager for Strategic Services is leading the development of Long Term Conditions Leadership Team. Representation includes; general practice; specialist services; consumer representative(Chair); HHB; Wairoa Primary Care representative; HIT; Initially this group will have a focus on diabetes service development but progress to a wider approach for long term conditions.	Trish Freer
Palliative Care	The Palliative Care Integration Group has requested a business case be developed for consideration in a future funding round to support the Palliative Care Programme post June 2017. The current programme is funded from CarePlus reserves but no future reserves will be accrued post June 2017 to support this programme.	Trish Freer
Respiratory	The majority of practices have resumed the delivery of respiratory services since the announcement of dedicated funding in February 2016. A business case is being prepared for sustainable funding from the current HBDHB funding bid process.	Trish Freer

Health Hawke's Bay Staff Directory		
For further information on any of the above information please contact the indicated management lead or author:		
Nicola Ehau	nicola@healthhb.co.nz	06 871 5669
Trish Freer	trish@healthhb.co.nz	06 871 5655
Victoria Speers	victoria@healthhb.co.nz	06 871 5680
Di Vicary	Pharmacist@healthhb.co.nz	06 871 5663
Adrian Rasmussen	Adrian@healthhb.co.nz	06 871 5831
Lillian Ward	lillian@healthhb.co.nz	06 871 5661
Sonya Harwood	sonya@healthhb.co.nz	06 871 5653
Haley Petkovich	haley@healthhb.co.nz	06 874 5654

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

14

RECOMMENDATION

That MRB and Consumer & Clinical Councils:

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

OVERVIEW

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

BACKGROUND

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

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

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

What does the evidence show as effective?

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

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

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

What did the stakeholder and community input say?

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

HOW HAVE WE RESPONDED TO COMMITTEE FEEDBACK?

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

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

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

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

What are the planned objectives?

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

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

Best Start: Healthy Eating and Activity

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

2016-2020

May 2016

Table of Contents

Executive Summary

Best Start: Healthy Eating Plan

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

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

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

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

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

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

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

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

What is the situation we aim to change?

Increase the number of health weight children

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

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

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

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

What has been shown to work?

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

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

Context

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

International

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

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

National

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

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

Local

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

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

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

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

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

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

Evidence

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

Current data

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

14.1

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

Obesity impacts

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

Addressing childhood obesity

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Stakeholder and Community Input

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

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

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

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

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

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

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

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

Initiatives, approaches and key messages identified:

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

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

Māori Relationship Board Feedback

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

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

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

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

Alignment

Leadership is critical and all stakeholders needs to use their influence

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

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

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

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

Plan Framework

As outlined earlier, this Plan was informed by:

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

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

Guiding Values

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

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

Objectives

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

Objectives, Indicators and Actions

Objective 1: Increase healthy eating and activity environments

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

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

What the data shows

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

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

14.1

Objective 2: Develop and deliver prevention programmes

Indicator 2a: Rates of breastfeeding at 6 weeks increase

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

What the data shows

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

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

Objective 3: Intervention to support children to have healthy weight

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

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

What the data shows

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

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

Objective 4: Provide leadership in healthy eating

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

Indicator 4b: Engage support from key partners

What the data shows

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

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

Monitoring process

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

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

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

Data limitations:

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

Delivery mechanism

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

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

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

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

Appendices

Appendix A: Obesity Prevention Strategy

Summary document previously presented to HBDHB Board.

Appendix B: Stakeholder Feedback

Full report are available on request for:

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

Appendix C: Population Health Annual Plan

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

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

15

RECOMMENDATION

That MRB and Consumer & Clinical Councils:

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

SUMMARY

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

BACKGROUND

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

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

1. DHB values and behaviours e.g. customers feel respected
2. Effective customer engagement for good health outcomes
3. Customer participation and input e.g. when arranging appointment times, so responsive to their needs
4. Ease of understanding and navigation e.g. customers know how and who to contact about their appointment
5. Support mechanisms for staff to enable them to deliver an exceptional customer experience are in place
6. IS systems that support the outcomes identified to occur
7. A mechanism to monitor the system and ensure continuous quality improvement.

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

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

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

LAST UPDATE

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

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

PROGRESS TO DATE

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

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

1. IS Solution

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

2. Clinic Scheduling

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

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

The high level findings included:

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

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

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

3. Customer Focused Booking Training

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

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

Five workshops were conducted in early February with a total number of 49 staff participating. The workshop goals were to provide skills and techniques that are required to communicate in ways that will enhance patient satisfaction, the overall patient experience and the experience of staff. The workshop facilitators have experience working with health professionals and administration staff in a number of different health settings across New Zealand.

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

4. Text to Remind and Demographics

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

Next Steps

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

The provisional IS timeframe is provided below:

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

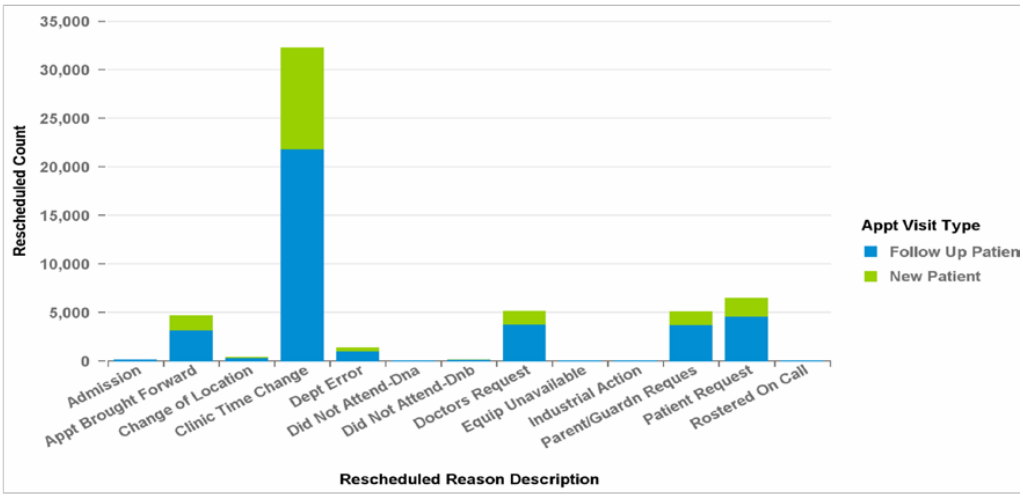
At time of the submission of this report it was anticipated that UBook would go live before the end of December 2016. One of the risks to achieving the go live date is gaining the necessary security clearance. The installation of UBook will be the first HBDHB experience of opening the DHBs IS patient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

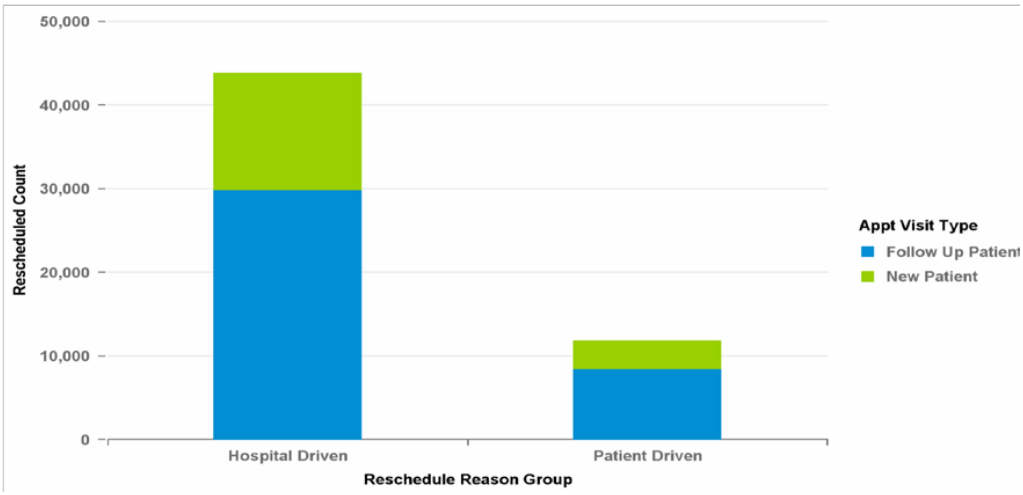
In parallel to the IS UBook work, the Clinic Scheduling project will commence with the aim of having a pilot speciality engaged and ready to be the first pilot for UBook outpatient booking in December.

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

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

Reason Grou
Hospital Drive
Patient Driver
TOTAL





Appendix Two: Customer Focused Booking Training – Participant Evaluation

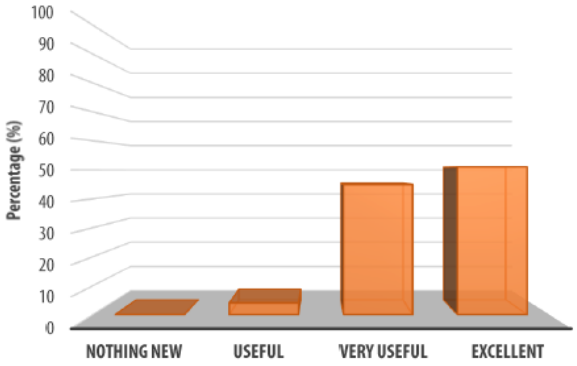
businesstraining NEW ZEALAND
MAXIMISING STAFF PERFORMANCE

Analysis of Participant Evaluations

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

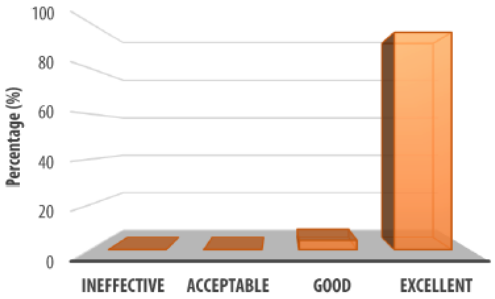
What did you think about the content of the workshop?	Nothing New	Useful	Very Useful	Excellent	Total Responses
No. of replies	0	2	22	25	49
Percentage	0	4	45	51	100

Thoughts on Workshop Content

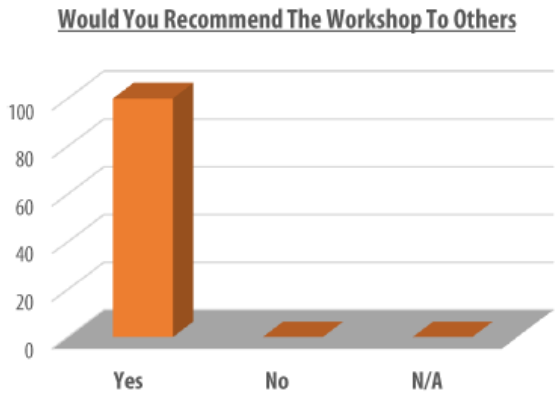


What was your impression of the facilitator?	Ineffective	Acceptable	Good	Excellent	Total Responses
No. of replies	0	0	2	46	48
Percentage	0	0	4	96	100

Impressions of Facilitator



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



15

HAWKE'S BAY District Health Board Whakawāteatia	**Quality Accounts – 2016**
	For the attention of: **Maori Relationship Board (MRB), Clinical and Consumer Council**
Document Owner:	Kate Coley, Director Quality Improvement & Patient Safety
Reviewed by:	Executive Management Team
Month:	May, 2016
Consideration:	For Information

RECOMMENDATION
That MRB and Consumer & Clinical Councils:

Note the contents of this report.

OVERVIEW

The publication of 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. Since that time HB health sector has published three sets of accounts detailing our performance against both national and local quality and safety indicators.

The accounts are intended to be an accessible assessment of quality in all health care services, and whilst they should contain detailed performance information in text and graph form, the audience is our community and therefore we need to be cognisant of avoiding overly technical specifics. The guiding principles are:-

- Accountability and transparency
- Meaningful and relevant whole of system outcomes
- Continuous quality improvement

This reports outlines a high level overview of the proposed content of our Quality Accounts for 2015/16, the working group membership and a provisional timeframe. The accounts need to be provided to the HQSC by the end of December 2016 however this year the intention is that these are published at the same time as our annual accounts.

BACKGROUND

In July 2012 the Health Quality and Safety Commission (HQSC) published its guidance manual to assist District Health Boards (DHBs) to prepare their own Quality Account documents. Quality Accounts are annual reports to the public from DHBs about the quality of services they deliver and should be viewed with the same level of intensity as our annual accounts.

The primary purpose of Quality Accounts is to encourage boards and leaders of health care organisations to assess quality across all of the services they offer. It allows leaders, clinicians, governors and staff to demonstrate their commitment to continuous, evidence-based quality improvement, and to explain their progress to their local community.

In December 2013 the Hawke's Bay DHB endorsed the Quality Improvement and Safety Framework, "Working in Partnership for Quality Health care in Hawke's Bay". This framework was developed in partnership between the HB Clinical Council and HB Health Consumer Council and aligned to our Transform and Sustain Strategy and Health Inequity report and continues to inform the focus for our Quality Accounts on an ongoing basis.

FEEDBACK ON HB QUALITY ACCOUNTS 2015

Annually the HQSC reviews all Quality Accounts providing feedback individually to DHB's and across New Zealand. This review provides an opportunity to compare our accounts with others, and identify opportunities and ideas for subsequent publications. The review considers the contents of each account, how successfully the account communicated with its intended audience and how it sets out the quality vision for the future. Feedback from HQSC was again very positive on our last year's accounts, with only minor comments around greater explanation of our future priorities. Appendix 1 provides a copy of the full feedback.

QUALITY ACCOUNTS OVERVIEW AND LAYOUT

The Quality Accounts are predominantly aimed at our community and therefore the aim is to keep them as short as possible, be visual, simple to read and understand, using photo's, images, stories, quotes, and examples to enhance the results and achievements. It is envisaged that the accounts will be no longer than 40 pages.

In regards to developing this year's accounts we have reviewed all the feedback from HQSC on all other DHB quality accounts, viewed all the accounts and considered how we might incorporate some of the positive aspects from others into our next account. The aim is to maintain the current format and flow of the document, focussing on improvements, innovations at the front with performance indicators in the latter stages.

Below provides an overview of the key sections and some examples/ideas for the content of the Quality Accounts for 2015/16:

Section 1: Introduction, setting scene, summarising HB system and challenges, strategic intent

- Opening statements jointly written by Chairs of Boards, Consumer and Clinical Council – aligned to our vision, values and quality framework
- Snapshot – a day in the life or a year in the life of our health sector system, e.g. number of ED presentations, births, discharges, district nursing visits, immunizations, patient meals etc.
- Health Profile – reminder of the health inequities within HB and the health profile challenges
- HB Demographics – map, age profile, deprivation etc.
- Executive Summary – summarising all of the quality and patient safety activities, progress against the QIPS Framework.

Section 2: Updates on Priorities identified in 2015 accounts

- Patient Experience Survey – show results, common themes, responding to complaints – you said – we did… potentially bring in Travel Plan
- Development of Consumer Engagement strategy, co-design, working together examples
- Heath Literacy progress and priorities
- Customer Focussed booking & National Patient flow
- Urgent integrated care
- Updates on Obesity, Rheumatic fever, suicide prevention and smokefree
- Inequities update.

Section 3: Service Improvements, Quality initiatives, cross sector and consumer engagement

Primary Care and each directorate to provide an overview of key facts/activities, results, achievements, and areas of focus for 2016/17 which align to their service plans. This allows us to showcase the improvement initiatives, investments, interactions and engagement with consumers.

For example: Acute & Medical – AIM 24/7 work, Urgent Care programme, Radiology productivity, Faster Cancer treatment progress
Older Persons & Mental Health – engAGE, Mental Health further changes
Women, Children & Youth – New build, cross sector working, change to models
Oral, Rural & Community – Wairoa Health Centre, CHB developments, DN / GP Roll out
Primary Care/Cross sector – clinical pathways, introduce health & social care networks
Electives – Operation Productivity, Ortho/MSK programme of work
Maori Health – initiatives, programmes, dashboard progress
Pasifika health – initiatives underway

Section 4: Performance and indicators

Performance Review – National Health Targets progress and IPIF Performance
Quality Indicators – focus will be on why they are important, results, achievements and future focus

- HQSC/Open Campaign targets – progress and initiatives
- Serious Adverse Events/HDC – learnings & improvements

Section 5: Future Focus/Priorities & Feedback

As in the past this section should summarise our key areas of focus, aligning them to the QIPS framework – e.g. Wellness, Peoples Experience of Health Care, Working with the People of HB and Leadership

Proposed Focus areas for 2016/17 : Implementation of a Health Literacy Framework, Quality Improvement Programme of Work; development of health & social care networks; wellness strategies e.g. obesity, youth; urgent care alliance; Consumer Engagement strategy; developing capability of our teams in improvement and co-design

COMMUNICATION STRATEGY

In 2015, 500 copies of the accounts were printed and distributed across the Hawkes Bay including community health providers, GP Practices, rural locations, Libraries, District Council offices and Maori Health providers. This was at a cost of $2,500 and it is recommended that we continue to print and distribute across our community in 2016.

In addition last year we considered developing specific information posters to share and summarise key information from the accounts, and this year this will be part of the communication strategy alongside utilising Quality Boards which are found in each of the Clinical / Patient areas.

The account will also be shared through our website, Facebook and publicised through adverts in the local free papers.

NEXT STEPS

As has been the practice in the past a working group will be established to support the development and review of the accounts. This will consist of the following individuals/groups:

- Consumer Engagement Manager
- Improvement & Innovation Team leader

- Communications / Publications design
- Consumer Council representatives (2)
- Chief Pharmacist
- Allied Health leaders (2)
- Primary Care representatives (2)
- Maori Health representative (2)
- Service Director
- Nurse Director
- Medical Director
- Population Health representative
- Business Intelligence (QIPS)
- Head of Planning
- Head of Strategic Services

TIMELINE

Activity	**Responsibility**	**Date**
Establishment of Working Group	Consumer Engagement Manager	End April
Liaison with Services and gathering of data and information	Working Group	May – June
First Draft – Completed	Consumer Engagement Manager	Early July
First Draft – Reviewed and amended	Working Group	By mid-July
Draft – Review & Feedback	EMT MRB Clinical Council Consumer Council Clinical Advisory Group HB Board HHB Board	26 July 10 August 10 August 11 August TBC 31 August TBC
Design drafted	Communications	Mid-August
Final Review & endorsement	Clinical Council Consumer Council Clinical Advisory Group	14 September 15 September TBC
Endorsement	HBDHB Board HHB Board	28 September TBC

Appendix 1 – Feedback from HQSC

DHB06	*Hawke's Bay*
Opening statements	• Your opening statements are well-expressed, and the *akina* definition sets a constructive tone. • The DHB map and population infographics do the job very well (p.6). • The NZ Triple Aim (p.7) is rather loosely paraphrased, but gets the message across.
Performance review	• We look forward to hearing about your progress in reducing inequity in due course (p.9). • Congratulations on your DNA reduction achievements, particularly the major drop in the rate for the Pacific community (p.13). • Your consumer focus (p.14–16) is commendable. Could space have been found for specific patient stories? • The focus on family violence intervention in primary care is welcome (p.21). Has it been shared with other DHBs? • The health target information (p.34–35) has been given an impressive amount of space, but it could be a little clearer what each result was, rather than just indicating that the target has been met. Your QSM page does this well (p.38). • Your adverse events break-down is useful (p.37), but you could add value by indicating what particular lessons have been learnt from the events and what changes have resulted.
Future focus	• Your future focus page (p.41) mentions some interesting priorities for the coming year, but could explain key goals in a bit more detail.
Readability	• A well-written, smartly-produced QA.
Comment	• Good use of photography too.

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

RECOMMENDATION

That MRB and Consumer & Clinical Councils and FRAC:

Note the contents of this report.

17

OVERVIEW

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

BACKGROUND

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

Project Goal Phase Two

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

Planned transition arrangements included:

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

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

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

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

Clinical integration of the medical gastroenterology and interventional gastroenterology teams

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

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

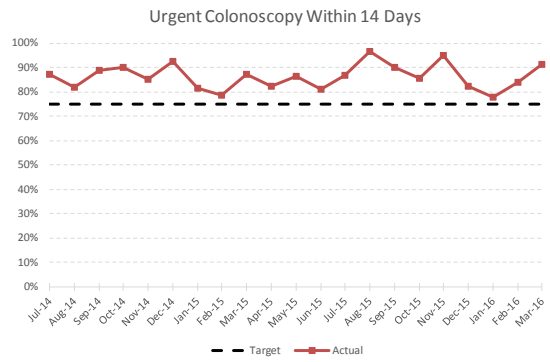
The gastroenterologist consultant work force is below full capacity currently and there are additional resources to be released as per business case. The credentialed scope of the roles is confirmed and gaps in capacity will be addressed with recruitment. Additional consultant capacity will be essential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

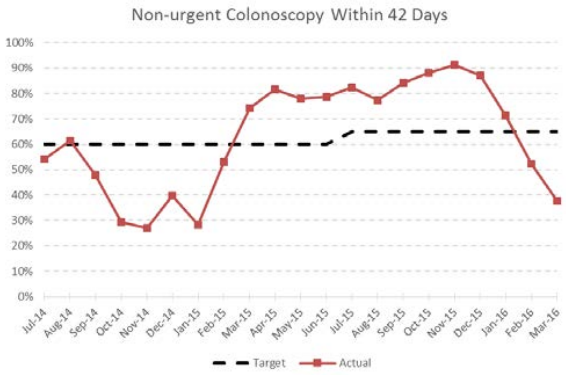
The proposed national bowel screening four year pilot (2012-2015) at Waitemata DHB has been extended until December 2017. This pilot is providing essential information that will help determine if a bowel screening programme should be rolled out nationally. Information from the Waitemata DHB bowel screening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

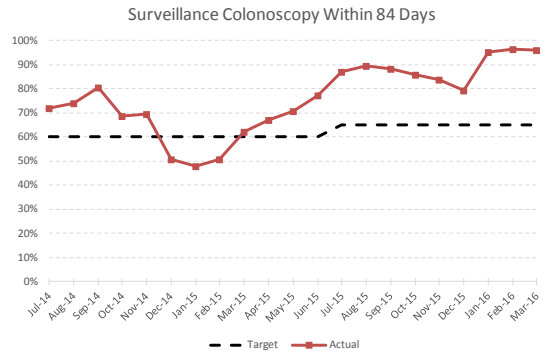
Service provision and model to meet increasing demand and health targets.

- **Health Targets**

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







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

Actual Colonoscopy volumes compared to Business case

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

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

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

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

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

- **Referral management**

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

- **Bowel preparation**

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

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

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

Review development of joint working with the private sector.

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

Confirm the RFP process for utilisation of latent capacity.

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

CONCLUSION

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

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

RECOMMENDATION

That MRB and Consumer & Clinical Councils :

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

OVERVIEW

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

BACKGROUND.

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

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

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

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

19.1

Creating Healthy Opportunities for Youth 2016 – 2019

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

OUR VISION

"HEALTHY HAWKES BAY"

"TE HAUORA O TE MATAU-A-MAUI"
Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community.

OUR VALUES / BEHAVIOURS

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

OUR GOALS FOR YOUTH

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

OUR OUTCOMES FOR YOUTH

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

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

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

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

CONTENTS

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

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

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

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

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

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

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

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

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

Five Outcomes to achieve by age 15 for healthy development:

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

Youth in the Hawke's Bay report healthy is

Feeling supported and accepted

Positive relationships with parents and connections with others

Good headspace

Positive influences

Independence

Taking responsibility

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

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

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

Case scenarios: 'everyday life for some teens'

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

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

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

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

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

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

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

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

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

"Support 100% and work together "

"Walk the Talk and Take Action"

Pacific Youth

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

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

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

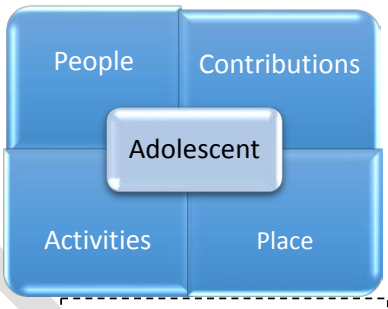
The strategy acknowledges "organisations need to work together with a focus on prevention, recognizing that good health begins in places where we live, learn, work and play long before medical assistance is required".

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

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

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

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



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

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

PCAP – A Model for Promoting Youth Health & Development

Adolescents need to be connected to:

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

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

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

19.1

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

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

New Zealand Research

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

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

NZ Research

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

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

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

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

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

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

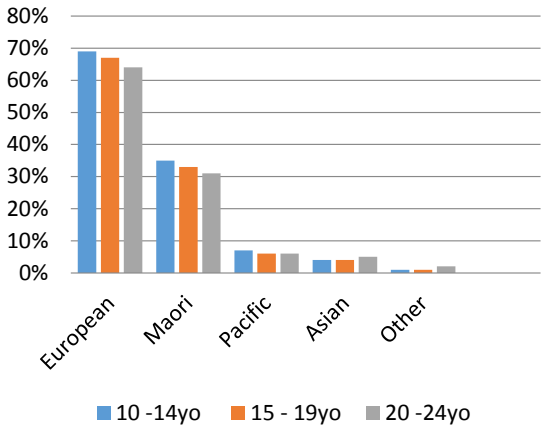
1. Hawke's Bay Region Census Data 2013:

Table 1: Demographics of Youth

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

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

Table 2: Ethnicity



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

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

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

Stakeholders feedback

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

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

19.1

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

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

The general trends show:

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

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

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

Implications for health services:

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

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

Young people report barriers to accessing services

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

Youth Focus Groups & Pacific Youth Survey 2016

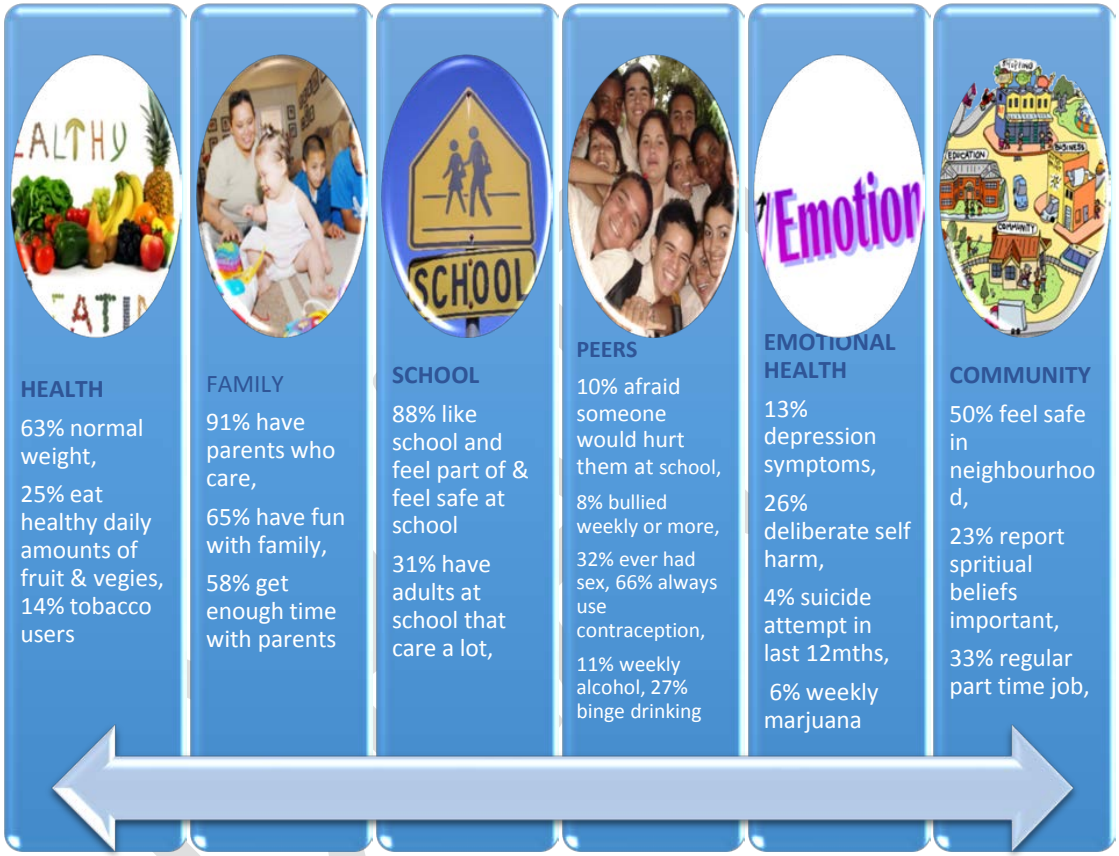
The health system must adapt to the needs of adolescents and their needs reside as much in preventive medicine as they do in curative medicine

– Michael Cohen

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

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

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



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

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

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

19.1

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

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

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

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

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

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

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

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

Implications for health services:

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

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

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

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

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

Professor Robert Blum recommends:

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

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

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

   (Barber and Stoltz, 2005)

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

   (Kirby & Cole)

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

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

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

1. Positive Youth Development in NZ (PYDA)

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

The framework outlines:

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

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

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

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

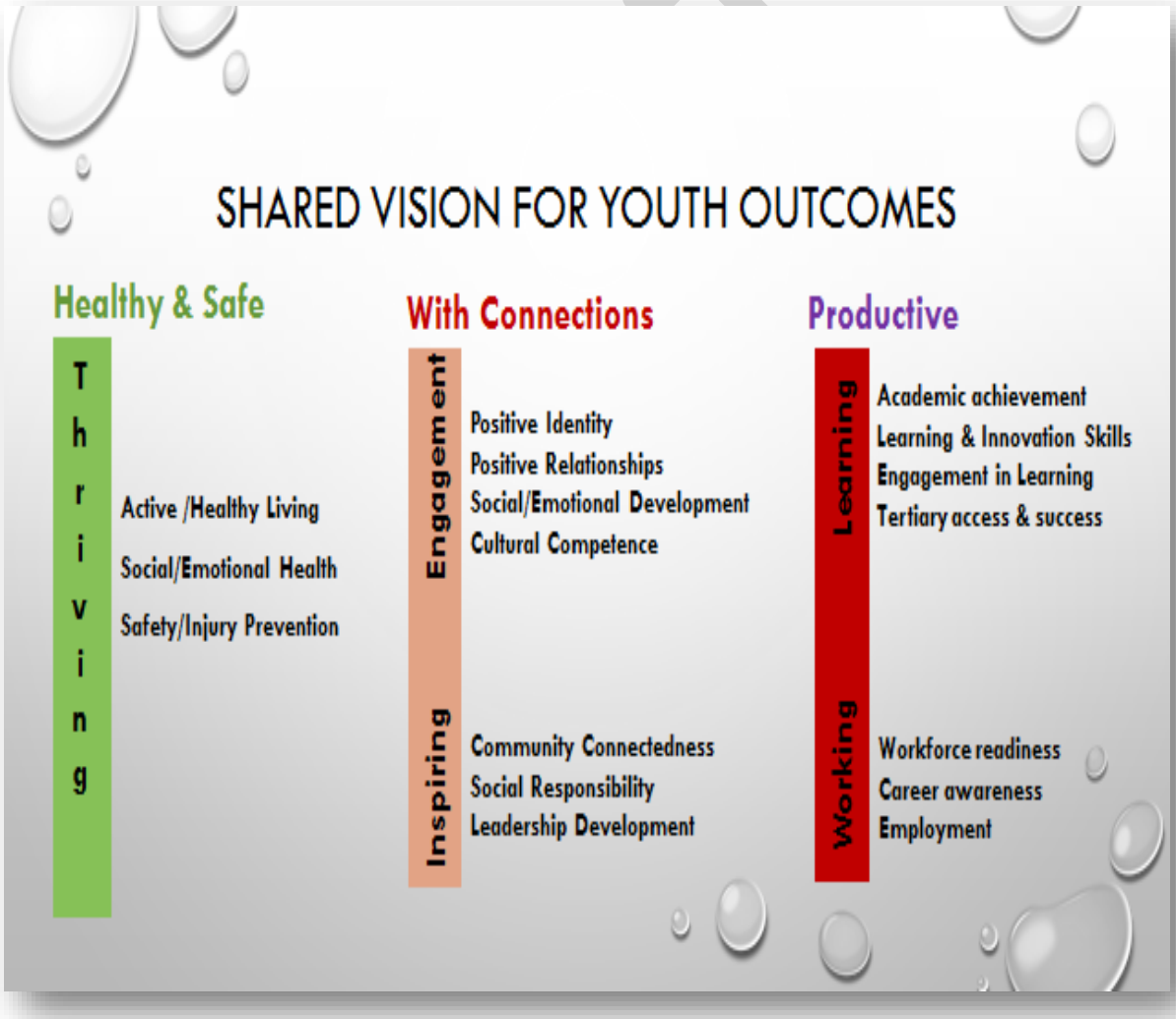
This is even more critical when we focus on vulnerable youth. Because "problem-free is not fully prepared, and fully prepared is not fully engaged". It is dangerous to be caught in the "fix then develop" fallacy. This argument holds that we must address problems facing young people who are vulnerable,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

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

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

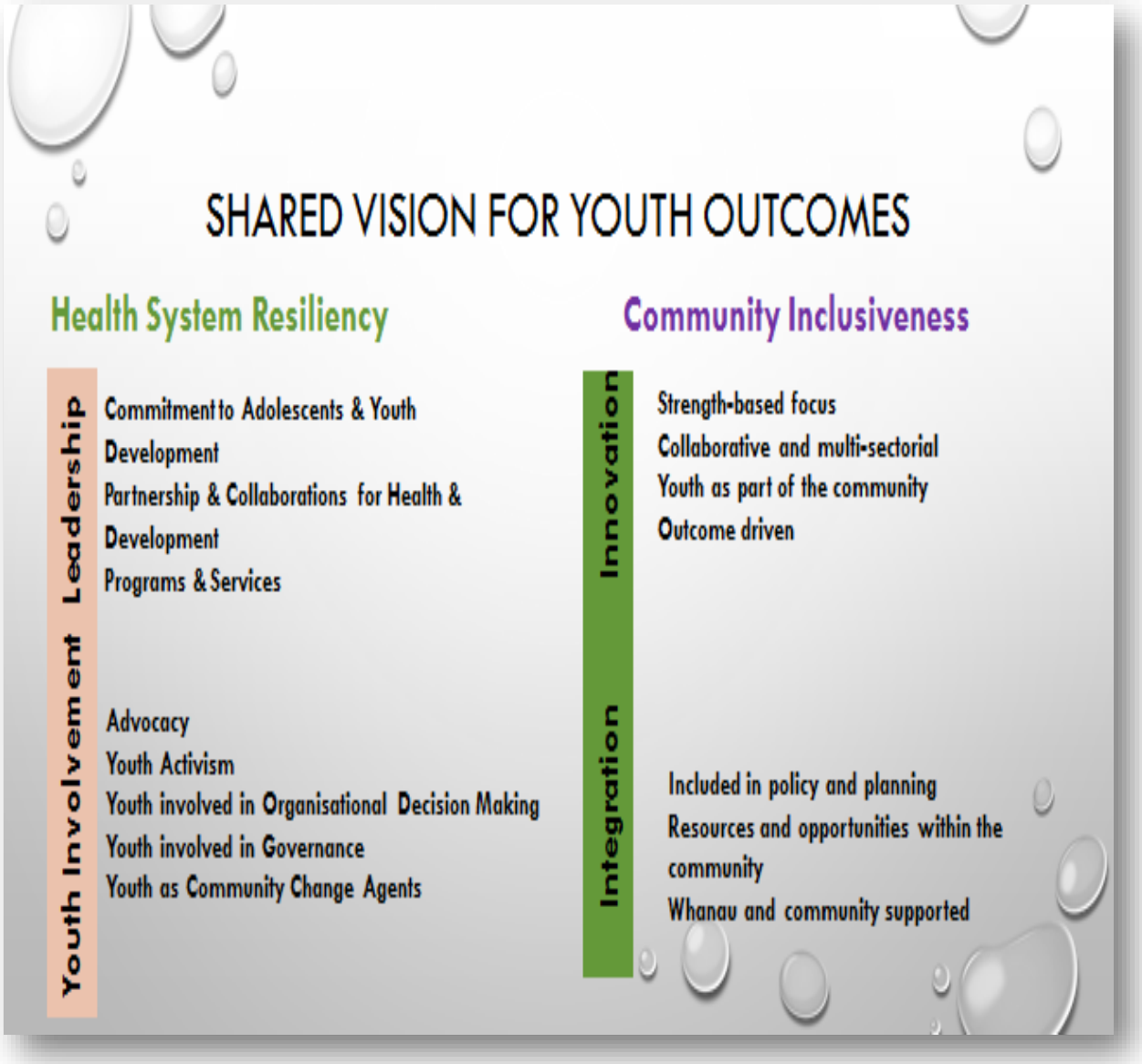
This Strategy aims to articulate a shared vision for young people by identifying a common set of youth outcomes and indicators that cuts across the work of many organisations/services working with youth. Though there are commonalities in how organisations/services talk about their goals and impact, the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

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



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

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



19.1

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

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

19.1

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

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

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

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

19.1

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

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

19.1

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

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

19.1

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

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

19.1

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

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

19.1

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

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

19.1

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

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

19.1

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

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

19.1

Sources of NZ Information

The Adolescent Health Research Group (AHRG)

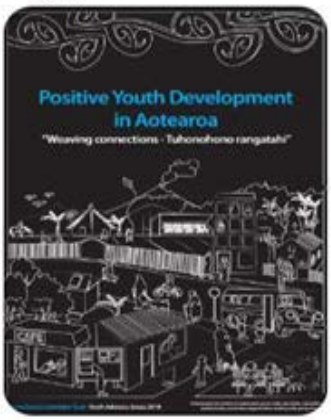
Youth2000 survey series

Christchurch and Dunedin Longitudinal Studies

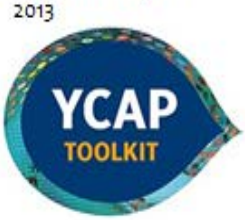
And more.....
The Pathways to Resilience Project (Massey)
The Collaborative (ChCh)
.....

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

2011



Vulnerable/ high risk - 2013



A resource manual for Primary Care - 2014

To be completed

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

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

RECOMMENDATION

That MRB and Consumer & Clinical Councils :

Note the contents of this report.

OVERVIEW

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

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

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

WHY IS THIS INDICATOR IMPORTANT?

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

FIGURE 1

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

ANZACS QI

Registry Completion Quarterly Report - Apr 2016

Central Region DHBs

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

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

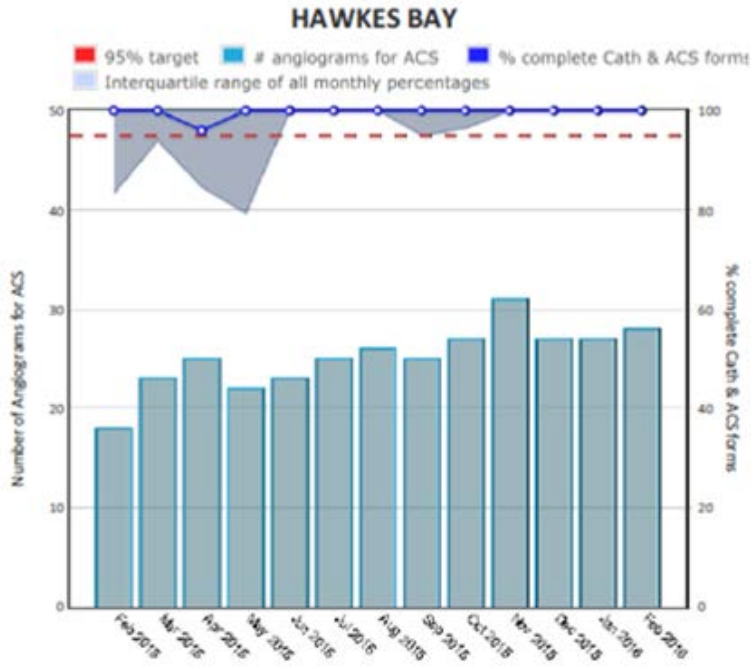


FIGURE 2

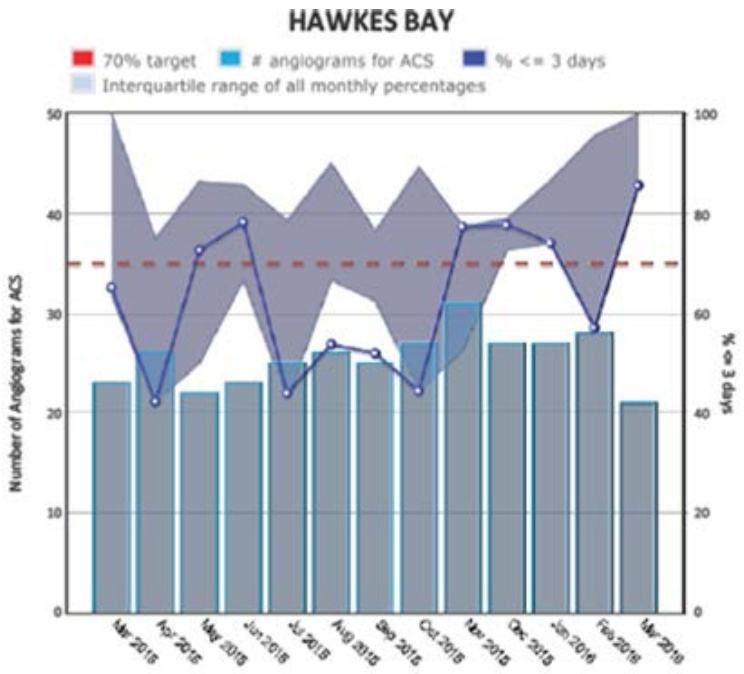
% of Patients Who Receive an Angiogram within 3 days of Admission

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

Central Region DHBs

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

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



20

MĀORI PLAN INDICATOR:

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

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

HAWKES BAY

2015/2016 Q3 (Dec 2015 - Feb 2016)

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

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

HAWKES BAY

2015/2016 Q3 (Jan 2016 - Mar 2016)

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

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

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

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

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

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

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

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

Strategies to improve compliance to the data registry indicator included:

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

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

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

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

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

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

RECOMMENDATIONS FROM TARGET CHAMPION

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

CONCLUSION

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

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Māori Health Plan Q3 (Jan-Mar 2016) Dashboard**
	For the attention of: **HB Clinical Council and HB Health Consumer Council**
Document Owner(s):	Tim Evans and Tracee Te Huia
Document Author(s):	Patrick Le Geyt, Programme Manager Māori Health Justin Nguma, Senior Health & Social Policy Advisor Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Not applicable
Month:	May 2016
Consideration:	For Monitoring

RECOMMENDATION

That the Clinical Council and Consumer Council:

Note the contents of this report.

CONTENTS OF THE REPORT

This is a report on:

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

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

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

KEY FOR DETAILED REPORT AND DASHBOARD

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

PERFORMANCE HIGHLIGHTS

Achievements

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

Areas of progress

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

Challenges

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

Please note:

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

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

Access to Care
PHO Enrolment and ASH rates

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

Child Health
Breastfeeding rates (3m)

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

Immunisation

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

Rheumatic Fever

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

Oral Health

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

SUDI

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

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

Time Series Key:
- Target
- Actual

Cardiovascular Disease

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

Cancer

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

Smokefree

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

Mental Health & Addictions

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

Maori Workforce

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

Cultural Responsiveness

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

Te Ara Whakawaiora Priorities

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