HB Clinical Council Meeting

Date: **Wednesday, 14 November 2018**

Meeting: **3.00 pm to 5:30 pm**

Venue: **Te Waiora Meeting Room (Boardroom), District Health Board Corporate Office, Cnr Omahu Road & McLeod Street, Hastings**

Council Members:

Dr John Gommans (Co-Chair)
Dr Andy Phillips (Co-Chair)
Chris McKenna
Dr Mark Peterson
David Warrington
Dr Robin Whyman
Lee-Ora Lusis
Dr Daniel Bernal
Jules Arthur
Dr David Rodgers
Dr Russell Wills
Debs Higgins
Anne McLeod
Dr Peter Culham
Dr Nicholas Jones

Apology: Andy Phillips

In Attendance:

Kate Coley, Executive Director - People and Quality (ED P&Q)
Ken Foote, Company Secretary
Tracy Fricker, Council Administrator / EA to ED P&Q
Ana Apatu, Māori Relationship Board Representative

Public

Item	Section 1 – Routine	Time (pm)
1.	Welcome and receive apologies	3:00
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	

5.	Clinical Council Board Report for October 2018	
6.	Workplan(s): 6.1 Annual Plan 2018-19 6.2 Monthly Workplan	3:10
	Section 2 – For Discussion / Decision	
7.	Clinical Services Plan (Summary of changes and feedback) – Ken Foote	3:30
8.	Health Equity Report – Andy Phillips, Nick Jones and Jess O'Sullivan	3:45
9.	Collaborative Pathways Update – Chris Ash, Penny Rongotoa & Mark Peterson	4:15
10.	Advance Care Planning – Colin Hutchison, Allison Stevenson	4.25
	Section 3 – Reporting Committees to Council	
11.	Clinical Advisory & Governance Group Update – Chris McKenna	4:35
12.	Council Committees Reports	4:40
	Section 4 – For Information (any feedback email document owners)	
13.	Scoping Report - Addictions	-
14.	Best Start Healthy Eating & Activity Plan update (6 monthly)	-
15.	Clinical Portal Project Update	-
16.	Te Ara Whakawaiora "Smokefree update" (6 monthly)	-
17.	Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator)	-
18.	Clinical Council Meeting dates for 2019	-
19.	**Section 5 – Recommendation to Exclude the Public**	4:50

Public Excluded

Item	**Section 6 – Routine**	
20.	Minutes of Previous Meetings	
21.	Matters Arising – Review Actions	
	Section 7 – For Discussion	
22.	Radiology Facility Development Business Case – Colin Hutchison, Paula Jones & Janet Heinz	4:55
23.	Election of Chair / Co-Chair – Ken Foote	5:15
24.	Topics of Interest – Member Issues / Updates	5:20

Next Meeting: Wednesday, 5 December 2018 4-6pm in the Corporate Boardroom

Interests Register

10 Oct 2018

Hawke's Bay Clinical Council

Name Clinical Council Member	Interest e.g. Organisation / Close Family Member	Nature of Interest e.g. 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 Care)	Taradale Medical Centre	Shareholder and Director	General Practice	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
	Family member employed by HBDHB since November 2015	Daughter, RMO	Will note interest if discussions occur around RMOs.	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
	Primary Health Alliance	Executive Member	Primary Care advocacy organisation	Yes	Low
	Council of Medical Colleges	Royal New Zealand College of General Practitioners representative and Council of Medical Colleges Executive	May impact on some discussions around medical training and workforce, at such times interest would be declared.	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)	Director of IMSANZ	The IMSANZ represents the interests of specialist General Internal Medicine physicians throughout Australia and New Zealand	Yes	Low
Jules Arthur (Midwifery Director)	National Midwifery Leaders Group	Chair	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	
	NZ College of Midwives	Member	A professional body for the midwifery workforce	No	
	Central Region Quality and Safety Alliance	Member	A network of professionals overseeing clinical governance of the central region for patient quality and safety.	No	
David Warrington (Nurse Director - Older Persons)	The Works Wellness Centre	Wife is Practitioner and owner	Chiropractic care and treatment, primary, preventative and physiotherapy	Yes	Low
	National Directors of Mental Health Nursing	Member		No	Low
Dr Tae Richardson (GP and Chair of Clinical Advisory & Governance Committee)	Loco Ltd	Shareholding Director	Private business	No	
	Clinical Advisory & Governance Committee (CAG) for Health HB (Tenure ends 27/06/18)	Member	Report on CAG meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Ministry of Health - First Specialist Assessment Oversight Group	Member		No	
	Locum General Practitioner			No	
Dr Andy Phillips (Chief Allied Health Professions Officer)	Health Systems Performance Insights Programme	Chair	Improving Health System Performance	No	
	The Health Foundation (UK)	Member of College of Assessors	Improving Health System Performance	No	
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
	City Medical	Director and Shareholder	Medical Centre	Yes	Low. Provides services in primary care
	National Advisory Committee of the RNZCGPs	Member and CP Teacher	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)	Eastern Institute of Technology (EIT)	Lecturer - Nursing	Education.	No	

Name **Clinical Council Member**	**Interest** **e.g. Organisation / Close Family Member**	Nature of Interest **e.g. 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**
	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	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	
Dr Russell Wills (Community Paediatrition)	HBDHB Community, Women and Children and Quality Improvement & Patient Safety Directorates	Employee	Employee	Yes	Potential, pecuniary
	Wife, Mary Wills employed as General Manager of Presbyterian Support East Coast	Employee	Presbyterian Support East Coast provide services within the HB and are a contractor to HBDHB	Yes	Potential, pecuniary
	Paediatric Society of New Zealand	Member	Professional network	No	
	Association of Salaried Medical Specialists	Member	Trade Union	Yes	Potential, pecuniary
	New Zealand Medical Association	Member	Professional network	No	
	Royal Australasian College of Physicians	Fellow	Continuing Medical Education	No	
	Neurodevelopmental and Behavioural Society of Australia and New Zealand	Member	Professional network	No	
	NZ Institute of Directors	Member	Professional network	No	
Lee-Ora Lusis (Clinical Nurse Manager, Totara Health)	Totara Health and Choices Kahungunu Health Services	Employee	Clinical Nurse Director	Yes	Potential, pecuniary
	Hawke's Bay Primary Health Nurse Practitioner Group	Member / Nurse Practitioner Intern	Professional network	No	
	Hawke's Bay Nurse Leadership Group	Member	Professional network	No	
	College of Nurses Aotearoa (NZ)	Member		No	
	Fusion Group Committee	Representative		No	
	ED High Flyers	Representative		No	
	Totara Health / Youth Contract with Directions	Employee of Totara Health			
	Kidney Health Australia - Caring for Australasians with Renal Impairment	Member		No	Guidelines group - involved with the group "Management of chronic kidney disease among Aboriginal, Torres Strait Islander Peoples and Maori".
Dr Nicholas Jones (Clinical Director - Population Health)	NZ College of Public Health Medicine	Fellow	Professional network	No	
	Association of Salaried Medical Specialists	Member	Professional network	No	
	HBDHB Strategy & Health Improvement Directorate	Employee	Employee	No	
Dr Peter Culham (GP)	Havelock North Properties Limited	Shareholder	Medical Centre owner	Yes	Low, pecuniary, hold leases with healthcare providers
	Te Mata Peak Practice	GP and Director	General Practice	Yes	Low, pecuniary, provides primary care services
	C&G Healthcare	Director	Private business	No	No further exposure beyond mentioned above
	Royal NZ College of General Practitioners	Fellow		No	
Daniel Bernal	New Zealand Hospital Pharmacists Association	Member	Discussion	No	
	Pharmaceutical Society of New Zealand	Member	Access their resources, record my CPD on their website.	No	

MINUTES OF MEETING FOR THE HAWKE'S BAY CLINICAL COUNCIL HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE ON WEDNESDAY, 10 OCTOBER 2018 3.00 PM

PUBLIC

Present:
Dr John Gommans (Chair)
Dr Andy Phillips (Co-Chair)
Dr Robin Whyman
Dr David Rodgers
Dr Peter Culham
Debs Higgins
Jules Arthur
Dr Daniel Bernal
Dr Russell Wills
Lee-Ora Lusis
Anne McLeod
David Warrington

In Attendance:
Ken Foote, Company Secretary
Kate Coley, Executive Director – People & Quality (ED P&Q)
Dr Kevin Snee, Chief Executive Officer *(from 3.35 pm)*
Tracy Fricker, Council Administrator and EA to ED P&Q

Apologies: Chris McKenna, Dr Mark Peterson and Dr Nicholas Jones

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Dr John Gommans (Chair) welcomed everyone to the meeting. Apologies were noted as above and from attendee member Ana Apatu.

Dr David Rodgers introduced Dr Jess Cooper, GP Registrar who attended the meeting as an observer. Roundtable introductions took place.

2. INTEREST REGISTER

No conflicts of interests were noted for agenda items.

3. MINUTES OF PREVIOUS MEETING

The minutes of the HB Clinical Council meeting held on 12 September 2018, were confirmed as a correct record of the meeting.

Moved and carried.

4. MATTERS ARISING / REVIEW ACTIONS

Item #1 Investments Update (Outcomes of Budget Prioritisation)
No further update. Discussion to be had at November meeting.

Item #2 Violence Intervention Programme
The Chair advised that discussion has taken place with Cheryl Newman. A one page update and reminder for DHB clinical staff has been developed. Debs Higgins has also spoken with Cheryl Newman regarding the primary care pathway.

Item #3 Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs
Key issues sent to Jill Garrett. Time to be allocated for further discussion at the November meeting.

Item #4 Health Awards Shortlisting
Clinical Council members allocated for each category to undertake the shortlisting process and provided to Anna Kirk. *Item can now be closed.*

Reminder shortlisting needs to be with Communications Team by end of day 11 October.

5. WORKPLAN

The workplan was provided in the meeting papers for information.

The Chair noted two significant items for discussion at the November meeting, being the Clinical Services Plan and the Health Equity Report.

It was also noted that there is more work to be done on the Bowel Screening Programme – Indicative Equity Outcome for Maori and Pasifika report before it comes to Council.

SECTION 2: PRESENTATION

6. QUALITY DASHBOARD

Kate Coley, Executive Director - People & Quality provided a presentation on the draft dashboard which included the principles of having it align with the Institute of Medicine; be across sector, keeping it simple and not to over complicate at the start, and that it will evolve overtime.

The draft dashboard will go to the Clinical Effectiveness and Audit Committee for them to work with business intelligence to look at how to get the data for the dashboard.

The draft "starter for 10" dashboard was discussed. Feedback from members included adding population health indicators; quality of care for people with disabilities and healthy aging. The need to show outcome indicators rather than process or output indicators, and that there may be a mix of monthly, quarterly and annual indicators was also discussed.

Council endorsed the format of the dashboard with the domains of quality and sectors.

Action: ***Draft dashboard to be sent to members to provide further feedback. Draft dashboard to then be sent to Clinical Effectiveness & Audit Committee as a 'starter for 10".***

SECTION 3: DISCUSSION

7. CONCEPTION TO FIVE YEARS INCLUDING THE FIRST 1000 DAYS

The Chair welcomed Shari Tidwell, Health Intersector Development Manager and Charrissa Keenan, Health Gains Advisor to the meeting. It was noted that the scope of the report was widened to look further than the first 1,000 days and be from pre-conception to 5 years, to

support wellbeing with a holistic approach, be culturally responsive and working with whanau to co-design innovative programmes.

Following discussion the Chair summarised that Council supported the rationale to extend the report to five years but that focus should not be lost on the critical first 1,000 days period. It was also pleasing to see a report that Council had initiated.

Council **supported** recommendations 1 to 5 in the report.

SECTION 4: REPORTING COMMITTEES TO COUNCIL

8. CLINICAL ADVISORY & GOVERNANCE GROUP (CAG)

The minutes from the last CAG meeting were provided in the meeting papers for information. Anne McLeod advised that there are three new GPs on CAG, who provided excellent comment at the meeting.

The Chair noted that there continues to be a vacancy on Clinical Council for a CAG member and new membership provides an opportunity to address that. This is under discussion with the chair of CAG.

9. PROFESSIONAL STANDARDS & PERFORMANCE COMMITTEE

This Chair advised that this was the first Committee of Council to provide a report under the new governance structure. The purpose of the committee is to provide assurance to Council that the essential requirements of credentialling, accreditation, professional standards, clinical standards, training and research as being done well.

Medical credentialing is working well with good engagement between meetings. The Nursing and Allied Health group had progressed their business by exchange of emails but had not met for 18 months, the group has new membership and held a meeting last week and has caught up on outstanding work. A process for multi-disciplinary credentialling of departments has not yet been resolved and this is not done well nationally. It is suggested that external reviews may be the most appropriate means to achieve this. Currently primary care is not linked into this advisory group.

The Clinical Research Advisory Group have good engagement with agencies working in the research sector. There was one issue with a private research facility, which has been resolved and communication channels re-established.

The report provided summarised the first year of activity.

General discussion held regarding having a credentialing schedule for all departments. As a starting point, work needs to be done in the directorates to identify what services have been reviewed and what is missing. There is also a need to look at maintenance of department credentialling once identified. In primary care, GP practices have Foundation Standard and some also have Cornerstone Accreditation.

Clinical Council **noted** the report.

Action: ***Professional Standards and Performance Committee to coordinate a register and schedule of departmental scheduling***

SECTION 5: FOR INFORMATION ONLY

10. HAVELOCK NORTH GASTROENTERITIS OUTBREAK (FINAL)

The paper was provided for information only. Kate Coley advised that this is the third update since the outbreak 18 months ago. The majority of the actions have now been closed or incorporated into other pieces of work.

11. CLINICAL PORTAL PROJECT UPDATE

The paper was provided for information only. No issues discussed.

12. TE ARA WHAKAWAIORA - CARDIOVASCULAR (NATIONAL INDICATOR)

The paper was provided for information only. No issues discussed.

13. SECTION 6: RECOMMENDATION TO EXCLUDE THE PUBLIC

The Chair moved that the public be excluded from the following parts of the meeting:

14. Minutes of Previous Meetings (public excluded)
15. Matters Arising – Review Actions
16. Cardiology Review and plan of action
17. Annual General Meeting Minutes, Actions and Workplan
18. Topics of Interest – Member Issues/Updates

The meeting closed at 3.57 pm.

Confirmed: _____
Chair

Date: _____

4

HB CLINICAL COUNCIL - MATTERS ARISING (Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	11/04/18	***Investments Update (Outcomes of Budget Prioritisation)*** • Paper and presentation to be provided	A Phillips	Dec	Deferred
2	08/08/18	***Violence Intervention Programme*** • Pathway details to be provided to guide clinicians. • Clinical Leaders (CMDO, CNMO, CAHPO and CMO (Primary) to discuss how to influence clinicians to screen for family violence: - HOD Meeting - Nurse Directors Meeting	C Newman J Gommans C McKenna	TBC Oct	Actioned - memo sent to clinical staff 12/10/18 Topic on agenda in the New Year
3	08/08/18	***Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs*** • Key issues to be sent to Jill Garrett • Paper to be dicussed further at a future meeting (Quarterly update due in November)	All members All members	Sep Nov	November Agenda Item
4	12/09/18	***Quality Dashboard*** Draft dashboard "starter for 10" to be sent for for feedback (for 2 weeks). Draft Dashbaord "starter for 10" to be sent to Clinical Effectiveness & Audit Committee following member feedback	All members K Coley	Deadline 26/10/18	Emailed 11/10/18 TBC
5	12/09/18	***Clinical Council Annual Workplan 2018/19*** • Members to provide feedback to update objectives/actions.	All	Deadline 24/10/18	November Agenda item 5.1
6	12/09/18	***New Clinical Governance Structure / Terms of References*** • CAG TOR to be provided • Clarification re: why Clinical and Consumer Council do not report directly to the Board • Committee & Advisory Group TOR to amend triple aim to "quadruple aim" • Committee Chairs to review/approve TOR for respective Committees	C McKenna Company Secretary Co-Chairs Committee Co-Chairs	Oct Oct Oct Nov/Dec	Awaiting approval Actioned Actioned ?
7	12.09/18	***Election of Chair / Co-Chairs 2018/19*** • Transparent election process to be put in place • Chair job description to be developed • Mechanism to enable a non-DHB chair to be confirmed	Company Secretary Co-Chairs CEO	Oct/Nov Oct TBC	In progress November agenda

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council** 145
	For the attention of: **HBDHB Board**
Document Owner:	Dr John Gommans (Chair) & Dr Andy Phillips (Co-Chair)
Month:	October 2018
Consideration:	For Information

RECOMMENDATION

That the Board

Review the contents of this report; and

Note that Clinical Council:

- **Discussed** the Quality Dashboard (draft)
- **Discussed** the report on Conception to Five Years - Including First 1,000 Days
- **Received** Committee reports
- **Received** reports for information only

Council met on 10 October 2018. An overview of matters discussed is provided below:

QUALITY DASHBOARD (Draft)

The ED People & Quality presented a draft Quality Dashboard which included principles of alignment with the Institute of Medicine's six domains of quality; covering whole of sector, keeping it simple at the start and allowing it to evolve over time.

The draft "starter for 10" dashboard was discussed. Feedback from members included need for indicators that addressed population health, quality of care for people with disabilities and healthy aging. Council expressed a preference for outcome indicators rather than process or output indicators, and acknowledged that there may be a mix of indicators reported monthly, quarterly and annually.

Council endorsed the principles. Members will provide feedback on specific indicators and the draft dashboard will then be considered by the Clinical Effectiveness and Audit Committee who will work with business intelligence to populate the dashboard with data.

CONCEPTION TO FIVE YEARS INCLUDING THE FIRST 1,000 DAYS

Shari Tidwell, Health Intersector Development Manager and Charrissa Keenan, Health Gains Advisor attended the meeting to discuss the report. It was noted that the scope of the report was widened to be from pre-conception to 5 years, to address a gap in the pre-school age group, to support wellbeing with a holistic approach, be culturally responsive and working with whanau to co-design innovative programmes.

Following discussion Council supported the rationale to extend the approach to lengthen scope to five years but asked that focus should not be lost on the critical first 1,000 days period Council was pleased to review a report that it had initiated.

COMMITTEE REPORTS

Clinical Advisory & Governance Group (CAG)
The minutes of the previous meeting of CAG were noted. A nomination to fill the CAG member vacancy on Council is under discussion with the Chair of CAG.

Professional Standards & Performance Committee
The purpose of the committee is to provide assurance to Council that the essential requirements of credentialling, accreditation, professional standards, clinical standards, training and research as being done well.

This is the first Committee of Council's new clinical governance structure to report back following its initial meetings, which focussed on the work of the following Advisory Groups that report to it.

- Allied Health Professions AG
- Hawke's Bay Clinical Research AG
- Medical Credentialing AG
- Nursing and Allied Health Credentialing AG
- Nursing and Midwifery Leadership AG
- Resident Medical Officers Training AG

Other Committee members include the CMO Primary Care, CMDO-Hospital, CNMO, CAHPO, ED People & Quality, Senior Advisor Cultural Competency and Consumer representative (or delegates). Of note the Clinical Research AG have good engagement with agencies working in the research sector. Medical credentialing is working well with good engagement between meetings. The Nursing and Allied Health group had progressed their business by exchange of emails but previously had not met for 18 months. This group now has new membership and has caught up on outstanding work. A process for multi-disciplinary credentialling of departments has not yet been resolved and it was noted that this is not done well nationally. It is suggested that external reviews may be the most appropriate means to achieve this; the recent cardiology services review being a good example. Currently primary care is not linked well into this advisory group. Council asked that the committee prepare a schedule to inform them of which departments had been credentialed or externally reviewed.

Reports for information were noted from the following:

- Havelock North Gastroenteritis Outbreak (final)
- Clinical Portal project Update
- Te Ara Whakawaiora - Cardiovascular (National Indicator)

HAWKE'S BAY CLINICAL COUNCIL – DRAFT ANNUAL PLAN 2018/19
FOR DISCUSSION

FUNCTIONS What we are here for:	UP: Provide Clinical advice and assurance to the Hawke's Bay health system senior management and governance structures	ACROSS: Work in partnership with the Hawke's Bay Health Consmer Council to ensure that Hawke's Bay health services are organised around the needs of people.	OUT: Provide oversight of clinical quality and patient safety	IN: Provide clinical leadership to Hawke's Bay health system workforce
ROLES Our job is to:	Provide advice and/or assurance on: • Clinical implications of proposed services changes. • Prioritisation of health resources. • Measures that will address health inequities. • Integration of health care provision across the sector. • The effective and efficient clinical use of resources.	• Develop and promote a "Person and Whanau Centred Care" approach to health care delivery. • Facilitate service integrations across / within the sector. • Ensure systems support the effective transition of consumers between/within services. • Promote and facilitate effective consumer engagement and patient feedback at all levels. • Ensure consumers are readily able to access and navigate through the health system.	• Focus strongly on reducing preventable errors or harm. • Monitor effectiveness of current practice. • Ensure effective clinical risk management processes are in place and systems are developed that minimise risk • Provide information, analysis and advice to clinical, management and consumer groups as appropriate. • Ensure everyone in the HB health sector are aware of their responsibility for quality improvement and patient safety.	• Communicate and engage with clinicians and other stakeholders within HB Health Sector, providing clinical leadership when/where appropriate. • Oversee clinical education, training and research. • Ensure clinical accountability is in place at all levels.
STRATEGIES To do this we will generally:	• Review and comment on all reports, papers, initiatives prior to completion and submission to the Board. • Proactively develop, promote and recommend changes to improve health outcomes, patient experience and value from health resources. • Develop, promote and advise on strategies and actions that could assist with the reduction in health inequities. • Develop and promote initiatives and communications that will	• Work collaboratively with the Consumer Council to design and implement a Person and Whanau Centred Care approach. • Understand what consumers need. • Understand what constitutes effective consumer engagement. • Promote clinical workforce education and training and role model desired culture. • Promote and implement effective health literacy practice. • Promote the development and implementation of appropriate systems and shared clinical records	• Develop and maintain relevant and effective Clinical Indicator reporting and performance management processes. • Establish and maintain effective clinical governance structures and reporting processes. • Ensure safety and quality risks are proactively identified and managed through effective systems, delegation of accountabilities and properly trained and credentialed staff. • Ensure the "quality and safety" message and culture is spread	• Ensure all HB clinicians and other stakeholders are aware of the role, membership and activities of the Clinical Council. • Oversee the development, maintenance and implementation of a HB Clinical Workforce Sustainability Plan. • Promote clinical governance at all levels within the HB heatlh system. • Ensure appropriate attendance/input into National/Regional/ Local

	enhance clinical integration of services. • Provide input through representation on EMT, Alliance Leadership Team and through attendance at HB Health Sector Leadership Forum.	to facilitate a 'smooth patient experience' through the health system.	and applied in all areas of HB health sector. • Promote "value-based decision-making" at all levels. This involves improving the processes by which decisions are made, so they take into consideration all ~~three Triple~~Quadruple ~~-~~Aim objectives: o Enhanced patient experience o Improved health outcomes o Better value for money o Improved experience of providing care • Ensure attendance at appropriate meetings/forums to provide appropriate assurance and confidence.	meetings/events to reflect HB clinical perspective. • Promote ongoing clinical professional development including leadership and "business" training for clinical leaders. • Facilitate co-ordination of clinical education, training and research. • Role model and promote clinical accountability at all levels.
FUNCTIONS	**Provide Clinical advice and assurance to the Hawke's Bay health system senior management and governance structures**	**Work in partnership with the Hawke's Bay Health Consmer Council to ensure that Hawke's Bay health services are organised around the needs of people.**	**Provide oversight of clinical quality and patient safety**	**Provide clinical leadership to Hawke's Bay health system workforce**
OBJECTIVES 2018/19 **Specifically this year we will:**	• Provide a proactive and prioritised clinical perspective on issues and strategies to be addressed in the new 5 Year Strategic Plan for the HB health sector by 28 Feb 19	• Co-design with Consumer Council and initiate the implementation of a detailed plan for the implementation of PWCC in HB by 30 Jun 19	• Ensure the Clinical Governance Structure is fully implemented and integrated, with appropriate reporting, management and administration processes in place, by 30 Jun 19 • Lead the development and implemention of a sector wide process for monitoring, managing and reporting clinical risk, by 30 Jun 19	• Facilitate the development of a HB Clinical Workforce Plan to support the new 5 Year Strategic Plan, by 31 Mar 19 • Promote and support the development and delivery of education and training of all clinicians on the Quadruple Aim and PWCC, and what these mean for clinicians, by 31 Mar 19

CLINICAL COUNCIL Workplan as at 6 November 2018 (subject to change)	**Destination Month**	**EMT Member**	**MRB Meeting Date**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**F R A C Meeting date**	**BOARD Meeting date**
Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-May-**Nov18**)	Nov-18	Andy Phillips	14-Nov-18	14-Nov-18	15-Nov-18		
Health Equity Report	Nov-18	Andy Phillips	14-Nov-18	14-Nov-18	15-Nov-18		28-Nov-18
Te Ara Whakawaiora "Smokefree update" (6 monthly May-**Nov**) each year Board action Nov 17	Nov-18	Andy Phillips	14-Nov-18	14-Nov-18	15-Nov-18		28-Nov-18
Clinical Portal Project Update (EMT Clinical & FRAC) - for information	Nov-18	Anne Speden		14-Nov-18		28-Nov-18	
National Bowel Screening Programme, Indicative Equity Outcomes in Māori and Pasifika	Nov-18	Chris Ash		14-Nov-18			
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-**Nov**-Feb-May	Nov-18	Chris Ash	14-Nov-18	14-Nov-18	15-Nov-18		28-Nov-18
Mental Health and Addictions (**Board action) late paper** (for info only)	Nov-18	Chris Ash	14-Nov-18	14-Nov-18	15-Nov-18		28-Nov-18
Clinical Advisory & Governance Group Report (July Aug Sept Oct **Nov** Dec Feb Mar 19) written requeste none forthcoming	Nov-18	Chris McKenna		14-Nov-18			
Radiology Facility Development Business Case	Nov-18	Colin Hutchison		14-Nov-18			28-Nov-18
Clinical Services Plan **(Summary** of changes and feedback)	Nov-18	Ken Foote	14-Nov-18	14-Nov-18	15-Nov-18		28-Nov-18
Collaborative Pathways update (**Nov** - May) 6mthly Clinical Council	Nov-18	Mark Peterson		14-Nov-18			
Mobility action plan implementation - progress update on the phases	Dec-18	Andy Phillips	5-Dec-18	5-Dec-18	6-Dec-18		
Te Ara Whakawaiora - Alcohol and other Drugs (National and Local Indicators)	Dec-18	Andy Phillips	5-Dec-18	5-Dec-18	6-Dec-18		19-Dec-18
Prioritisation Process Presentation - (**Clinical Council Action** 8 Aug 18) paper and presentation	Dec-18	Andy Phillips / Chris Ash		5-Dec-18			
Clinical Advisory & Governance Group Report (July Aug Sept Oct Nov **Dec** Feb Mar 19) **VERBAL**	Dec-18	Chris McKenna		5-Dec-18			
Te Ara Whakawaiora - Improving First Specialist Appointment Access (previously did not attend)	Dec-18	Colin Hutchison	5-Dec-18	5-Dec-18	6-Dec-18		19-Dec-18
People Plan (6 monthly - **Dec**, Jun)	Dec-18	Kate Coley	5-Dec-18	5-Dec-18	6-Dec-18		19-Dec-18
Using Consumer Stories (for information)	Dec-18	Kate Coley and Ken Foote		5-Dec-18	15-Nov-18		19-Dec-18
Maternal Wellbeing Programme Update	Dec-18	Patrick LeGeyt	5-Dec-18	5-Dec-18	6-Dec-18		19-Dec-18
Te Ara Whakawaiora REVIEW (paper and discussion) -	Dec-18	Patrick LeGeyt	5-Dec-18	5-Dec-18	6-Dec-18		19-Dec-18
Alcohol Harm Reduction Strategy (6 monthly update) **Nov**-May-Nov-May 9 ..... Realign dates	Feb-19	Andy Phillips	13-Feb-19	13-Feb-19	14-Feb-19		27-Feb-19
IS updates/presentation on **"Business Intelligence"** 30 mins - Bi-monthly	Feb-19	Anne Speden		13-Feb-19		27-Feb-19	
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov-**Feb**-May	Feb-19	Chris Ash	13-Feb-19	13-Feb-19	14-Feb-19		27-Feb-19
Clinical Advisory & Governance Group Report (July Aug Sept Oct Nov Dec **Feb** Mar 19)	Feb-19	Chris McKenna		13-Feb-19			
Ngatahi Vulnerable Children's Workforce Development - annual progress **Feb 19** (annual update)	Feb-19	Colin Hutchison	*43509*	13-Feb-19	*43510*		27-Feb-19
Quality Dashboard Quarterly Report (July, Oct, jan for **Feb19** mtg, Apr, July)	Feb-19	Kate Coley		13-Feb-19		27-Feb-19	
Matariki Regional Development Strategy and Social Inclusion Strategy update (6 mthly) Sept-**Mar**	Mar-19	Andy Phillips	13-Mar-19	13-Mar-19	14-Mar-19		27-Mar-19
Clinical Advisory & Governance Group Report (July Aug Sept Oct Nov Dec Feb **Mar 19**)	Mar-19	Chris McKenna		13-Mar-19			
Te Ara Whakawaiora - Breastfeeding (National Indicator)	Mar-19	Chris McKenna	13-Mar-19	13-Mar-19	14-Mar-19		27-Mar-19
Violence Intervention Programme Presentation Committees reviewed in July - EMT Nov - March 19	Mar-19	Colin Hutchison	13-Mar-19	13-Mar-19	14-Mar-19		27-Mar-19
After Hours Urgent Care Service Update 6mthly (Sept-Mar-Sept)	Mar-19	Wayne Woolrich	*43537*	13-Mar-19	*43537*		27-Mar-19
IS updates/presentations 30 mins - Bi-monthly Feb **Apr** Jun Aug Oct Dec	Apr-19	Anne Speden		10-Apr-19		24-Apr-19	
Quality Dashboard Quarterly Report (July, Oct, jan for Feb19 mtg, **Apr**, July)	Apr-19	Kate Coley		10-Apr-19		24-Apr-19	
Alcohol Harm Reduction Strategy (6 monthly update) Nov-**May**-Nov-May	May-19	Andy Phillips	8-May-19	8-May-19	9-May-19		29-May-19
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov-Feb-**May**	May-19	Chris Ash	8-May-19	8-May-19	9-May-19		29-May-19
Collaborative Pathways update (Nov - May) 6mthly Clinical Council	May-19	Mark Peterson		8-May-19			
IS updates/presentations 30 mins - Bi-monthly Feb Apr **Jun** Aug Oct Dec	Jun-19	Anne Speden		12-Jun-19		26-Jun-19	
Annual Plan 2019/20 SPEs to Board by end of June (include committees?)	Jun-19	Chris Ash	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19
People Plan (6 monthly - Dec, **Jun 19**)	Jun-19	Kate Coley	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19

	CLINICAL SERVICES PLAN (CSP) – Final Draft Clinical Services Plan Engagement Feedback Summary
	For the attention of: **Māori Relationship Board; HB Clinical Council; and HB Health Consumer Council**
Document Owner:	Kevin Snee, CEO
Document Author:	Hayley Turner – Clinical Services Plan Project Manager, Planning and Strategic Projects.
Reviewed by:	Ken Foote – Clinical Services Plan Project Sponsor, Company Secretary.
Month:	November 2018
Consideration:	For Review and Endorsement

RECOMMENDATION:

That the Māori Relationship Board, Clinical Council and Consumer Council:

1. **Review** the summary of the engagement feedback
2. **Endorse** the listed changes for the final version of the CSP document
3. **Recommend** that the Board approve the final CSP

PURPOSE OF THIS PAPER

The purpose of this paper is to provide a summary of the process collating all feedback at close of the CSP engagement activity, key themes of feedback received and a summary of changes to be included in the final CSP document.

The recommendation is that the listed feedback of changes is endorsed for a final CSP document to be produced as planned for final approval by the HBDHB Board on 28th November 2018.

Attached are the following:

- Two versions of the CSP document (one with tracked changes and one clean)
- Copy of the feedback report including responses

Questions:

- Do you agree with the listed changes made to the CSP document based on feedback?
- Do you feel this is sufficient based on the feedback and are happy to now endorse for a final CSP document based on these changes?

CONTEXT

The Engagement Activity concluded on the 31st October, and overall the feedback received was positive and accepted the CSP direction.

Feedback Received:

- Total feedback received =55
  - Phone=0
  - Email (including letters)= 33
  - Pamphlet= 22
- Sources of feedback came from:
  - Community (general public, community groups)
  - Health sector (DHB staff, PHO, community providers)
  - Intersectoral partners (At Matariki and formal feedback received from Hastings District Council and Napier City Council)
- Additionally the project team received a lot of general feedback and valued discussions from various meetings/individuals throughout the engagement process.

Feedback Responses:

Not all feedback received was relevant to complete the final version of the CSP. Response to this type of feedback was "noted" and a summary of this type is listed below:

- Support/affirmation of the CSP with no highlighted gaps or feedback.
- Next phase: Requests for more detailed planning to be carried through to the next phase as part of the strategic planning process.
  - Phasing - this was indicative only at this stage.
  - Information around the how all the plans will be integrated and where services feature.
  - Detail around the elements/options in terms of priority and decision making for investment.

Accepted changes to be incorporated into the final CSP:

Feedback received that has been included in the updated version included the following

- Language changes
  - Incorrect/ lack of use of the Te Reo Māori. An example includes the description of using Māori health model, Te Whare Tapa wha but thereafter only using English to describe the four dimensions and not Te Reo. This has now been incorporated into the plan.
  - Terminology or spelling corrections
  - Definitions: including extra definitions such as "Equity and inequity"
  - Clarification
  - Enhanced elements/options

- Additional paragraphs/section to the CSP
  - Environmental sustainability – Not originally covered, but have now included reference this as part of determinants of health and impact on inequity and long term conditions.
  - Dying well – Not originally covered, but have now included under person and whanau centred care and wraparound services.
  - Preventative care/population health/public health – covered within the "plan in a nutshell" but was not sufficiently covered within the plan. This has now been carried through and developed within the plan, examples include the three pillars of health (diet, exercise and sleep).
  - Behavioural economics – Linked to the above as part of understanding the consumer and their needs.
  - Early intervention to dementia – has been added.

- Tamariki (Children) and Rangatahi (youth) - as a key focus of the plan, this was deemed too general and required further development within the plan.
- Support services – previously community pharmacy, radiology, laboratory and dietitians were not sufficiently covered. It is recognised that these services may need to change to support the new models of care and therefore have now been included through relevant sections of the CSP.
- Place based planning – Whilst important to recognise community needs by geography, it was also highlighted that the plan did not include “communities of interest” being cohorts of consumers with similar health needs and not necessarily within a geographic area. Applying the same approach and principles used within place based planning would fulfil this requirement.

Next steps:

A final version of the CSP will now go to the board for final approval.

8

Governance Report Overview

HAWKE'S BAY District Health Board Whakawāteatia	**Health Equity Report**
	For the attention of: **Maori Relationship Board, Pasifika Health Leadership Group, HB Clinical Council, HB Health Consumer Council and HBDHB Board**
Document Owner	Andy Phillips, Tumuaki O Te Puni Tūmatawhānui
Document Authors	Jessica O'Sullivan, Andy Phillips, Nick Jones, Patrick LeGeyt, Lisa Jones, Charrissa Keenan, Rachel Eyre, Rowan Manhire-Heath, Shari Tidswell
Reviewed by	Executive Management Team
Month/Year	November 2018
Purpose	Discussion
Previous Consideration Discussions	N/A
Summary	This report acknowledges that in Te Matau a Māui, Hawke's Bay, our people have pervasive and enduring differences in health that are not only avoidable but unfair and unjust. Equity is defined as the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. *To achieve health equity we will need to acknowledge that different people with different levels of advantage will require different approaches and resources to get the same outcome.* The inter-generational traumatic impact of colonisation has had long term impacts on Māori health, wellbeing and culture. Socioeconomic factors account for almost half of all health inequity. Health care is responsible for a further 10%. To achieve our commitment to equal outcomes, we will all need to work across sectors to overcome the barriers to equity - poverty, discrimination, powerlessness, lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare. We know that many in our community face barriers to accessing high quality health care services. These barriers include difficulties in navigating our complex systems, limited cultural competence of providers, lack of transport, out-of-pocket costs and co-payments for GP services. We know that to address health inequities across the life span that we need to work across sectors and with communities to: • give all tamariki the best start in life • strengthen the role and impact of ill-health prevention

	• ensure that all tamariki and rangatahi experience few adverse childhood events, many positive childhood experiences and have an education that enables them to maximise their capabilities and have control over their lives • create fair employment and a healthy standard of living for all adults • create and develop healthy and sustainable places and communities • deliver excellent health services that produce the best outcomes for people with conditions such as cardiovascular disease, cancer, respiratory disease and diabetes • deliver excellent mental health and addictions services
Contribution to Goals and Strategic Implications	Improving Health and Equity for all populations
Impact on Reducing Inequities/Disparities	This report sets out actions required to reduce with the intent of eliminating health inequities
Consumer Engagement	A wide range of stakeholders have had input into this report No specific consumer engagement has been undertaken.
Other Consultation /Involvement	There is an intention for the report to undergo peer review prior to final publication.
Financial/Budget Impact	This paper signposts the need for reallocation of resource and investment priorities for any additional resource to achieve health equity
Timing Issues	Due to be presented at December 2018 Board meeting
Announcements/ Communications	This report is likely to have very significant media exposure and a communication plan will be developed

RECOMMENDATION:

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

- **Discuss** the Health Equity Report and provide feedback.

Draft Health Equity Report 2018

Contents

Introduction

What is this report about?

Equity in health means that all groups within a population have fair opportunities to attain their full health potential. Inequities are differences in health (and factors that influence health) that are not only unnecessary and avoidable but, in addition, are considered unfair and unjust. We want to see these inequities eliminated in Hawke's Bay.

This is our third Health Equity report. The purpose of this report is to:

1) **Continue monitoring progress against previously reported measures.** By tracking progress we can hold ourselves to account, identify successful approaches and identify the greatest opportunities to eliminate health inequities. As with the previous reports we report on progress towards reducing early deaths (before the age of 75 years) that are avoidable through disease prevention or health services. These overarching measures provide a big picture view of health equity, and reflect not only our current services but the influence of service provision over many years along with our wider social and economic situation in Hawke's Bay.

It's important to remember that mortality measures are looking back in time. The process of collecting and checking information about why people die takes around three years and for the most part this report covers deaths up until the end of 2014. Mortality in any one year is also affected by events or illnesses, behaviours and services provided over a much longer period of time for many causes.

Although we do not yet have information on what has happened since 2014 for mortality, we do have access to current hospital stay information and information about changes in behavior that we know are linked to health. These measures provide a more forward facing view of trends that help to determine whether any recent changes are likely to have already impacted on mortality.

2) **Explore issues such as family violence and mental health in more depth.** More in-depth analysis allows us to begin to understand some of the root causes of inequity and some of the pathways by which social position contributes to inequity in Hawke's Bay.

3) **Introduce a greater focus on the life course journey**. The introduction of a life course framework recognises the profound impact that events and illness that occur early in life have on health as we age.

The underlying principle is that: there is no justification for an individual's social position (for example their socioeconomic status, sex, educational attainment, sexual orientation or ethnicity) to determine their level of health or length of life.

This report focuses more on ethnicity than other dimensions of social position, such as socioeconomic status. First and foremost, this reflects our obligations under Te Tiriti O Waitangi to ensure Māori achieve the level of health necessary to fully participate in society and to retain autonomy over the systems and resources needed for health. Also, changes to the New Zealand Deprivation Index since the last Health Equity report made it difficult to assess changes in inequities according to socio-economic deprivation. However, as ethnicity and other measures of social position are highly inter-related, we can assume that many of the findings in this report for Māori and Pacific people would also apply for people living in greater socio-economic deprivation.

What did we find?

Perhaps the starkest form of health inequity lies in the fact that Māori, Pacific people and people living in higher deprivation are still more likely to *die early from avoidable causes.* This provides a central focus for this report as we look closely into how deaths from avoidable causes could be prevented.

A recent study showed Hawke's Bay was one of New Zealand's most successful DHB's in producing life expectancy gains for Māori for the period 2006 to 2013.[1] This success was noted in previous reports along with positive trends for related mortality measures such as a reduction in inequity for early and avoidable deaths. The news this time is not so positive with most measures of early and avoidable deaths showing no further progress has been made over the last two years of available data (2012-2014).

This report does indicate the actions we need to take to address inequity:

- For Māori nearly a quarter of all avoidable deaths can be prevented if we can improve heart health
- Another quarter will be prevented when we prevent lung cancer deaths through smokefree living (and early detection and more effective treatment) and when we address the underlying causes of suicide and vehicle crashes
- For Pacific people we also need to focus on preventing and managing diabetes and preventing stroke
- Pacific pre-schoolers are experiencing higher rates of avoidable hospital stays, particularly for cellulitis, and have the highest rates of dental decay by the time they reach school
- Avoidable hospital stays for Māori and Pacific adults aged 45-64 years are increasing. This is driven by increases in hospital stays for heart attacks, chronic lung disease and skin infection.

The role of health services in eliminating inequity

The potential for health services to eliminate health inequity is clearly demonstrated by the continuing progress in immunisation and screening. Successes in delivering these preventive services show what can be achieved when we purposefully set out to understand the needs of our community and deliver our services in a way that meets the needs of whānau where the social and economic conditions of life create barriers to service access. We need to learn from these successes to address other inequities such as those in sexually transmitted infection.

The role of social and economic factors in eliminating inequity

In terms of the contribution of social and economic factors, several measures have deteriorated since the last report:

- As a measure of housing related illness we are seeing persistence in the difference between Māori, Pacific and NZ European/Other rates for bronchiolitis.
- The influences of the social, economic and physical environment are also linked to the way we live and it is perhaps not surprising to find that increases in inequity for measures of socio-economic factors have been accompanied by trends in behaviours that increase health risk.
- NZ Health survey data are used to measure trends in key risks such as obesity, nutrition, tobacco and alcohol use. Notwithstanding limitations in survey methods (see below) recent survey data show worsening risks in many of these measures. Reduction in physical activity and increase in harmful alcohol use are prevalent across society and we need to strengthen our collaborative efforts if we are to reverse these trends.

A focus on mental health

This report provides a new focus on mental health and well-being. The report uncovers important inequities in mental health such as the much higher rate of mental illness and hospital stays for Māori and the higher rate of self-harm hospital stays for Māori and for women. The picture of higher psychological distress in Hawke's Bay along with persisting levels of family violence suggests we have much more work to do in addressing these issues that in turn influence so many other aspects of health.

Summary

The key finding of this report is that we are far from achieving health equity. We cannot afford to wait and see if more positive trends are around the corner. Some of these issues of inequity are clearly linked to deterioration in socioeconomic determinants over that time. For example, we know that the quality of housing for many whānau in Hawke's Bay has deteriorated. We will work across sectors with our partners locally and nationally on these issues.

[1] Sandiford P, Consuelo D J V, Rouse P. How efficient are New Zealand's District Health Boards at producing life expectancy gains for Māori and Europeans? Australia and new Zealand Journal of Public Health. 41(2) 2017.

In order to reduce avoidable hospital stays for adults, we need to listen to our communities to understand what services they need. This is particularly true for services to Māori and Pacific whanau and also for other disadvantaged groups such as people with disability. We need to understand better the biases that have been built into our systems that result in poorer quality of service for these groups. We know from successful programmes both in Hawke's Bay and elsewhere that tackling inequity requires system and culture change, deliberate and sustained focus, realistic resourcing, accountability at all levels, and real community partnership.

Next steps

Our next steps will be focused on embedding equity as an intrinsic property of our health system and wider society. We will conduct check whether our communities agree with the priorities identified through this report. The engagement with our whanau experiencing inequity wil inform our redesign of the health system and our work with intersector partners on social determinants.

This summary report is a distillation of a much larger and more detailed technical report. We encourage readers who have more questions to delve into the technical report that provides a more comprehensive analysis.

Interpretation Guide:

1.The New Zealand Health Survey:

A number of measures in this report are derived from the New Zealand Health Survey. The survey has a number of limitations to be kept in mind. Firstly the survey is based on a sample of randomly selected households and the numbers of households in Hawke's Bay is limited. The households chosen also change over time. This means that a break down of results into age or ethnic groups often requires information from several years to be combined to get a large enough sample. The survey reports ethnicity in a different way to the rest of the report. People who identify as belonging to more than one ethnic group are counted in each group whereas other measures in this report use prioritised ethnicity so that people are counted in only one group. The measures published so far this year also do not contain any measures for NZ European/Other. This means measures for Māori and Pacific must be compared with the total population measure. Such comparisons are likely to reduce the magnitude of true differences in the measure between Māori or Pacific and the NZ European and other ethnic group.

2. Ethnicity:

In this report, we have used the term NZ European/Other to denote the non-Māori, non-Pacific population of Hawke's Bay. Due to small Pacific numbers, many graphs in this report show only Māori and NZ European/Other. It is therefore important to note that in these graphs, the NZ European/Other does not include Pacific.

3. Amenable Mortality:

In this 2018 Health Equity Report, a new definition for amenable mortality has been used. The new definition aligns Hawke's Bay's reporting to the national System Level Measure. This means that graphs for amenable mortality in this report cannot be compared with graphs in previous reports as the new definition includes some deaths that were not previously counted.

Summary of key findings

HEALTH EQUITY ACHIEVED	
	Immunisations
GOOD PROGRESS TOWARDS HEALTH EQUITY	
	Breast screening
	Cervical screening
	Teenage pregnancy
	Youth not in employment education or training
SOME PROGRESS TOWARDS EQUITY BUT SLOWING OR STALLED	
	Premature mortality
	Avoidable mortality
	Amenable mortality
	Years of Life Lost
	Acute Bronchiolitis
	Ambulatory Sensitive Hospitalisations (0-4 year olds)
	Oral health – 5 year olds
	Breastfeeding
	Childhood obesity
NO PROGRESS OR INEQUITY WORSENING	
	Fruit and vegetable intake
	Physical activity
	Adult obesity
	Hazardous drinking
	Maternal smoking
	Sexual health
	Mental health
	Assault hospitalisations
	Diabetes
	Ambulatory Sensitive Hospitalisations (45-64 year olds)

Equity for Life

Health is a resource for everyday living. It provides us with a capacity to participate in society and contributes to quality and length of life. Our "health capacity" accumulates over our life. If our health capacity grows, so does our resilience and ability to recover from health threats that occur later in life. But if our health capacity is depleted, we become more vulnerable.

This chart shows how health related events, social, economic and physical environments, and behaviours can either grow or deplete our health capacity. This is not intended to be a complete picture of all relevant factors. Its purpose is to illustrate how life experiences can contribute to the inequities we are seeing in illness and death.

The dotted lines illustrate fluctuations in health capacity for two hypothetical people. For one person their health capacity grows over their life, becoming depleted as death approaches late in life. For the other person their health capacity becomes depleted earlier in life resulting in a premature death. The lines also illustrate the difference in quality of life between the two life courses.

The chart reminds us of the importance of building our health capacity early in life. But it also shows the potential for positive factors to increase our health capacity even after negative influences early in life.

In the middle of the chart is a line representing biology. Our genes are fixed but our biology can change and interact with other factors as we age. Our biology also influences the way that external factors impact our health capacity.

		preconception, pregancy and infancy - HE PĒPI	pre-school - TAMARIKI NOHINOHI (0-1yr) and	middle childhood - TAMARIKI TAIŌHI	adolescence - TAITAMARIKI	early adulthood - RANGATAHI	middle adulthood - RANGATAKAKAU	late adulthood - RANGATIRA/PĀKEKE
increasing health capacity (increasing resilience)	Health Services and Health Events	access to sexual health service, safe from environmental toxins, Supportive post natal care, well child checks and immunization	immunization and well child checks, oral health care	connected to primary care, oral health services	access to sexual health and adolescent health services	maternity services	screening on time	good access to primary care and support services
	Behaviours - Protective	good nutrition and health for mother at conception and during pregancy, no alcohol and tobacco in pregancy, breast feeding	good family nutrition, regular adequate sleep	educational achievement, regular sleep, physical activity,	engated in school and community, culturally connected	low or no alcohol use, active, smokefree	low or no alcohol use, active, smokefree	maintain social connection
	Social, Economic and Physical Environment	safe warm and dry smoke free home, loving emotionally stable violence free home, safe from environmental toxins	material wealth, safe warm and dry smoke free home, loving emotionally stable violence free hom, early childhood education	material wealth, safe warm and dry smoke free home, loving emotionally stable violence free home, safe connected urban environment, healthy nutritional environment	mentoring, supportive relationships and whanau, whanau provides structure limits, rules and predictability	healthy and safe work enironment	healthy and safe work enironment	safe home environment
	BIOLOGY	interaction with capacity factors	interaction with capacity factors	interaction with capacity factors	interaction with capacity factors	interaction with capacity factors	interaction with capacity factors	interaction with capacity factors
reducing health capacity (increased vulnerability)	Social, economic and physical environment	unsafe cold damp smoking home, emotion distress, family violence	poverty, unsafe cold damp smoking home, emotion distress, family violence, neighbourhood violence	poor nutritional environment, poorly connected unsafe urban environment, poor quality or transient housing	low self-estem, lack of cultural connection, parental substance use or mental illness, family violence or other traumatic event	unhealthy or unsafe work environment, criminal conviction and prison	unhealthy or unsafe work environment, criminal conviction and prison	unsafe home environment
	Behaviours - Increased Risks	poor nutrition and health for mother at conception and during pregancy, alcohol and tobacco in pregancy, no breast feeding	poor nutrition eg sugar sweetened bevereges, irregular or inadequate sleep	educational achievement limited, limited physical activity	early substance use, lack of social engagement eg no sport, lack of parental supervision and support	alcohol and other substance use, tobacco use	unsafe alcohol use, poor nutrition, inactivity, tobacco use	poor social connection and loneliness
	health services and events	poor access to sexual health service, late or no antenatal care, not connected to post natal care well child checks or immunization	lack of access to immunization, well child checks, oral health care, developmental or behavioural disorder	not connected to primary care or oral health services, chronic disease or disability, developmental disorder, rheumatic fever	depression or anxiety	late maternity services	late or no access to screening services	poor access to primary care and support services, increased frailty, dementia
Leading Cause of Deaths (Years of lost life)*		other accidents, SUDI, cancer, vehicle crashes, diarrhea and pneumonia		suicide, vehicle crashes, other injuries, cancer, neurological disorders			cancers, cardiovascular (heart disease and stroke), suicide, vehicle crashes, diabetes	cardiovascular (heart disease and stroke), cancers, neurological, chronic lung, diabetes

* Adapted from: Ministry of Health. 2018. Health and Independence Report 2017

Social and economic factors are associated with unequal health outcomes

The social and economic conditions that people are born into and live in have a profound impact on health outcomes. These factors include housing, education, income, social support and connection and they are closely linked. For example, education will impact on income, and income will subsequently impact on housing. These links lead to an accumulation of disadvantage among some people and an accumulation of privilege among others.

The health of Māori whanau is deeply rooted in the impacts of colonisation and subjective bias in the design of our health system. Epidemics brought by European settlers decimated Māori communities and losses of land, languages, traditions and economic livelihood followed. These ordeals and accumulated trauma have induced further illnesses present in Māori today. Medical research suggests that molecular changes resulting from social trauma and illness may be passed on from generation to generation.

Social and economic factors also underpin health behaviours: people living in poverty have fewer choices available to them, greater stress and poorer access to opportunities such as education, and all of these experiences can lead to higher levels of unhealthy behaviours.

[Key messages for laying out graphically:] In Hawke's Bay:

40% of tamariki Māori aged 0-4 years live in a household receiving a main benefit compared to 14.5% of NZ European children.

61% of total food grants are to Māori compared with 27% to NZ European.

1 in 3 Māori school leavers do not not have an NCEA Level 2 qualification or equivalent. This compares with one in four Pacific leavers and one in seven NZ European leavers.

22% of young Māori are not in employment, education or training (NEET) down from 30% in the 2014 Health Equity Report.

Partnering for community gains

Superintendent Tania Kura, Eastern Police District Commander, speaks on the importance of community partnerships.

"As Eastern Police District Commander, I believe in taking an open approach to developing partnerships within our communities. After six years here in Hawke's Bay, I've seen first-hand the strong, well-established relationships our officers have strived to build and maintain.

Real differences come when leaders collaborate with a common purpose. We're very fortunate to have a number of like-minded agency leaders across the Eastern District who are very willing to take a pragmatic approach to making things happen for the good of our communities.

An example of this is the positive approach we're taking to encourage truants back to school with the support of parents, the Ministry of Education, truancy services and schools. One key benefit of this initiative is a reduction in the number of young people going to Youth Court.

Our focus on crime prevention means thinking differently about how we solve problems as we aim to reduce both reoffending and re-victimisation. We can't be the safest country in the world unless we work with others. I'm grateful for the support extended to Police from other agencies, non-government organisations

and iwi groups. I'm also heartened by the willingness of others to invite us to the table to help create coordinated solutions."

Good health begins with the way we live

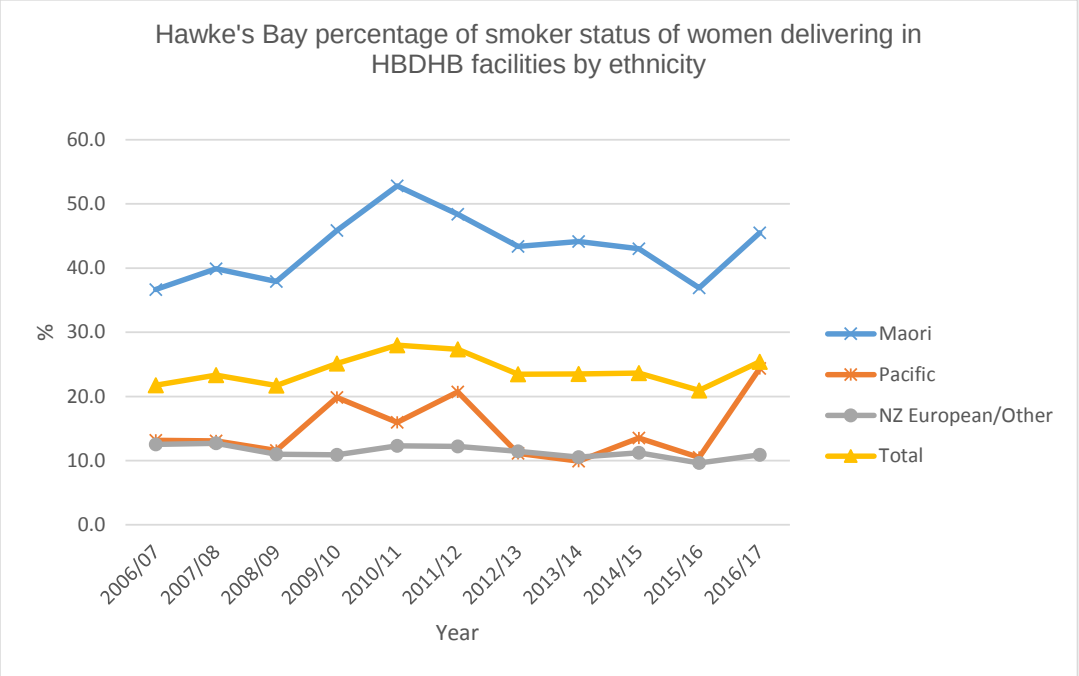
The environment we live in influences our day-to-day behaviours, including nutrition and obesity, smoking, alcohol and other drug use. Health behaviours have a large impact on our health and wellbeing.

Fewer youth are smoking but more Hawke's Bay adults smoke than nationally

A growing proportion of young people in Hawke's Bay are choosing not to smoke. However one in five Hawke's Bay adults still smoke daily compared with one in six nationally. Māori have the highest smoking rates at 40 percent and Māori women are three times more likely to smoke than non-Māori women. Efforts to achieve the 2025 smokefree target (of less than 5 percent) must focus on supporting Māori to quit and on preventing uptake amongst rangatahi Māori.

Little change in reducing maternal smoking since 2007

Maternal smoking is still of great concern with little change in the overall trend for maternal smoking since 2007. Maternal smoking is more likely among women living in more deprived areas. Helping women, and Māori women in particular, to stop smoking must remain a DHB priority.



Source: HBDHB Data Warehouse

Hawke's Bay people are drinking more harmfully than New Zealanders as a whole

29 percent of Hawke's Bay adults drink at harmful levels compared with 21 percent nationally and harmful drinking is rising over time. Alcohol-related hospital admissions rates have doubled since 2009.

Recent age and ethnicity break-downs are not available for Hawke's Bay, but past and national patterns showed:

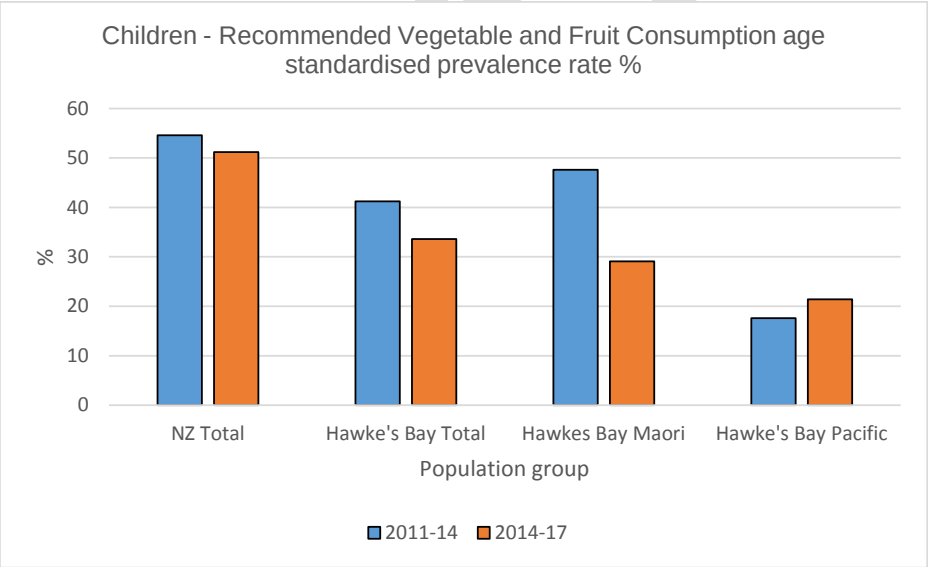
- 15-24 year olds drink the most hazardously although 25-44 year olds are not far behind
- Māori women are more likely to drink during pregnancy than non-Māori
- fewer Māori drink alcohol than non-Māori (Pacific and Asian also lower) but Māori experience more harm overall than non-Māori.

In New Zealand, hazardous drinking is higher in more deprived areas, and there is a strong association with increased alcohol outlet density in these areas.

[Include DHB graphic – 3 in 10 HB adults are hazardous drinkers]

Fewer adults and children are eating enough fruit and vegetables

Just one third of Hawke's Bay adults and children meet the recommended guidelines for daily fruit and vegetable intake (3+ serves of vegetables and 2+ serves of fruit). This trend has worsened over the past three years. Adults living in the most deprived areas consume less fruit and vegetables than the least deprived areas. This finding is particularly troubling given the plentiful supply of locally grown produce in our region.



Source: New Zealand Health Survey

Our food environment influences our food choices. As shown in the table below, people living in our most deprived areas have more dairies and fast food outlets in their neighbourhoods than those in the least deprived areas. On the other hand there was little difference in the density of supermarkets and fruit and vegetable stores.

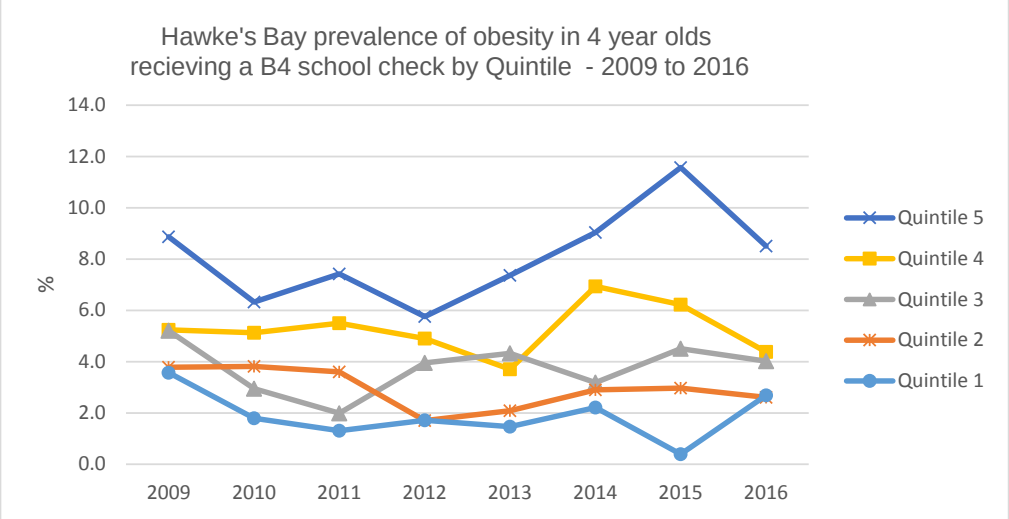
Indicator	Most deprived	Least deprived

Average density of convenience stores per 10,000 people in Hawke's Bay census areas	10.2	3.4
Average density of fast food and takeaway outlets per 10,000 people in Hawke's Bay census areas	10.4	4.9
Average density of supermarkets and fruit and vegetable stores per 10,000 people in Hawke's Bay census areas	4.2	3.4

Source: INFORMAS (University of Auckland)

More children are living with healthy weight in our most deprived communities

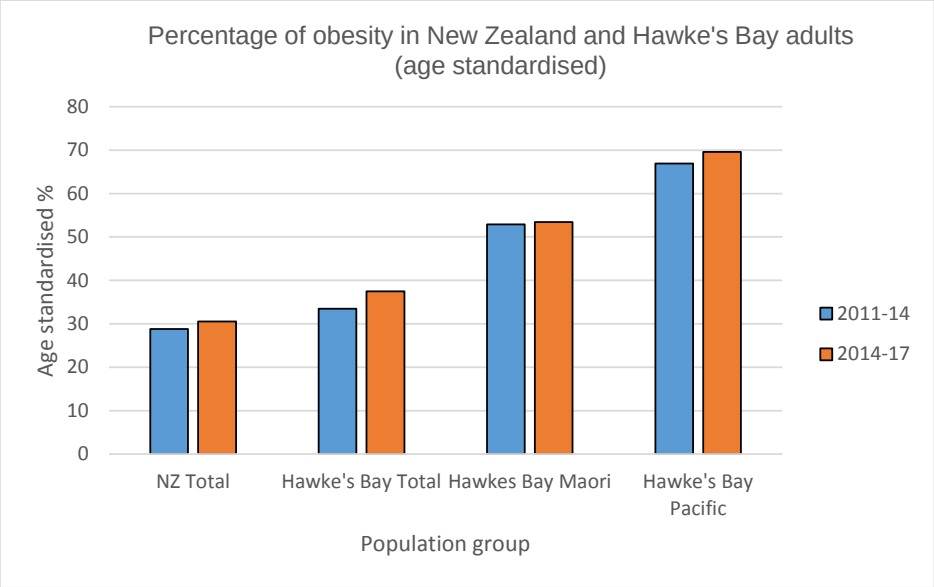
There has been an increase in the percentage of children living in our most deprived communities (Quintiles 4 and 5) who are assessed as having healthy weight at their B4 School Check. However, inequities still remain. Children living in Quintile 5 (highest deprivation) are less likely to be a healthy weight compared with children living in other Quintiles. Also, there are fewer Māori children who are a healthy weight than non-Māori children and even fewer Pacific children at healthy weight.



Source: B4 School Check database extract provided by Health Hawke's Bay

Fewer Adults across all ethnic groups are living with healthy weight

Over a third (37.5 percent) of Hawke's Bay adults are not living at healthy weight compared with just under a third nationally (30.5 percent). Over the last three years, rates of people living at healthy weight in Hawke's Bay have worsened across all ethnic groups. Māori (53 percent) and Pacific people (70 percent) experience higher levels of obesity in Hawke's Bay. Adults who live in more deprived areas are less likely to live at healthy weight than those living in less deprived areas.

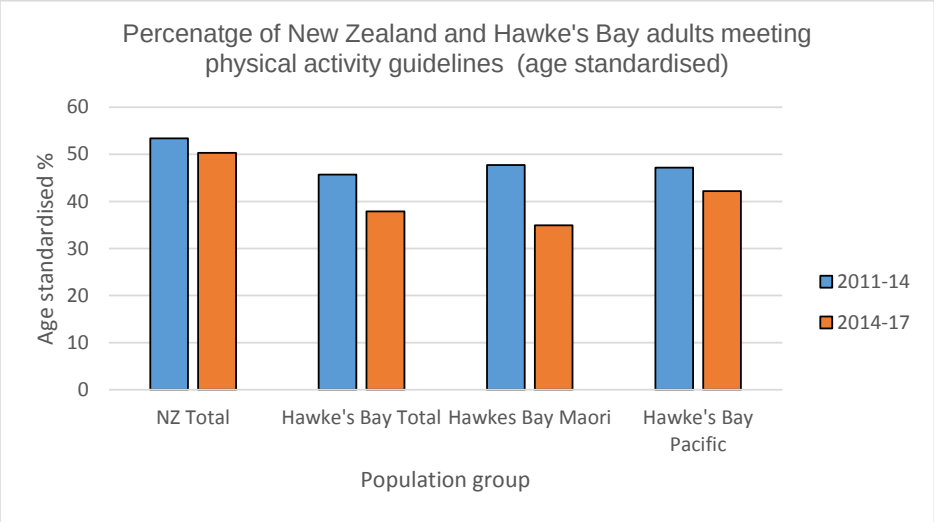


Source: New Zealand Health Survey

Physical activity levels for Māori and Pacific have fallen

Hawke's Bay adults are less active than their New Zealand average counterparts. Only 38 percent of Hawke's Bay adults meet physical activity guidelines compared with 50 percent nationally, a decline of 5 percent since the first Healthy Equity Report in 2014. The percentage of Māori meeting the guidelines has dropped from 48 percent to 35 percent in the period between 2011-14 and 2014-17 and the percentage of Pacific people has dropped from 47 percent to 42 percent.

Over recent years we have seen increasing participation in programmes such as Iron Māori but we need to work harder to ensure that activity gains from these programmes are carried over into daily life.



Source: New Zealand Health Survey

Health across the life course – Introduction

The indicators chosen for inclusion in this report were not chosen to provide a comprehensive picture of equity at different stages of life. Nevertheless we have grouped some measures into life stage to show the importance of equity across the life course and to tell the story of how events earlier in life can influence our health as we age.

Health across the life course – Childhood

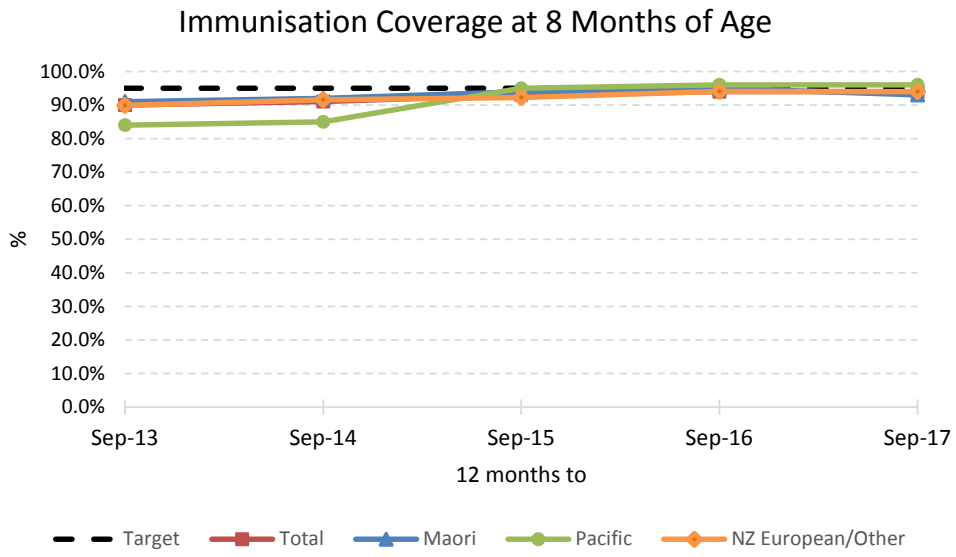
"Many challenges in adult society have their roots in the early years of life, including major public health problems such as obesity, heart disease and mental health problems" (WHO, 2008).

Immunisation shows equity is possible

Equity has been achieved in eight month immunisation rates for both Māori and Pacific infants. 97 percent of Pacific eight month olds are immunised. This is an increase of 12 percent since 2013.

Hawke's Bay continues to achieve good immunisation coverage at 24 months of age with 94.6 percent of two year olds fully immunised (just under the Ministry of Health target of 95 percent). There have been small but constant gains across all ethnic groups with 93 percent of NZ European/Other, 95 percent of Māori, and 99 percent of Pacific children fully immunised at 24 months age.

The school based Human Papilloma Virus (HPV) programme, that prevents cervical and other cancers, has achieved greater coverage among Māori and Pacific adolescents than for NZ European/Other. This shows the pro-equity value of delivering programmes through schools by removing barriers to service.

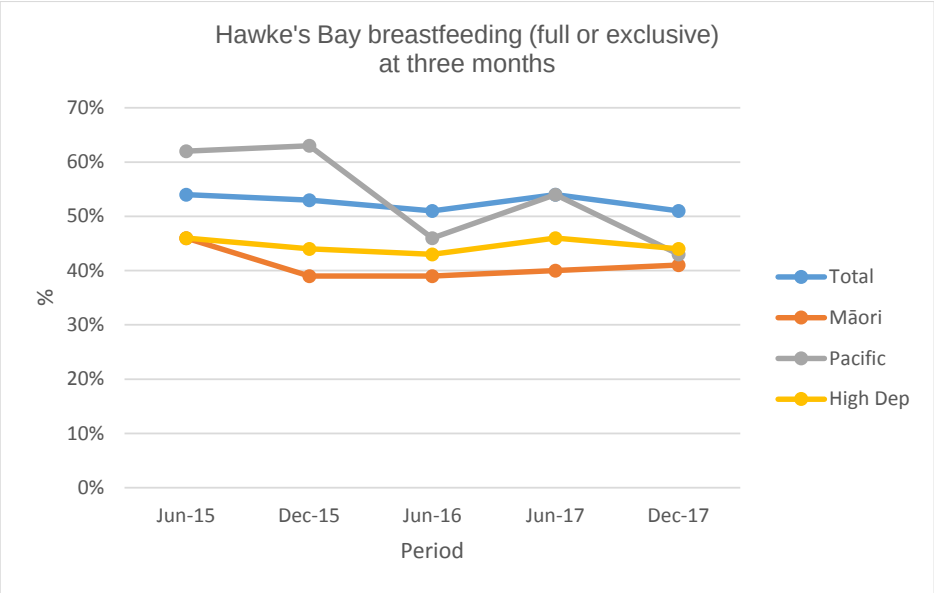


Source: National Immunisation Register

Breastfeeding rates for Māori and Pacific are lower than in 2015

Breastfeeding rates in Hawke's Bay at six weeks, three months and six months are persistently below the national average and show consistent inequity for Māori, Pacific and people living in areas of high deprivation. Breastfeeding rates at three months are lower than in 2015 for all ethnic groups.

We have however seen some improvements in the percentage of women (including for Māori and Pacific) breastfeeding at two weeks after discharge. The challenge is how we can adequately support women to maintain these higher rates of breastfeeding for longer.

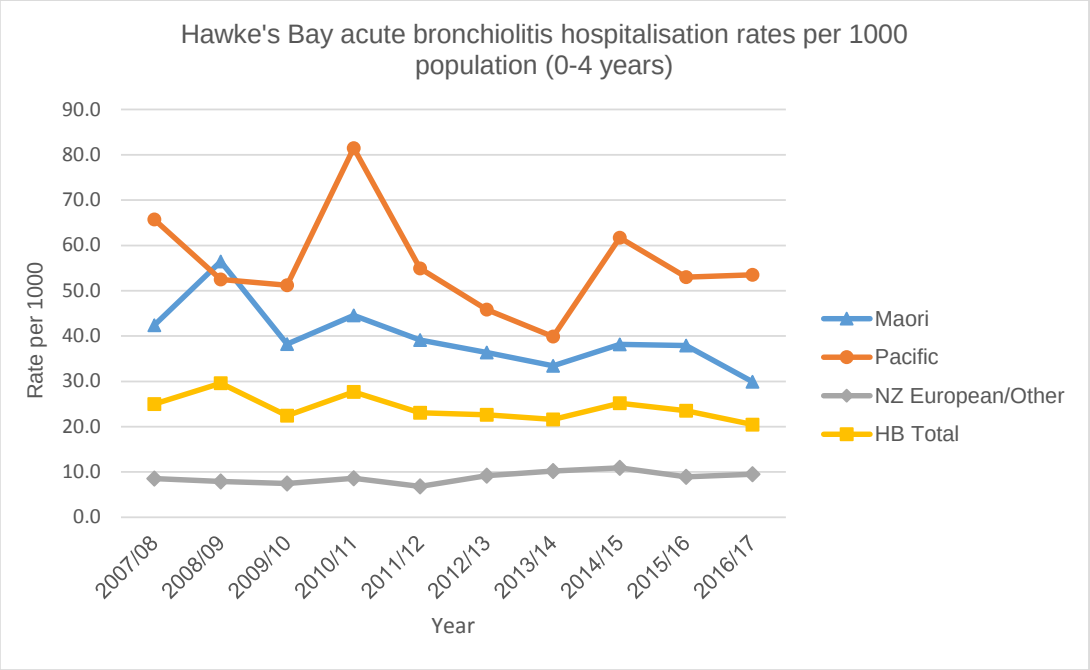


Source: Wellchild Tamariki Ora dataset

The gap in housing-related childhood illness stopped closing in 2013

Bronchiolitis (an acute respiratory illness which affects infants) is linked to housing conditions and other environmental factors such as smoking in the home. The gap between Māori and NZ European/Other for bronchiolitis hospital stays reduced between 2009 and 2013. There has been little or no decline for Māori infants since that time and rates for Maori infants remain significantly higher than for the NZ European and Other group. Pacific infant hospital stays for bronchiolitis remain significantly higher than for both Maori and NZ European/other infants.

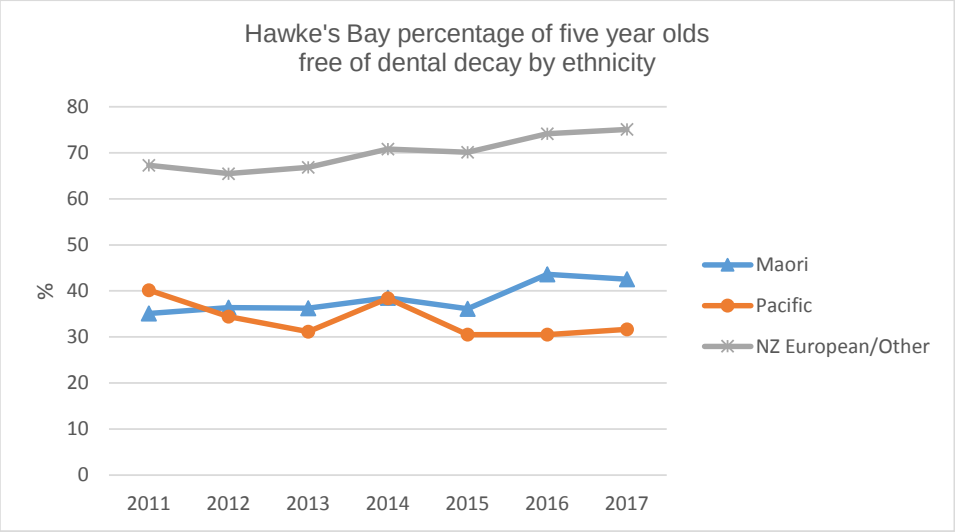
Over the same period, housing demand has increased and demand for social housing has tripled over the last three years. Families are forced to share housing and to accept unhealthy living conditions.



Source: National Minimum Dataset

Māori 5 year olds have less dental decay but a large and persistent equity gap remains for Māori and Pacific children

There has been a small improvement in the percentage of Māori children who are free of dental decay since 2015. However a large inequity persists which is partly due to the improvements for NZ European children. There has been no improvement in dental health for Pacific children and rates are worse now than they were in 2011.



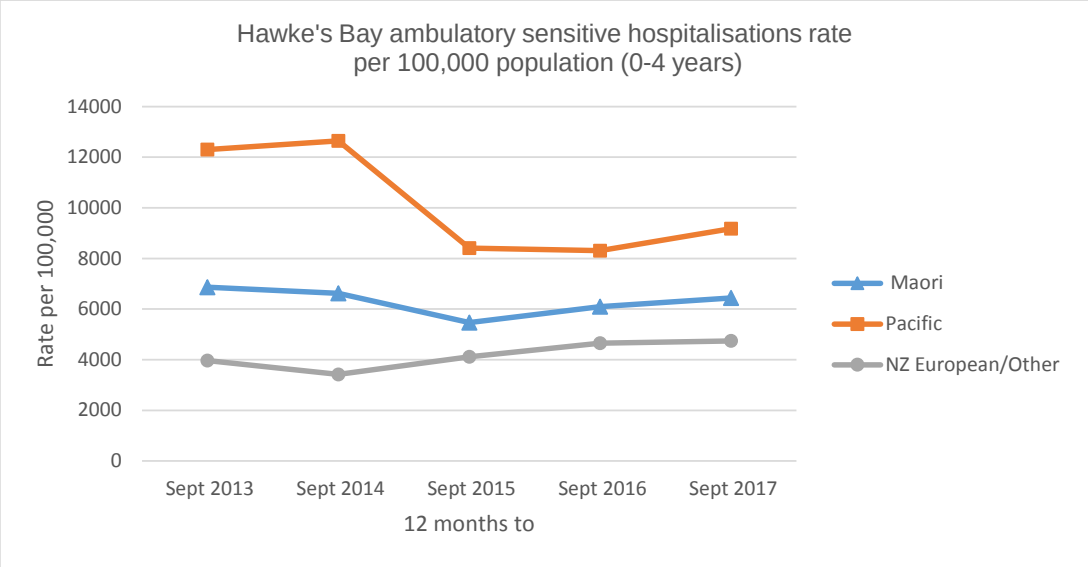
Source: HBDHB Oral Health Information System

Progress stalled in reducing Māori and Pacific children's hospital admissions for conditions that can be prevented by primary care

Ambulatory Sensitive Hospitalisations (ASH) are hospital stays for conditions that are potentially treatable or could have been treated earlier in the community. ASH rates provide a useful gauge for primary care access and quality.

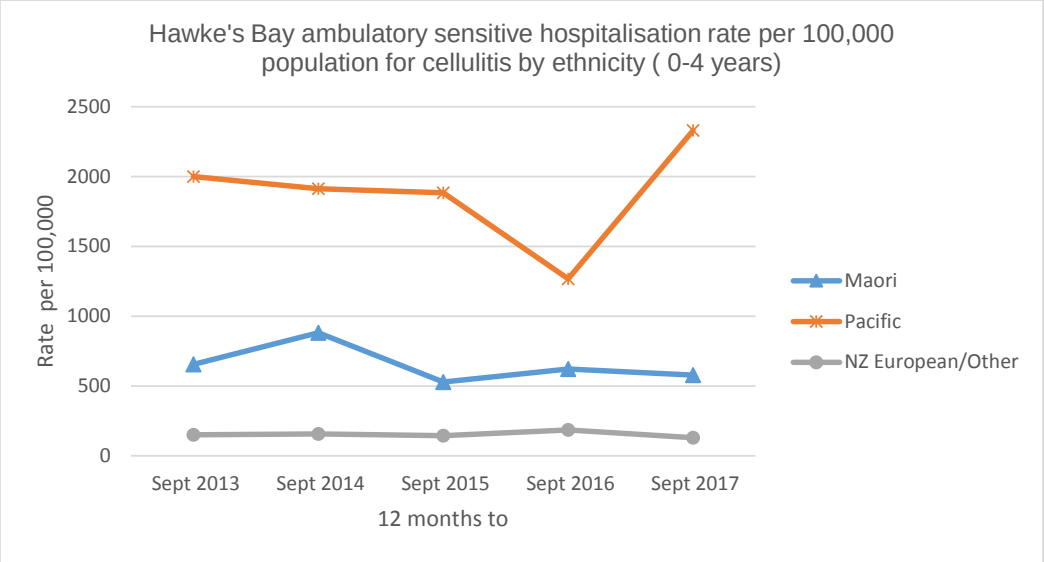
Overall, Hawke's Bay ASH rates for 0-4 year olds remain lower than New Zealand.

Between 2013 and 2015, considerable progress was made towards closing the equity gap for tamariki Māori and Pacific. However since 2015 this trend has stalled, with ASH rates increasing for Māori, Pacific and NZ European/Other children. Good progress continues in reducing avoidable hospital stays for asthma, gastroenteritis and oral health problems.



Source: National Minimum Dataset

Progress on reducing ASH rates for cellulitis in Pacific children has been reversed over the last 12 months.



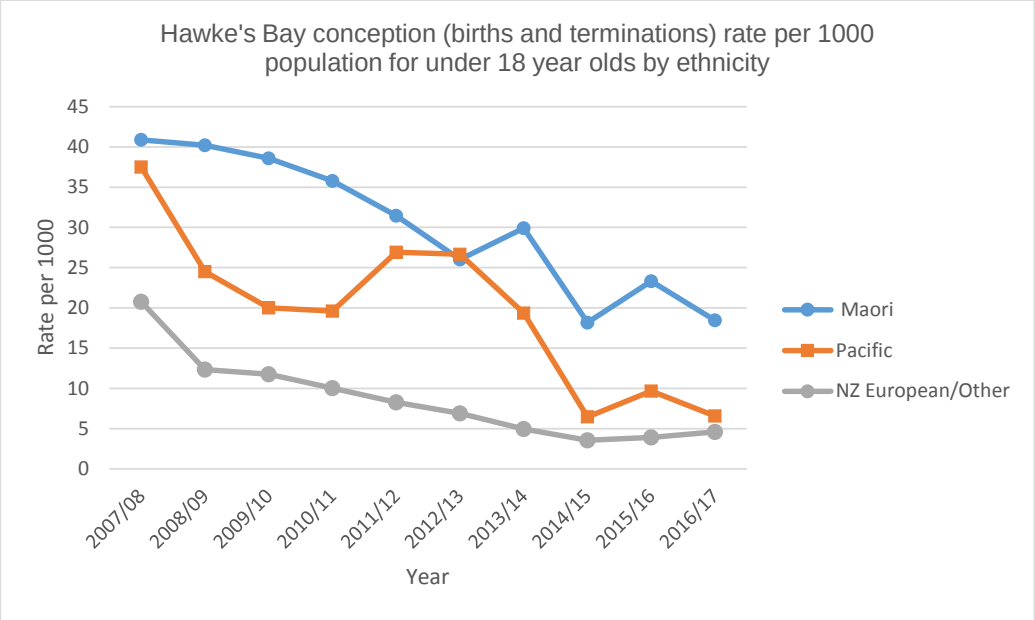
Source: National Minimum Dataset

Health Across the Life Course – Youth

This section presents two key measures where there are significant and persistent inequities for our young people: pregnancy (under 18s) and sexually transmitted infections. These measures provide an indication of the quality and adequacy of our youth health services.

Significant progress made in reducing pregnancy in under 18 year olds but access to services remains an issue

Since 2007/08 the Māori rate of pregnancy for under 18 year olds has decreased by more than half from 41.4 per 1000 to 18.5 per 1000. Despite these health gains, persistent equity gaps for Māori remain. In 2016/17, Māori under 18 year olds were almost four times more likely to have a pregnancy than NZ European/Other. Adolescent pregnancy can have negative health, social and economic effects on girls, their families/whānau and communities, which makes access to appropriate health care for young men and women even more important.

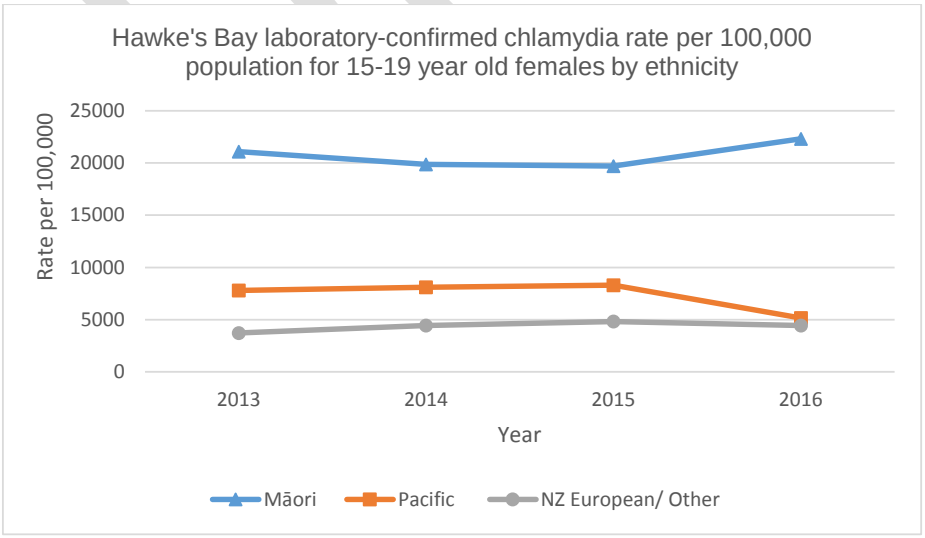


Source: National Minimum Dataset

Large inequities continue in sexually transmitted infections and some sexually transmitted infections (STIs) are increasing

Large equity gaps exist across most STIs, with rangatahi Māori (male and female) most vulnerable to undetected and untreated STIs. Chlamydia and gonorrhoea levels are higher in Hawke's Bay than nationally and syphilis is on the increase.

Improving access to youth-friendly and culturally appropriate care is critical to reduce the harmful effect on individuals and prevent wider STI spread in the community. This will also help to protect the health of future generations, given the harmful impact of STIs on reproductive health and fertility.



Source: Institute of Environmental Science and Research (ESR)

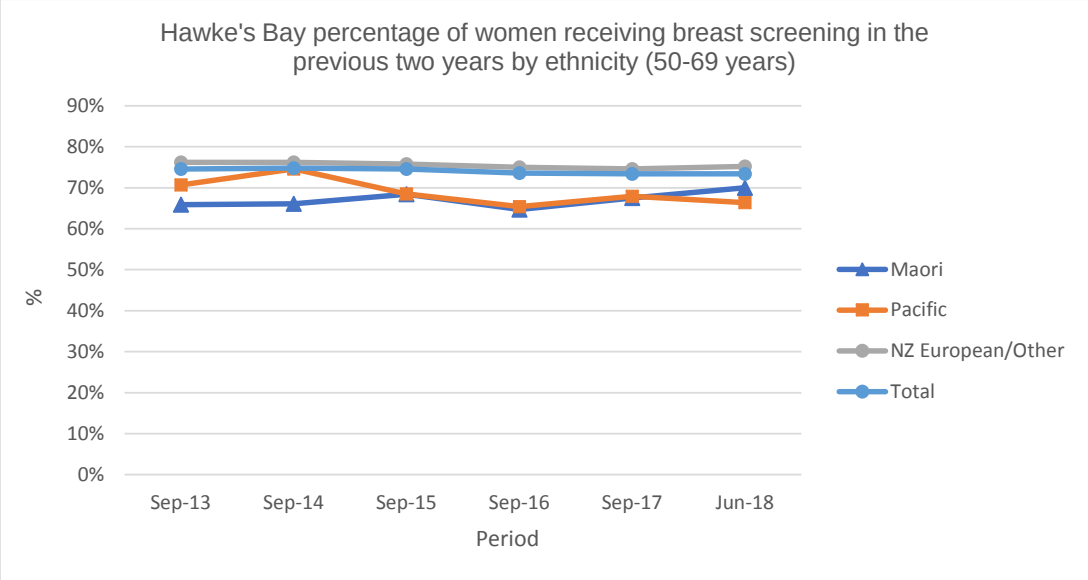
Health Across the Life Course – Adults

Long-term conditions are the leading cause of poor health and early death for adults in Hawke's Bay. This section describes trends for some of the key conditions that contribute most to health loss: cancer, cardiovascular disease, mental illness, respiratory conditions and diabetes.

Breast screening target for wahine Māori achieved this year for the first time

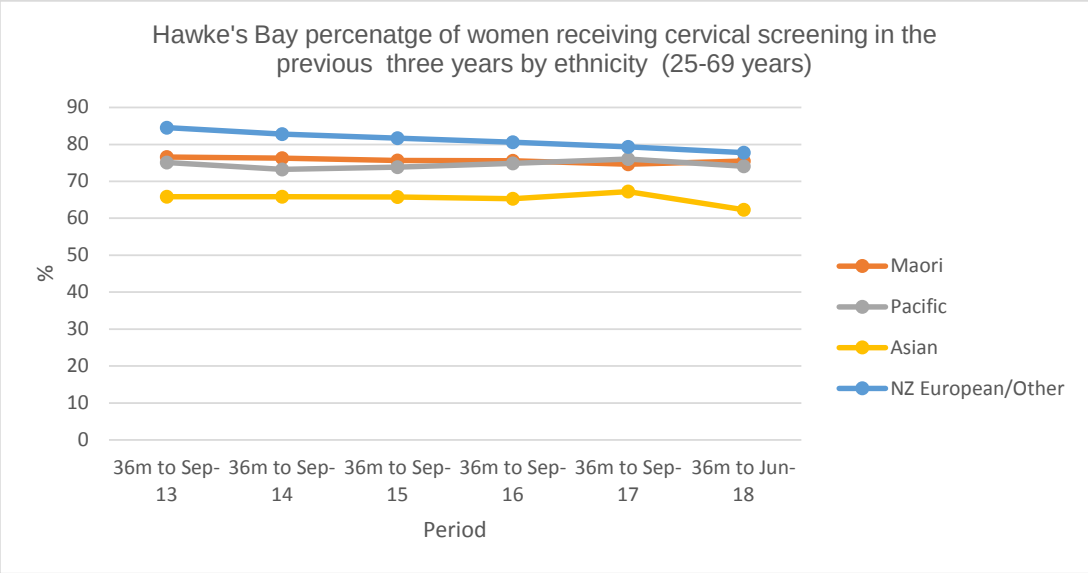
In June 2018, Hawke's Bay reached the Ministry of Health target for breast screening for wahine Māori of 70 percent. This is the first time this target has been achieved.

Rates for Pacific women have however decreased creating an increasing inequity for Pacific women.



Source: BreastScreen Aotearoa

Māori cervical screening rates are holding despite an overall decline



Source: National Cervical Screening Programme

At a national level, overall cervical screening rates are in decline and this trend is also reflected in Hawke's Bay. However in Hawke's Bay, Māori and Pacific screening rates are remaining constant, and this is most likely due to the increased efforts of outreach services for Māori and Pacific women (refer page XX).

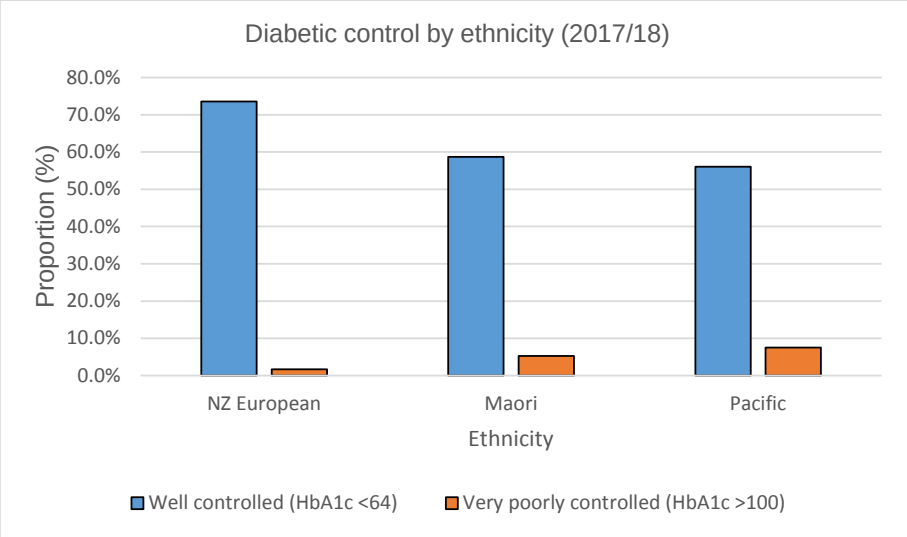
Of concern is that Asian screening rates are persistently lower than other ethnic groups and have declined further in the most recent period to June 2018.

Diabetes remains more common among Pacific and Māori and is less likely to be well controlled

Diabetes is responsible for a significant burden of ill health including cardiovascular disease, kidney disease, and blindness. This is especially the case for Māori and Pacific people who have the highest prevalence of diabetes but are also less likely to have had an annual diabetes check or have their diabetes under good control (HbA1c <65). This is a significant area of mismatch between health need and health service utilisation.

Furthermore, equity between Māori and Pacific and NZ European[2] populations does not appear to have improved between 2015 and 2018.

[2] NZ European only. Does not include Asian/Other

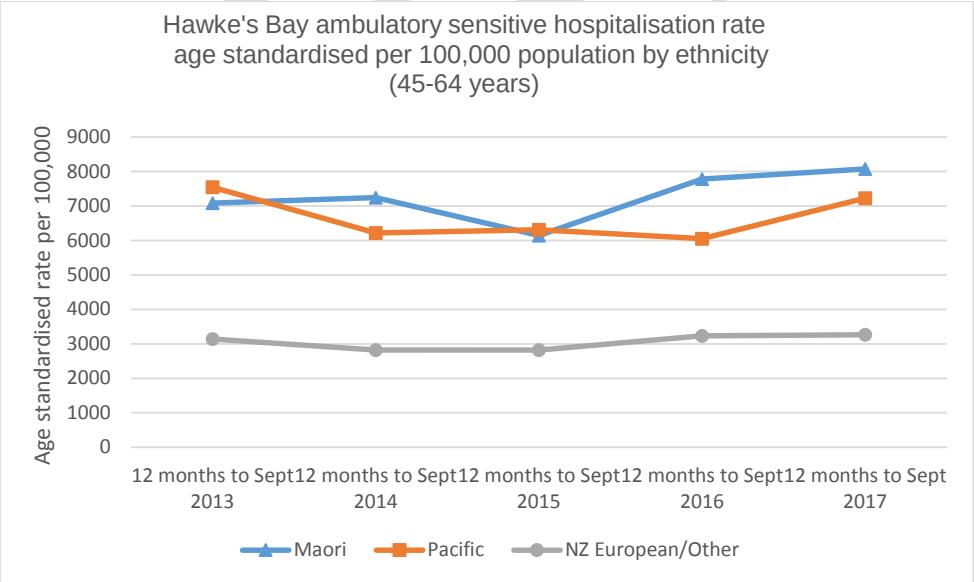


Source: Health Hawke's Bay

Hospital admissions for Māori and Pacific adults (45-64 years) for conditions that could be prevented by primary care are increasing

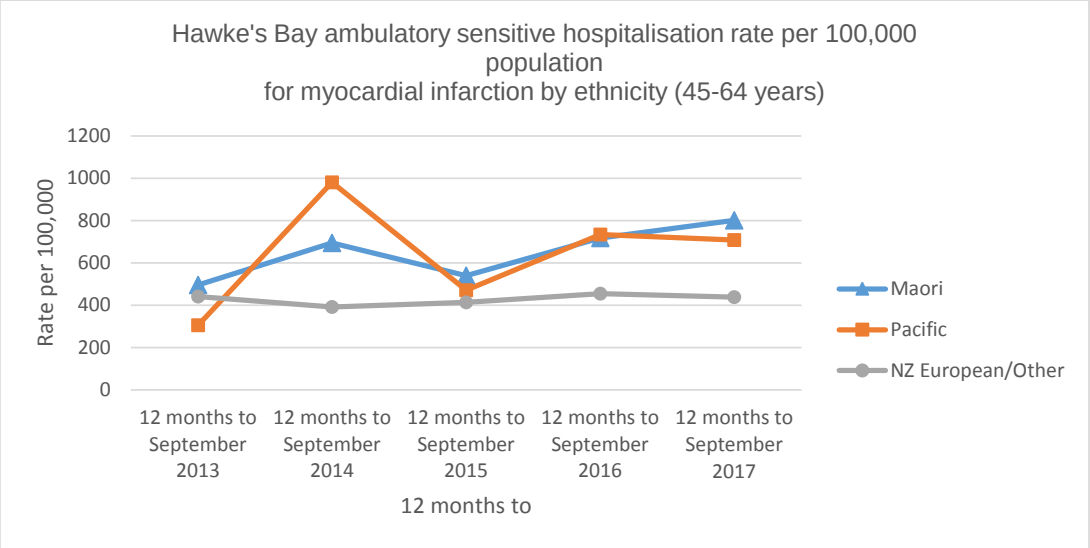
Ambulatory Sensitive Hospitalisations (ASH) are hospital stays for conditions that are potentially treatable or could have been treated earlier in the community. ASH rates provide a useful gauge for primary care access and quality.

Māori and Pacific ASH rates for 45-64 year olds were reducing between 2013 and 2015 but now appear to be increasing. ASH rates for 45-64 year olds in Hawke's Bay are now significantly higher than New Zealand.

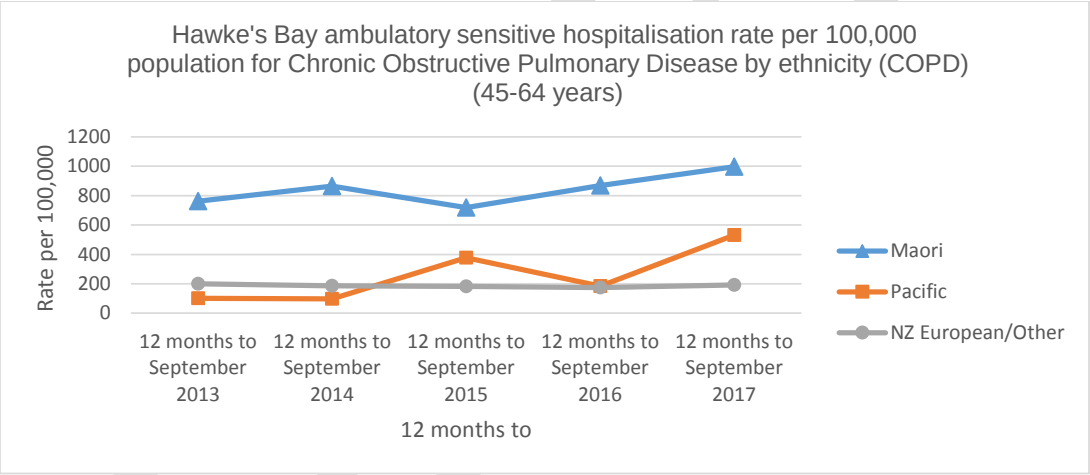


Source: National Minimum Dataset

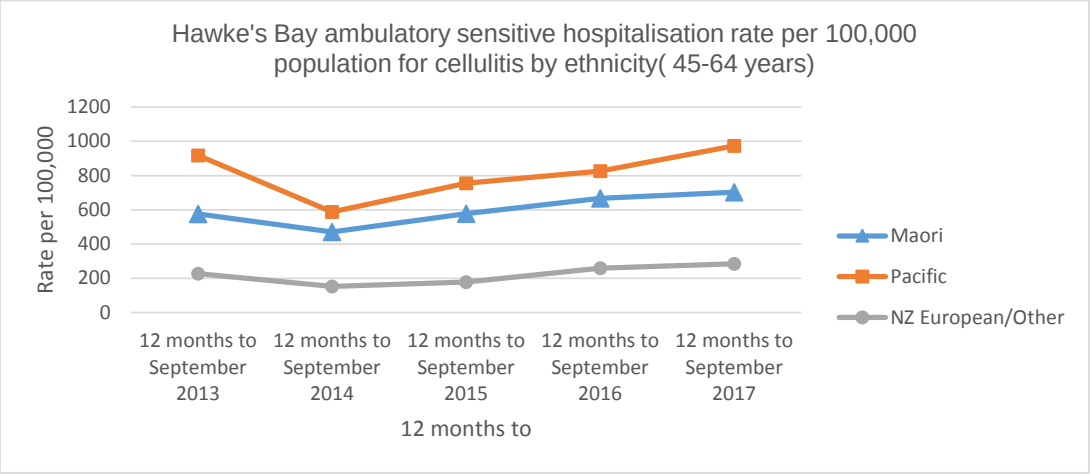
The increase in the overall ASH rate for 45-64 year olds is driven by growth in ASH rates for heart attacks, skin infections and chronic bronchitis and emphysema (COPD).



Source: National Minimum Dataset



Source: National Minimum Dataset



Source: National Minimum Dataset

Health across the life course – The end of life

We have stopped making progress towards equity in early avoidable deaths.

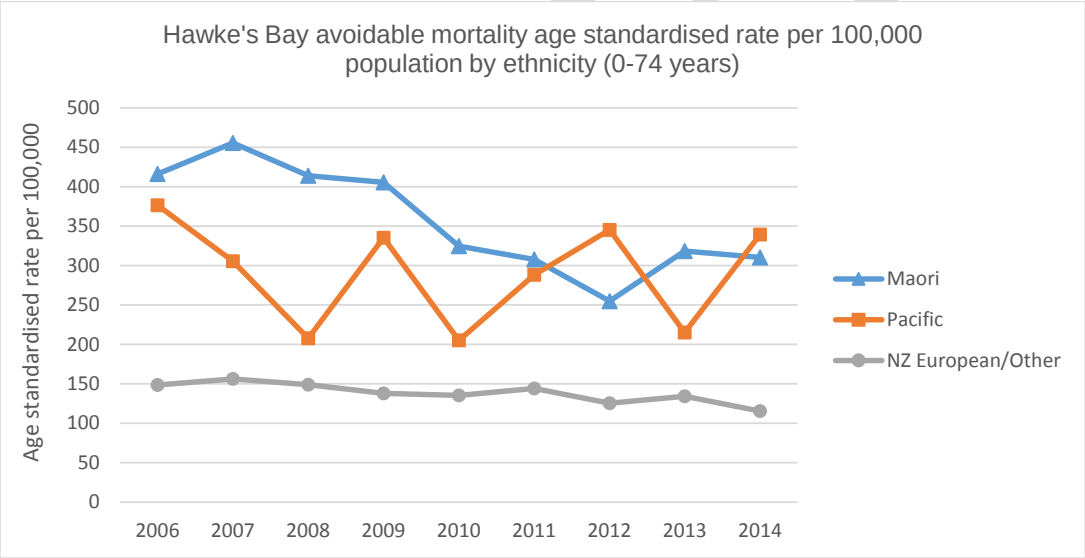
Premature deaths

Premature deaths are deaths that occur before the age of 75 years. An increasing gap in premature death rates due to lung cancer, suicide and heart disease have resulted in an overall stalling of the previous trend towards reducing inequity. Not all deaths prior to 75 years are considered avoidable.

Avoidable deaths

Avoidable deaths are deaths before the age of 75 years that could have been avoided either by disease prevention or effective treatment and health care.

Avoidable death rates for Māori improved significantly from 2006 to 2012 but there have been no further improvements since that time. For Pacific people, there has been no discernible decline in avoidable deaths since 2006/2007. Avoidable death rates for NZ European/Other have been in slow decline since 2006. The result is an increasing equity gap in avoidable deaths for Māori and Pacific people.

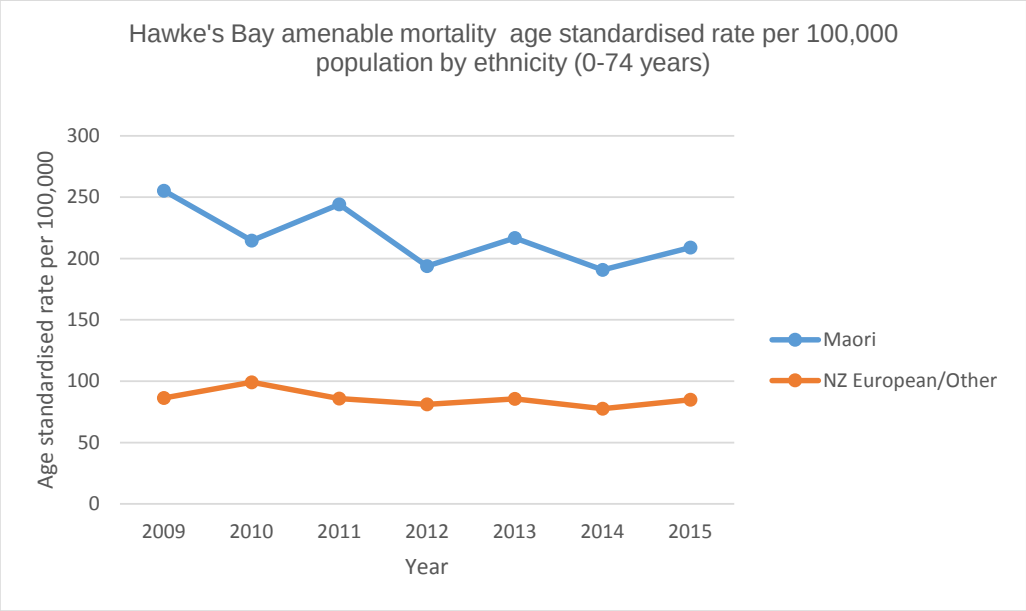


Source: National Mortality Collection 2018.

Amenable deaths

Amenable deaths (a sub-set of avoidable deaths) are deaths which could have been avoided through access to quality health care. Amenable deaths are therefore a good "big picture" indicator of how the health system is performing.

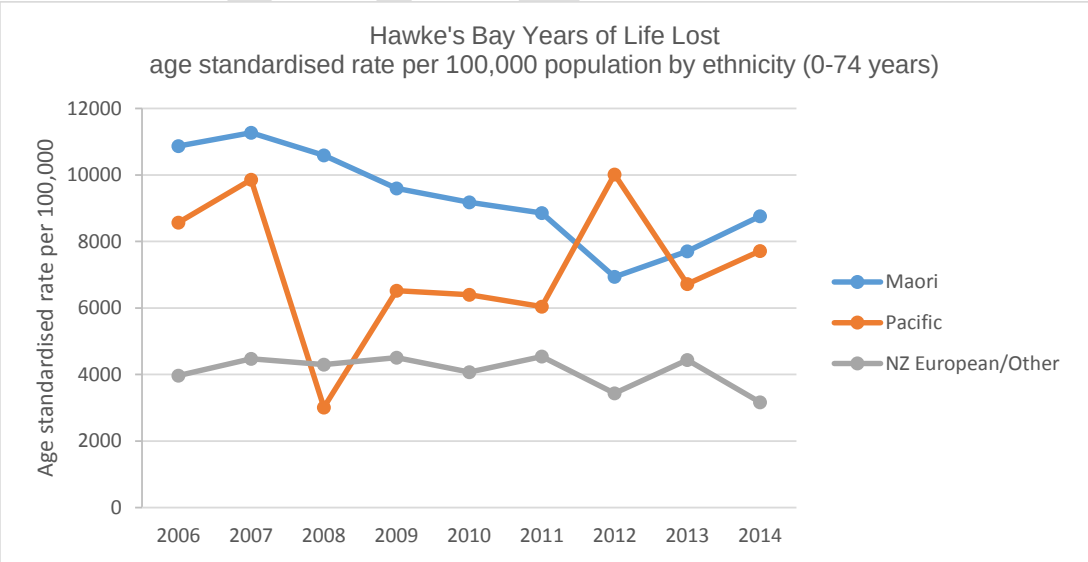
Between 2009 and 2012, amenable deaths for Māori were in decline but in the last three years of available data (2012-2015) that positive trend has stalled.



Source: National Mortality Collection 2018

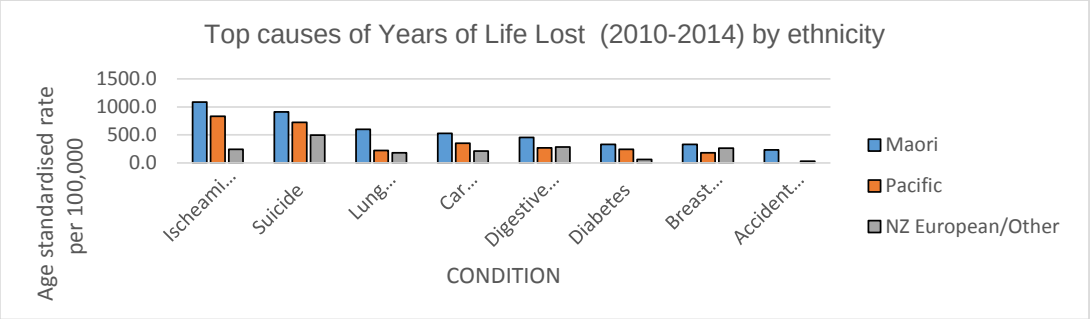
Years of Life Lost

Another way of looking at premature deaths is to calculate the average years a person would have lived if they had not died early. This method, known as Years of Life Lost (YLL), emphasises the importance of deaths which occur at earlier ages because there are more years of life lost. The equity gap in YLL between Māori and NZ European/Other reduced between 2007 and 2012 but in the last two years of available data (2012-2014) progress has stalled. YLL is also increasing for Pacific people.



Source: National Mortality Collection 2018

Top causes of Years of Life Lost for Māori are ischaemic heart disease, suicide, lung cancer and road traffic crashes.



Source: National Mortality Collection 2018

A spotlight on Pacific health

Doing well: Immunisations

Doing OK, could do better: Teenage pregnancy, breast and cervical screening

Biggest challenges: Housing related conditions (acute bronchiolitis, cellulitis), physical activity, obesity, smoking, child oral health, breastfeeding, diabetes, cardiovascular disease.

[Pull outs for inclusion on this page:
99 percent of Pacific two year olds are immunised
Pacific five year olds have the highest rates of tooth decay
Pacific children have the highest rates of avoidable hospital stays]

Towards healthy, strong lives

Talalelei Taufale, Hawke's Bay DHB's Pacific health manager, speaks about Pacific health in Hawke's Bay.

Pacific health in Hawke's Bay

It is important to acknowledge that Pacific people want to live healthy, strong lives. But many Pacific families struggle with socio economic pressures, as well as the demands of balancing Pacific values, culture, language, family and church expectations with societal norms and expectations.

Pacific communities are made up of separate and unique ethnic groups, and approaches may need to vary between them. Also, Pacific and Māori are often addressed as one group.

Our current health system presents obstacles for the Pacific community such as language barriers, cost, transport and hours of opening. The local Pacific community would benefit from a health system that is culturally responsive to Pacific people; and greater understanding of what quality care for Pacific people looks like.

Some health services serve the local Pacific community very well, for example breast and cervical screening. These services have made an effort to understand the Pacific world view and to orient their services to work better for Pacific people.

The DHB's Pasifika health service was established in 2017 and includes a team of outreach navigators (further detail in the story over the page). It is the only dedicated Pacific Health team in the DHB; and is culturally responsive, delivering a whānau-centred service that is making a difference. One Pacific family described our navigators as "angels from heaven".

The Pasifika health service works closely with other health services on how to provide the best service for Pacific people but this takes time. The willingness of services to be involved and undertake this journey of learning is encouraging and will create some real shifts for the way we work with the Pacific community and the outcomes we achieve.

What are the building blocks for improving Pacific health?

1. We need to cement a "turangawaewae" - a place to stand and a sense of belonging for Pacific health at all layers and levels of the DHB. Having a place to stand and a voice to effect change will give assurance to the community that Pacific health is a priority - not an afterthought or an add on.
2. Growing the Pacific health workforce is a priority, especially in the services that Pacific are using the most. We need to create working environments where Pacific staff and patients feel welcomed and supported.

3. We need to reshape the way that our health services work with Pacific communities. We should innovate and work smarter, not harder.
4. The traditional approach of working with individuals does not work for Pacific families. A flexible, whole-of-family approach is a lot more effective. This way we can capture other health conditions and outstanding health checks, as well as improve community understanding of how and when to use services.

Working with families - Pacific style

Paul Faleono is a Pacific Health Navigator with the DHB's Pasifika Health Service and shared this story of how a Pacific-based, whānau centred approach works.

"The Kaotiras migrated from Kiribati to Hawke's Bay in early 2017 to work on a Patoka dairy farm with their five children. Their house was an hour's drive from the nearest doctor. They were isolated geographically and culturally, and they spoke little English.

When we first visited the family, we greeted them in Kiribati and Samoan then sat on the floor and began to talk. We spoke about their family, their village, their island and the reasons they had migrated. From there we were able to talk about health and other issues. We then went away and connected with other health and social services as well as the Healthy Homes team to get the Kaotiras the support they needed.

During the following school holidays we visited the family again, accompanied by a public health nurse. In just one visit, all the children received health checks, were shown how to brush their teeth, skin and ear infections were addressed, and the family was shown how to use their unopened asthma medication. We also provided the father with some patches and gum to help him quit smoking.

The Kaotira family emerged from this visit with more knowledge about the health issues affecting their family and a greater connection with the services that can help them. We visit the Kaotira family at regular intervals and continue to support them on their health journey."

A spotlight on mental health

This Health Equity Report takes a closer look at mental health in Hawke's Bay following from the recommendations in the 2016 Health Equity Report.

A strong sense of mental wellbeing is vital to enable people to live life to the fullest and engage actively in their family or whānau, in employment, hobbies and the wider community.

Data on self-rated health, psychological distress, alcohol and other drug use and mood/anxiety disorders are sourced from the New Zealand Health Survey.

Self-rated health
Self-perceived health is an important measure of both physical and mental wellbeing. Rather than simply capturing physical disease, it provides a degree of insight into a person's lived health experience.

- 87 percent of Hawke's Bay adults describe their health as excellent, very good, or good.
- However only 81 percent of Māori report excellent, very good or good health.
- People living in the least affluent communities also rate their health lower.

Psychological distress:
Psychological distress is where someone is significantly affected by feelings of anxiety, confused emotions, depression or rage.

- Levels of self-reported distress slowly increased in New Zealand between 2011 and 2017. For the 2014 to 2017 period HBDHB was among the DHBs with the highest levels of self-reported distress and Hawke's Bays rate was significantly above the rate for New Zealand.
- Psychological distress is highest for Māori and Pacific people.[3]

Alcohol and other drugs:

- 30 percent of Hawke's Bay adults are hazardous drinkers. This means they are likely to be harming their own health or harming others through their drinking. Young people are particularly vulnerable as earlier initiation, and heavier drinking sessions are more likely to lead to the development of a harmful drinking pattern later in life.
- Amphetamine use in Hawke's Bay appears to be slowly decreasing and is now in line with the rest of New Zealand (having previously been much higher[4]). Unfortunately, this survey data does not include synthetic substances which are a serious concern for many whānau.
- Cannabis[5] use remains significantly higher than the rest of New Zealand. Māori men are the highest users of cannabis in Hawke's Bay.

Mood/anxiety disorders:
Mood/anxiety disorders include depression, bipolar disorder, panic attacks, phobia, post-traumatic stress and obsessive compulsive disorders.

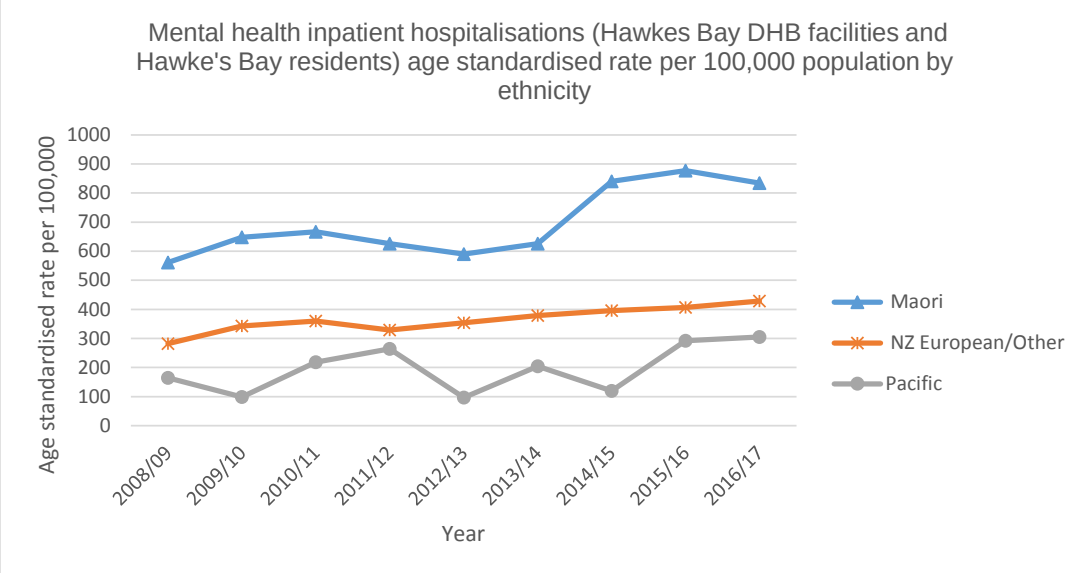
[3] Based on national findings as the Hawke's Bay survey size was too small to reach statistical significance.
4 New Zealand Health Survey
[5] Does not include synthetic cannabis

- Almost one in five Hawke's Bay adults report being diagnosed with a mood or anxiety disorder during their lifetime.
- Women's rates are double those of men.
- People living in our most deprived communities have higher rates than those living in least deprived areas.

Mental Health Inpatient Services and Compulsory Treatment Orders* [footnote at bottom of page: Pacific numbers are very small and below NZ European/Other. Further investigation is needed to establish whether this reflects less need for inpatient services or barriers to access]

Mental health inpatient services and compulsory treatment orders are used only for the most severely ill patients. A compulsory treatment order is a court order requiring a person to receive treatment for up to six months.

- While mental health inpatient hospitalisations have been slowly increasing since 2008/9, the more rapid increase following 2013/14 has likely been influenced by the way clinical services have been delivered with less respite care available in the community, rather than a being driven by a significant increase in community need.
- Māori are 2.5 times more likely to be admitted to mental health inpatient services than non-Māori.
- Compulsory treatment orders for Māori are three times those of non-Māori.



Source: HBDHB Data Warehouse

Intentional self harm

Intentional self-harm is a deliberate act which may not be done with the intention of ending life but nevertheless reflects extreme emotional distress. Traumatic life experiences and a lack of secure relationships increases the risk of self harm.

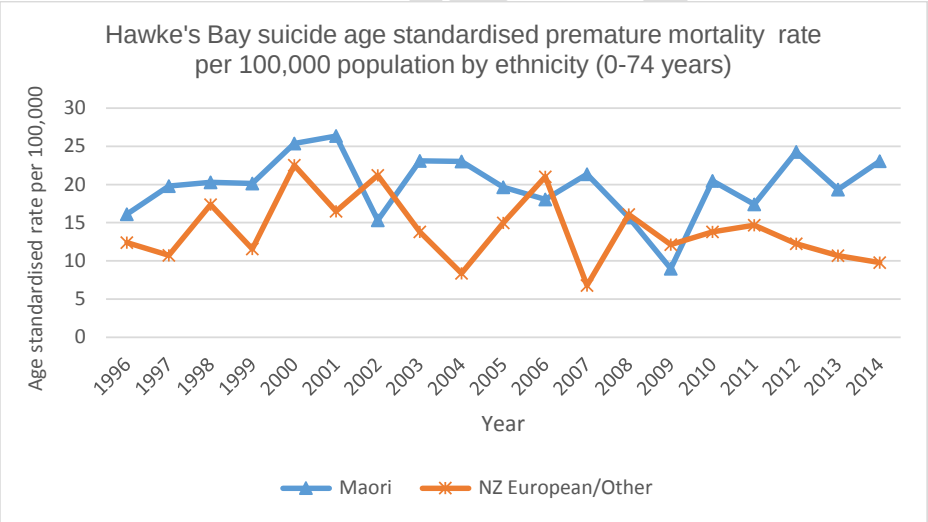
- Hawke's Bay self-harm hospitalisation rates have increased by 30 percent between 2013/14 and 2016/17. While the overall numbers are not large (180 admissions in 2013/14 increasing to 241 admissions in 2016/17) it is a concerning marker of suffering for both individuals and whānau. This is

not solely a Hawke's Bay phenomenon with a similar increase in self-harm hospital stays occurring for New Zealand over the same time period.

- Women's hospitalisation rates for self-harm are double those of men and Māori are more likely to self harm than non-Māori.

Suicide

- Suicide is a major cause of early, avoidable death in Hawke's Bay, especially for Māori. Suicide is the second highest cause of years of life lost (YLL) for Māori and Pacific people (refer page XX).
- The rate of suicide deaths appears to have been reducing for NZ European/Other while Māori suicide rates appear to have increased. Suicide data does need to be interpreted with caution given the small numbers of deaths that occur each year.
- Provisional coronial data (which hasn't been adjusted to account for population growth) indicate that that suicide deaths are increasing over time.
- Alcohol intoxication or a history of alcohol abuse are often associated with youth suicide[6].



Source:

[6] Sir Peter Gluckman. Youth suicide in New Zealand – a discussion paper.

Working in partnership with other agencies to support young people/rangatahi with mental health issues

For Luke, detail is very important so a job researching and digitising historic cemetery records at Hastings District Council was ideal. Luke was employed for six months to get Hastings' old hand-written burial records into an easily searchable on-line format. During this time, Luke built up his computer and research skills while growing his confidence. His completed proposal to Council identified further work – he proposed a 12 month contract and is now the official 'cemetery intern'.

Luke's initial job with Hastings District Council was created as part of the *Rangatahi mā Kia eke* programme – a programme designed to support young people who are experiencing mental health issues (or other health and disability conditions) to overcome barriers to employment. Sponsor organisations identify a project which delivers community or environmental good. A young person is recommended and both the sponsor and young person are supported to deliver the project by the partner agencies.

Over the past 12 months the *Rangatahi mā Kia eke* has delivered some really positive outcomes including re-engaging young people with education, career direction and experience and employment opportunities. The young people have also made a positive contribution to the sponsor organisations they worked for.

The programme is a great example of collaboration in action. The programme is delivered by Hastings District Council and funded by the Ministry of Social Development, who also provide Work Broker support and links to other Work and Income services. EIT, Oranga Tamariki, Te Puni Kokiri and Hawke's Bay DHB provide expert information, links to services and advisory group membership.

Engagement in society including employment is an effective tool in supporting wellbeing and for rangatahi on this programme experiencing mental health issues, it has been life changing.

A spotlight on family violence

This Health Equity Report takes a closer look at family violence in Hawke's Bay following from the recommendations in the 2016 Health Equity Report.

"Family violence is a long-standing and complex problem. It has contributing factors from multiple levels of society. Family violence is preventable, but it will require long-term commitment and sustained action across many sectors. Along the way, we will continue to need high quality responses to those who have experienced violence, and those who have perpetrated it." (New Zealand Family Violence Clearinghouse)

There is no monitoring framework for family violence in Hawke's Bay and there is no straight forward way of measuring the prevalence of family violence in our community. For this report, we look first at a snapshot of key national statistics and we then present two indicators at the Hawke's Bay level. The first is female hospital admissions due to assault and the second is the relationship of offenders of serious assaults to their victims. Both of these indicators capture only the most serious cases of assault and therefore are no measure of the prevalence of family violence in our community.

The national picture in family violence[7]:

- 47% of all homicide deaths in New Zealand are family related
- Almost a third of all family violence deaths in New Zealand are children, who have died as a result of abuse and neglect
- 1 in 3 New Zealand women experience physical and/or sexual abuse from a partner in their lifetime
- 3/4 of intimate partner violence is perpetrated by men and 1/4 by women
- ¾ of interpersonal offences by a family member are not reported to Police
- Pacific young people are 3 times more likely to be exposed to family violence than NZ European
- Māori children are 6 times more likely to die from child abuse or neglect

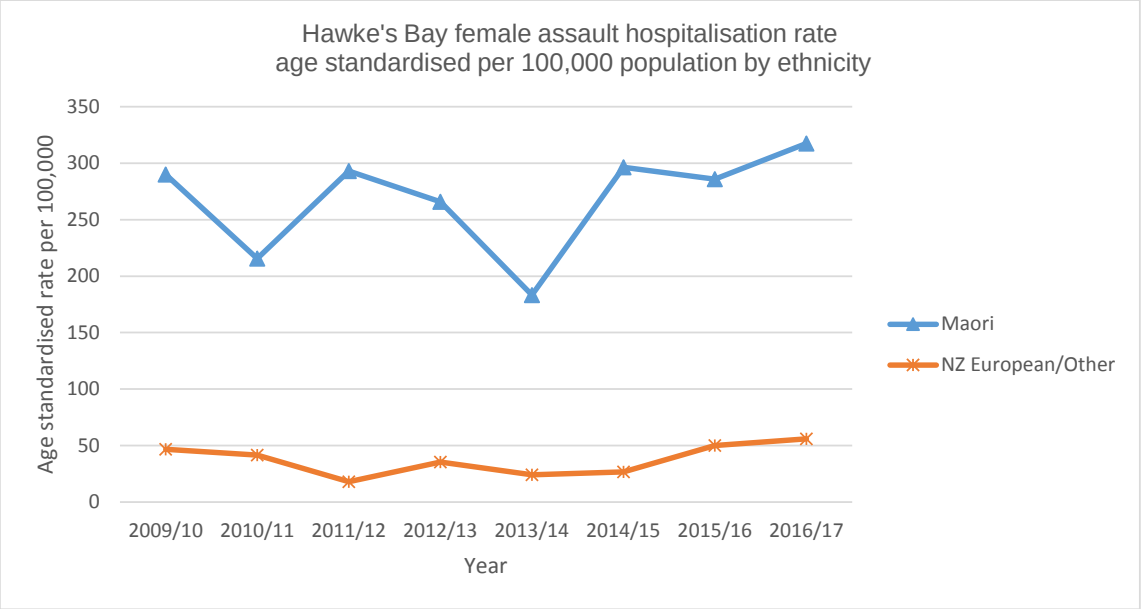
Female hospitalisations for assault in Hawke's Bay

Hawke's Bay female hospital admissions[8] due to assault are presented below. These hospital admissions include assaults by any person, not just family members. They are not, therefore, a direct measure of family violence but they do provide part of the picture.

Female hospitalisation rates for assault are increasing over time and in 2016/17, Hawke's Bay female hospitalisation rates for assault were higher than New Zealand female rates (reaching statistical significance). Hawke's Bay Māori female hospital admissions due to assault are six times those of NZ European/Other.

[7] Family Violence Clearinghouse

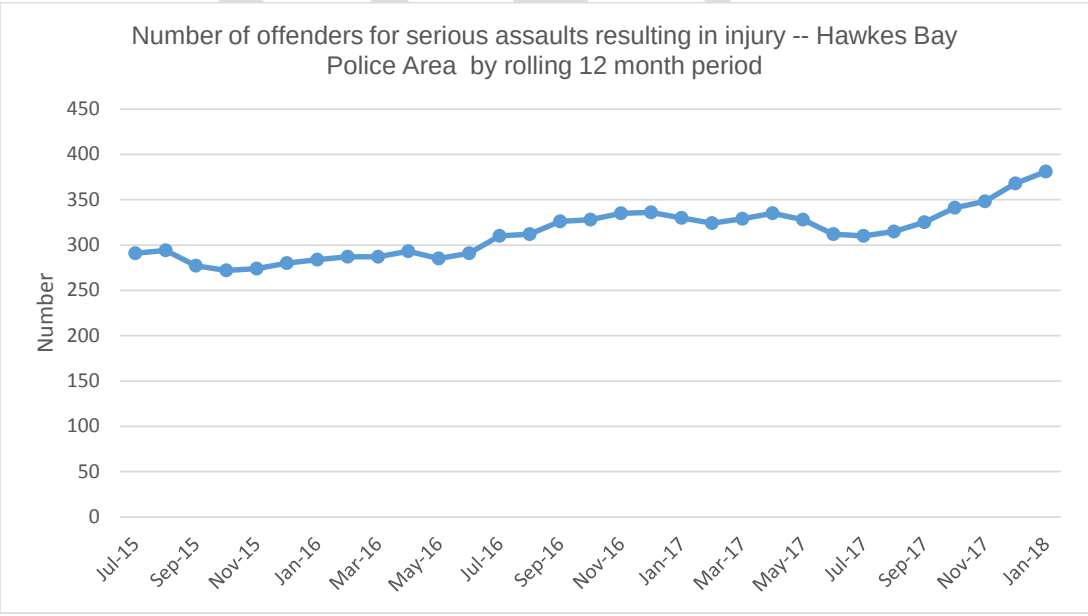
[8] Includes females of all ages but predominantly adult females



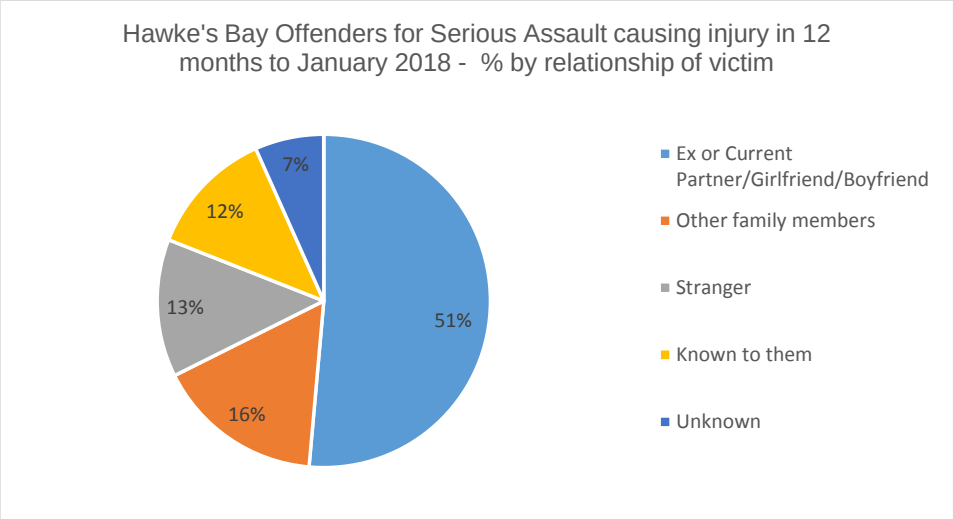
Source: National Minimum Dataset

Serious assault causing injury

Police data records serious assaults causing injury and the relationship of the offender and victim. Over half of the victims of serious assault causing injury are a current or past partner of the offender. A further 16 percent are other family members.



Source: New Zealand Police



Source: New Zealand Police

A spotlight on housing and health

Poor housing causes poor health.

Cold and damp housing coupled with household crowding continues to affect the health and wellbeing of many Hawke's Bay families.

Poor housing conditions are regularly linked to presentations of young children suffering from acute bronchiolitis – a viral infection of the airways. Māori children are three times and Pacific children five times more likely to get bronchiolitis than NZ European/Other children. Acute bronchiolitis is not easily treated by a visit to the doctor, but there is clear evidence it can be reduced with warm, dry and uncrowded housing.

Household crowding is also an important risk factor for a range of infectious diseases including pneumonia, bronchiolitis, gastroenteritis, rheumatic fever, tuberculosis and skin infections.

Pacific children are more likely to be admitted to hospital for a skin infection while acute rheumatic fever and tuberculosis continue to impact Māori and Pacific people at much higher rates than NZ European.

Hawke's Bay's challenges:

- Demand for social housing has tripled over the last three years
- Two thirds of people on the social housing register are Māori
- There are many rental homes in the private rental market in substandard condition adding to poor health outcomes for tenants.

Turning health outcomes around for Māori and Pacific families requires addressing these challenging housing situations. Hawke's Bay DHB has responded to this need with a Child Healthy Housing Programme where there are many initiatives making a positive impact on the health and wellbeing of families. Complimenting this work is a Ready to Rent programme, supported by the Hawke's Bay Housing Coalition and wider networks (see separate story).

These programmes are a step in the right direction to achieving healthier homes and a healthier population but there is much work to be done to curb the insufficient or unacceptable housing situation faced by many.

Home is where the health is

Mel Westwood is a kaiawhina for the DHB's Child Healthy Housing Programme and shares a story about the work it does to support families in need.

A grandmother and her five grandchildren were referred to Hawke's Bay DHB's Child Healthy Housing team after one child got pneumonia. All six of the family had respiratory issues and one child was in a wheelchair with high health needs.

The rental property the family were in was uninsulated and droughty. Weatherboards and flashings were missing and black mould was growing in the bedrooms. The ceiling was sagging in parts and falling down in others. Mouse droppings and other debris would fall into the house through holes in the ceiling. There was not a single smoke alarm in the house.

The Child Healthy Housing team helped this family to find a long term rental which was dry, insulated, had new carpets and curtains as well as a compliant fireplace. The team arranged for wheelchair modifications and donated bunks and bedding. This family are feeling very happy and secure in their new home thanks to the instant health benefits. They enjoyed a warm winter with no hospital admissions.

The Child Healthy Housing Programme has helped over 800 families to improve the health of their homes.

Ready to Rent

Ready to Rent (R2R) began as a small idea which is fast growing into a local gem, receiving nationwide attention.

The brainchild of the Hawke's Bay Housing Coalition, a group of local organisations who joined forces to improve access to quality housing, R2R is led by Hawke's Bay DHB, supported by the Hawke's Bay Property Investor's Association, Te Taiwhenua o Heretaunga, WINZ, budget advice services and others.

This local initiative is aimed at up-skilling potential tenants struggling to find a rental property and providing them with a 'support letter' they can use when applying for tenancies in the future.

Since its launch in 2017, 140 people have attended R2R, of which 75 percent have been Māori. The programme has assisted attendees successfully enter a competitive private rental market by building their skills and knowledge around renting. The programme includes sessions on the rights and responsibilities of tenants, what landlords want in a tenant, how to keep your home warm, dry and healthy as well as managing money and debts.

The New Zealand Property Investors' Federation (NZPIF) has praised the initiative saying that combined with compulsory insulation, the Ready to Rent programme was a cost-effective solution that would see the living standards of renters improve considerably.

"The New Zealand Property Investors' Federation (NZPIF) fully supports the Hawke's Bay District Health Board's Ready to Rent Program," it stated in a press release. "A study of local landlords showed that 85 percent would use this scheme to find the best candidate for their property."

Ready to Rent is a great example of local people with local relationships, ready and willing to address a local issue.

A spotlight on screening

Reaching Out

A new pathway implemented in 2017 has resulted in the most successful breast screening year yet in Hawke's Bay, with record numbers of wahine (female) Māori receiving their mammogram in 2018 and the region achieving national Ministry of Health targets for wahine Māori of 70 percent for the first time.

The new pathway was implemented to prioritise women (Māori and Pacific) who were due or overdue for breast screening. The women were invited to attend a mobile screening facility, offered incentives to attend their appointment and were well supported through their journey. This support was thanks to the collaboration between the Hawke's Bay DHB's population health screening team, BreastScreen Coast to Coast, general practices and Māori health providers.

Cervical sceening was another area where an increased focus on Māori and Pacific women saw an improvement in screening rates and a narrowing of the equity gap.

Cervical Screening Outreach Service Insight

Margaret Alexander is a kaiawhina working with Hawke's Bay DHB's cervical screening outreach service.

"Our service reaches out to Māori and Pacific women in high need communities by visiting them in their own homes and offering a smear service within their home environment. The women we reach out to do not typically engage with their doctor or respond to recalls because the system hasn't met their needs. The first thing we do is be accessible and gain trust and understanding of their situation. We also educate these women about the positive health benefits of screening. If you can engage positively you're half way towards meeting their needs.

We will often visit hesitant women a number of times, but we don't give up. In a culturally sensitive way, and in their own time and space, we get to the bottom of why someone may be unsure about having a smear.

We know our approach is working because most women will re-engage with their general practice at the end of our time with them. New relationships are also made with other women in the whānau who express a desire to connect with the service."

The outcomes

Cervical cancer is one of the easiest cancers to prevent, so long as cell changes are detected early. Many of the women we screen tell us that they wouldn't have done it if we hadn't come to them. So we know we are saving lives.

We support women to come together and recognise their worth as individuals, get aboard the waka and tautoko (support) each other to address their health needs and complete their smear as whānau. The benefits of having three generations of women in the same room giving each other awhi is so rewarding.

Benefits beyond screening

The nature of our service means that once kaiawhina are in the homes, other health needs can also be discussed and guidance or referrals given. "

Culture counts – the significance of age in Māori society

As a society everyone values a long and healthy life. Yet for Māori, Pacific and people living in greater deprivation, the reality is one of a shorter, less healthy life.

Premature mortality and living with long term conditions take a huge toll on Māori leadership, whānau, hapū and iwi and it erodes Māori culture or "cultural capital".

What is cultural capital?
"Cultural capital" is the fabric that holds Māori society together, it is about holding fast to the treasures of your ancestors. Acquiring cultural capital takes a life-long dedication to its practice, recital and song. It is also the expected behaviour under the leadership of kaumātua, koroua and kuia. The marae, or centre for cultural and traditional activities remain the most enduring Māori institution.

Age, mana and tribal integrity
A flourishing community and culture depends on the transfer of tradition, roles and responsibilities, and language down through the generations. With age comes mana. It is the older generation who carry the status, tradition and integrity of their people. Elders are recognised for their life experiences and the knowledge they have accumulated over the years. Without leadership at that level, a Māori community will be the poorer and, at least in other Māori eyes, unable to function effectively or to fulfil its obligations.

Yet many are not surviving long enough to take up the challenge and to play their role in ensuring the continuation of Māori culture.

It is well established that a strong sense of "cultural identity" has benefits for physical, mental and spiritual health for Māori and Pacific people. The loss of culture through premature mortality, therefore, has important implications for younger generations.

Mauri ora!

What is the cause of early and avoidable death among Māori and Pacific people?

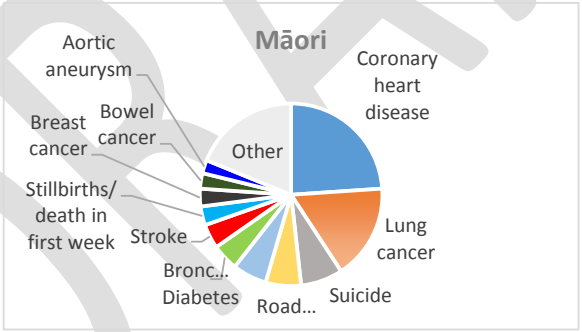
In Hawke's Bay, the gap in life expectancy between Māori and non- Māori is 8.2 years for males and 7.7 years for females[9]. This shorter life expectancy is because Māori, along with Pacific and people living in the least affluent parts of Hawke's Bay, are more likely to die at younger ages from conditions which are preventable or treatable. We call these "avoidable" deaths.

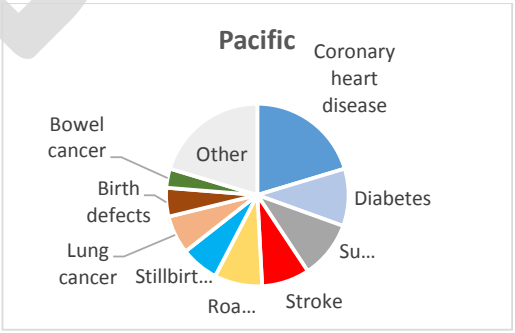
Avoidable deaths are deaths before the age of 75 years that could have been avoided either by disease prevention or effective treatment *and health care.*

After a long period of improvement, avoidable death rates for Māori have stopped falling. For Pacific people, there has been no discernible change in avoidable deaths since 2006/2007. Meanwhile, the long term picture for NZ European/Other is one of steady improvement, resulting in a widening of the equity gap.

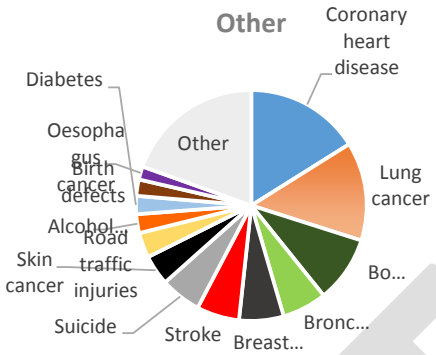
Māori and Pacific people also live less years in good health. Living with long-term conditions such as diabetes, cancers, cardiovascular diseases, respiratory diseases and mental illness are part of the modern Māori health story.

Top causes of avoidable deaths
Coronary heart disease is the biggest cause of avoidable death across all ethnic groups. For Māori, lung cancer is the second biggest, followed by suicide and road crashes. For Pacific people, coronary heart disease is followed by diabetes, suicide and stroke. For NZ European/Other, coronary heart and lung cancer are also top causes, alongside bowel and breast cancer.





[9] Based on life expectancy analysis by Statistics NZ for 2012-14. Updated life expectancy data expected in 2020.



How could these early deaths be avoided?

Prevention
Most of the top causes of early avoidable deaths are underpinned by behavioural factors including smoking, poor nutrition, insufficient physical activity and hazardous drinking.

However, the solution is not as simple as saying behaviour needs to change. Health behaviours are linked to underlying social conditions, emotional trauma early in life, inter-generational disadvantage and the effects of colonisation, feelings of empowerment (which are lower in more deprived communities) and the ease of healthy choices in the surrounding environment. An example of this is the higher density of fast food and alcohol outlets in low income communities, making the healthy choice much harder to make.

A recent New Zealand study[10] found that socioeconomic factors are responsible for 42-46 percent of inequities. This tells us that reducing socioeconomic disparities would greatly reduce the equity gap in deaths over the long term.

Providing equitable and timely health care services
Māori are more likely to die early from a condition which was potentially avoidable through the effective and timely use of health services than NZ European/Other. Coronary heart disease is by far the largest of these causes of death.

Why are Māori and Pacific people not using the health services that will help them to live longer? What is preventing them from entering the system at the right time, and what is happening on their journey through the system? Key factors include opening hours, transport and cost, difficulties navigating a complex health system, cultural responsiveness of the services they use and subjective/ethnic bias within the system.

[10] Blakely, T, Disney, G et al (2018). Socioeconomic and Tobacco Mediation of Ethnic Inequalities in Mortality over Time. Repeated Census-mortality Cohort Studies, 1981 to 2011. *Epidemiology* 2018;29: 506–516.

What does this all mean and what are our next steps?

This report demonstrates that in Te Matau a Māui/Hawke's Bay, different groups within our population experience differences in health outcomes that are not only avoidable or preventable, they are also unfair and unjust.

As New Zealanders we have a strong sense of fairness. We understand that life can provide more challenges to some than to others but we don't accept that disadvantage should prevent any of us from participating fully in society. We believe that everyone should have enough nutritious food to eat, safe and healthy housing and that all children should have the opportunity to enjoy educational success. This report reflects the view that social and economic disadvantage should not prevent any of us from enjoying a full and healthy life. In fact, health is one of the most important resources each of us needs to achieve the goal of full participation.

In the same way as providing equal educational opportunities for all children requires different approaches and resources for different groups, achieving health equity in Hawke's Bay will require different approaches and resources for different groups to get the same health outcomes.

The priority health issues

All of the findings in this report are important but when we consider the picture overall some common themes emerge.

- Rates of premature and avoidable deaths for Māori and Pacific people have stopped declining while decline has continued for NZ European/Other. Reducing inequity will require focusing on heart disease, lung cancer, suicide and vehicle crashes for Māori and heart disease, diabetes, suicide and stroke for Pacific people. The analysis of deaths by life years lost highlights the particular importance of suicide and vehicle crashes. The deaths due to these causes occur at a higher rate among young people making these issues a particular priority.

- Similar patterns of inequity are also evident in hospital stays that can be avoided through better community care. For the middle adulthood population inequity for Māori and Pacific people is increasing and the biggest inequities are in avoidable hospital stays for heart attacks, chronic lung disease and skin infections.

- For preschool children good progress continues in reducing avoidable hospital stays for asthma, gastroenteritis and oral health problems but skin infection hospital visits are increasing for Pacific children.

- There is more to health than hospital stays and dying and other measures of health service performance such as those linked to sexual health show persisting inequities reflecting the need for an increased focus on youth health services. This report also highlights the importance of mental health and family violence as key issues.

The underlying causes

The health issues identified above are influenced by inequities in behavioural and other known risk factors. These factors operate over a lifetime and so trends in deaths will be linked to behaviours over many years. However it is also concerning to find that alcohol use is increasing, tobacco use remains much higher in Hawke's Bay, and that smoking among hapu (pregnant) wahine Māori is not declining. An adequate intake of fruit and vegetable is still not being achieved by many despite the horticultural resources of our district and physical inactivity is increasing despite pro activity initiatives such as the iWay cycle programme and Iron Māori.

Our reviews of mental health and family violence highlight key health issues that can also be seen as a symptom of more fundamental causes. Inequities for Māori in: mental distress rates, hospital stays for mental illness, self-harm and assault, and suicide rates all point to more fundamental and persisting inequities in

socioeconomic determinants of health within our society. Differences in socioeconomic determinants can in turn be linked to the inter-generational, traumatic and long term impacts that colonisation has had on Māori health, wellbeing and culture in Hawke's Bay.

Learning from our successes

The successes in immunisation, screening programmes, reductions in teenage pregnancy and youth not in employment, education or training (NEET) all demonstrate that equity can be achieved. When we deliberately focus on eliminating inequity and establish services that provide culturally appropriate services to whānau at a time and place that meets their needs we can succeed. Other successes such as the reductions in some ASH rates for children demonstrate the potential for achieving equity with whānau centred and integrated approaches to healthcare or, in the case of the NEET rates, through concerted multi-agency action. We need to take the lessons from these successes and incorporate them into our social and organisational structures so that we create health sector and society-wide equity promoting systems.

Learning from world best practice

The Nuka System of Care is a holistic healthcare system owned, created, and implemented by Alaska Native people to maximise physical, mental, emotional, and spiritual well-being. There is much that we can learn from Nuka which is recognised internationally for its success. Nuka are particularly skilled in asking their communities about whanau health priorities and negotiating with them around delivering these services. They use real time feedback from the communities they serve as well as clinical data to rapidly improve services to meet desired outcomes. In Hawke's Bay, this will mean changing the nature of our relationships with Māori providers to one where Māori owned providers have greater self-determination and autonomy. This will also mean challenging non-Māori, non-Pacific world views of health care systems, funding, and power. Partnering with people and whānau in meaningful, participatory ways where power is shared is critical if we are going to understand the root causes of inequities and design successful solutions.

We know that health care is responsible for around 10% of health inequities. This is something that is within our control as a sector and we can make immediate progress on this. Barriers to high quality health care include difficulties in navigating our complex systems, the cultural competence of providers, limited knowledge of how and when to use services, lack of transport, out-of-pocket costs and co-payments for GP services. The Nuka example can help guide is as we address these issues.

Wider opportunities to achieve equity

Almost half of inequities would be eliminated by addressing disparities in socio-economic conditions. We all know that this is not simple, nor is it something that we can address quickly. But we must work together as a whole community to find ways to increase the pace of change. Current government priorities align well with increased focus on issues such as reducing child poverty, increasing housing supply, and improving mental health. Locally we have already established the Mātariki partnership. As this partnership moves to focus more on equitable outcomes as a key priority there will be more opportunity for local system change to achieve health equity.

Meeting our treaty obligations remains critical to achieving health equity. As Treaty Settlement groups move into their post settlement phase there is much cause for optimism. Post treaty settlement groups will not only assist in addressing economic disadvantage for Māori but will become key partners in reducing health inequities.

Next Steps

1. Listen to our communities most impacted by health inequities and act to change services

   This report identifies some priority health issues and determinants but this is just a starting point. Our next step must be to go to our communities and ask 'what matters to them' and 'how they can inform service responses to meet their needs'

2. Partner with Māori and Pacific leaders to develop an action plan to address health inequities

This report discusses some of the ingredients of success above but many of the solutions to the issues identified in this report will come from the communities most affected. A next step must be to establish an equity action planning process with these communities.

3. Invest in whānau ora approaches to community needs

More root cause analysis of specific issues such as cardiac health inequity will assist in designing issue specific responses. However we also need to ensure that rather than limiting our response to issue specific action plans we take a system wide perspective that focuses on total system and cultural change based on whānau ora approaches.

4. Establish an organisational response to inequity that establishes an equity promoting system and explicitly tackles structural ethnic bias

In order for us to achieve equity we must establish equity as core property of the health system in Hawke's Bay. This means changing the way we do things across the system and making sure that everything we do will reduce inequity. Part of that process will involve dealing with ethnic bias within our system. The existence of bias or disadvantage based on ethnicity and socioeconomic status are well established in New Zealand and elsewhere. Even when we account for socioeconomic factors inequities based on ethnicity remain. This bias, sometimes known as institutional or structural racism, remains an important cause of inequity and we will engage in a fearless, honest and respectful discussion about this so that we can work together to address it.

To eliminate inequities in life expectancy we must focus on preventing Māori and Pacific people from dying early

Due to

Māori:	Pacific:
Coronary heart	Coronary heart
Lung cancer	Diabetes
Suicide	Suicide
Road crashes	Stroke
	Stroke

Which could have been avoided through

Healthy behaviours *Effective and timely health services*

Which are influenced by

Social conditions	Intergenerational disadvantage	Feeling disempowered	Whether our environment makes healthy choices easy	Cost and logistical barriers	Difficulties navigating complex systems	Culturally appropriate services	Subjective/ethnic bias

HAWKE'S BAY District Health Board Whakawāteatia	**Collaborative Pathways** For the attention of: **HB Clinical Council**
Document Owner:	Mark Peterson, Chief Medical Officer – Primary Care
Document Author(s):	Penny Rongotoa, Planning and Commissioning Manager
Reviewed by:	Jill Garrett, Senior Planning and Commissioning Manager
Month:	November, 2018
Purpose	Endorse local direction for Collaborative Pathways
Previous Consideration Discussions	Previous EMT papers discussing options that has progressed to next phase of decision making
Summary	**Background** With the dis-establishment of Map of Medicine platform, Hawke's Bay DHB have been considering alternative options. Discussions have been had with Streamliners (Health Pathways), Mid-Central and Wanganui DHB. Information gained from Hawke's Bay DHB Intelligence Team, along with learnings from other DHB regions; Midlands and Capital Coast have also informed HBDHB options and recommendations. **Ideas behind our recommendations** • Currently pathways come at a high cost for low utilisation • They are resource intensive particulary in the development phase • We already produce localised pathways • Capacity within the DHB has been created to co-create pathways across both primary and secondary services • There are significant cost/ budget gains to be made by HBDHB having a localised approach to pathway development that support clinical and collaborative best practice guidelines **Recommended approach** • Hawke's Bay DHB temporarily make current clinical pathways available whilst working with IT Team to create a platform for current and new simplified pathways.
Contribution to Goals and Strategic Implications	New Zealand Health Strategy • Smart System • Closer to home • Value and high performance Hawke's Bay Clinical Services Plan • Evolving primary care • Hospital takes a narrower focus in future • Well supported transitions to and from hospital

Impact on Reducing Inequities/Disparities	The work of pathways aligns to equity and triple aim. HEAT aligns with LTC HEAT
Consumer Engagement	N/A
Other Consultation /Involvement	Chief Medical Officer – Primary Care
Financial/Budget Impact	As described above
Timing Issues	Service agreement with temporary platform Care Pathways ends 30th December 2018
Announcements/ Communications	Clinical Council

RECOMMENDATION

That HB Clinical Council recommend to Commissioning Leadership Team that they:

1. **Endorse** local direction for Collaborative Pathways

ADVANCE CARE PLANNING

Late Paper

11

CLINICAL ADVISORY & GOVERNANCE GROUP UPDATE

Verbal

CLINICAL COMMITTEE REPORTS

HAWKE'S BAY District Health Board Whakawāteatia	**Patient Safety & Risk Management Committee Update**
	For the attention of: **HB Clinical Council**
Document Owner(s)	Russell Wills, Medical Director Quality & Patient Safety Chris McKenna, Chief Nursing & Midwifery Officer
Document Author	Russell Wills, Medical Director Quality & Patient Safety Chris McKenna, Chief Nursing & Midwifery Officer
Reviewed by	N/A
Month/Year	November, 2018
Purpose	For Information
Previous Consideration Discussions	N/A
Summary	Key risks to note this quarter: • Falls prevention equipment availability and storage • Installation of handrails limited by acute demand • Partner violence and child protection assessments not performed • Maternity unfilled positions and worthwhile but unsustainable demands from quality improvement projects • Capacity for air transports to and from Wairoa and Wellington • Access to Clinical Skills Lab for resuscitation training • Ongoing funding for ICNet
Contribution to Goals and Strategic Implications	To provide assurance to the Hawkes Bay Clinical Council that essential requirements relating to patient safety and clinical risk within the Hawkes Bay health system, are effectively monitored and appropriately managed and enhanced
Impact on Reducing Inequities/Disparities	Terms of Reference include quadruple aim re pursuit of improved health and equity for all populations
Consumer Engagement	Consumer member attends meeting
Other Consultation/ Involvement	Chairs of Advisory Groups reporting to this Committee
Financial/Budget Impact	N/A
Timing Issues	N/A
Announcements/ Communications	N/A

RECOMMENDATION:

It is recommended that the HB Clinical Council:

1. **Note** the contents of this report
2. **Provide feedback** on any issues/points of interest raised

Patient Safety & Risk Management Committee

Author:	Russell Wills and Chris McKenna
Designation:	Medical Director Quality & Patient Safety / Chief Nursing & Midwifery Officer
Date:	November 2018

OVERVIEW

This is the first report of the Patient Safety & Risk Management Committee (PS&RMC) that contributes to Council's new Clinical Governance Committee Structure.

The purpose of the Committee is to provide assurance to the Hawke's Bay Clinical Council that all matters relating to patient safety and clinical risk within the Hawkes Bay health system are effectively monitored and appropriately managed and enhanced.

The PS&RMC governs the following Advisory Groups (AG):

- Clinical Risk & Events AG. Chair: John Gommans
- Family Violence Intervention & Child Protection AG. Chair: Claire Caddie
- Infection Prevention & Control AG. Chair: Andrew Burns
- Maternity Clinical Governance AG. Chair: Jules Arthur
- Patient at Risk AG. Chair: Ross Freebairn
- Reducing Harm from Falls AG. Chair: Kerri Cooley
- Restraint AG. Chair: Peta Rowden
- Pressure Injury & Wound AG *(new)*. Chair: Kerri Colley, transferring to Jill Lowrey
- Consumer Representation: Heather Robertson, former member of HB Health Consumer Council

Discussion was held at the meeting to accept a further advisory group called Pressure Injury and Wound Advisory Group. This Group will provide oversight for the introduction and implementation of the "Pressure Injury Treatment and Prevention in NZ framework" and will be sector-wide with multi agency inputs.

ESTABLISHMENT OF NEW STRUCTURE

The PS&RM Committee has met twice and agreed to meet quarterly going forward. The initial meetings focused on the purpose and functions of the PS&RMC and the Advisory Groups, finalising membership and aligning and updating ToR (ongoing). The TOR for the PS&RMC were reviewed and minor changes made following the first PS&RMC meeting on 3 September and was subsequently approved by Clinical Council on 10 October. The TORs for the Advisory Groups are currently being reviewed and will be standardised into the agreed format.

ADVISORY GROUP REPORTING

Whilst this is a new process, the agreed method of reporting was discussed and it has been agreed that there will be a generic template developed for Advisory Groups by Clinical Council Chairs. Verbal reports from the Chairs of the Advisory Groups (or their appointed delegate) are provided at the meeting.

The Committee has chosen to only report to Council items of concern or significant points of interest that it believes should be drawn to the attention of Clinical Council

CONCERN OR POINTS OF INTEREST

Falls Minimisation Advisory Group
The ongoing training programme for Falls Minimisation is in progress but uptake has been slow to date, recent renewed emphasis - 443 nurses have completed the Ko Awatea online training. The hospital working group has been revitalised to provide assurance that there is a working plan to reduce harm from falls. From 1 July 2018, there have been three reports of falls with serious harm. A facilities programme is in place for installation of handrails. B2 will be the first area for installation.

Pressure Injury and Wound Management Advisory Group
This group is in formation with a draft terms of reference. An application has been made to ACC for funding of $100k per year to deliver the "Pressure Injury Treatment and Prevention in NZ framework".

Clinical Risk and Event Group
Patient Safety & Adverse Event Report has been presented to the Board and the DHB is preparing for national report release on 7 December 2018.

There are some concerns around cardiology services, which are still under review. A service improvement programme has been established.

Family Violence Advisory Group
There has been a presentation to EMT around family and partner abuse screening; there has been an increased number of patients with serious harm who were not screened appropriately. EMT has given approval for a 6-month project to look at barrier to screening using a strength-based approach. A known factor is work pressure issues, but this needs validation from the project.

Infection Control Advisory Group
A concern is that Canterbury has upgraded the ICNet platform and with the upgrade HBDHB will lose access to the system. Trevor English, CanterburyDHB is keen to support HBDHB to acquire all components of ICNet. He is working closely with HQSC, MOH, ACC and Baxter to assist with this transition.

Patient Safety week will focus on Hand Hygiene, which we have usually scored greater than 90% but of recent out, compliance has dropped off. Some key equipment is required to be upgraded for gold auditors i.e. iPhone and iPad which will support compliance. HQSC has acknowledged and commended Racquel MacDonald, IP&C Advisor and Orthopaedic Service for submission of data for SSI programme.

Maternity Governance Advisory Group
Midwifery Workforce remains a concern, as this is a National issue where there are not sufficient midwives to care for our population. We do have a number of mitigation strategies in place. There is development of a EWS Chart, which is linked into the National roll out. The Maternity Service Annual Clinical Report has gone to the MoH and workshop was held on Monday 5 November.

Patient at Risk Advisory Group
There is seismic upgrade to the education centre, which means that all patient at risk training is being displaced, but there is good mitigation plans in place. There is some access issues to the Clinical Skills Lab, which are being resolved. The ACT Course training is on target. Reported concerns around sustainable (without delay of activation) flight service for transports to and from Wairoa and Wellington.

Restraint Advisory Group

The policy has been updated and signed off. SPEC training is being rolled out with most of MH RNs, Security personnel and RMOs being trained and we need to consider how we roll this out to the wider DHB.

OURHEALTH HAWKE'S BAY Whakawateatia	**Consumer Experience Committee**
	For the attention of: **HB Clinical Council and HB Health Consumer Council**
Document Owner:	Dr Diane Mara and Debs Higgins (as co-chairs)
Reviewed by:	Not applicable
Month:	November, 2018
Consideration:	For Information

12.2

RECOMMENDATION

That Clinical Council and Consumer Council

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

Consumer Experience Committee met on 15 October 2018. An overview of issues discussed and/or agreed at the meeting is provided below.

UNDERSTANDING THE ROLE OF THE COMMITTEE

Discussion took place around the role of this committee and it was agreed it is to oversee the development and implementation of strategies, systems, policies, processes and actions that will contribute to the continuous improvement of the consumer experience within the Hawke's Bay health system.

PWCC IMPLEMENTATION PLAN

The first draft of the PWCC implementation plan outlining the work required to embed a PWCC approach was discussed. This includes governance and socialisation, making health easy to understand, working collaboratively with consumers, gathering consumer experience and broadening mechanisms to get the consumer voice, using feedback to drive improvements, closing the loops and reporting back ("you said we did") and effective utilisation and coordination of volunteers. Work will need to be done to create an awareness of PWCC and socialise this across the sector.

AGREED PRIORITIES FROM THE PWCC IMPLEMENTATION PLAN

It was agreed that the work on the implementation plan would need to be prioritised and we should look at achieving five key priorities over the next twelve months.

1. Building Awareness of what we mean when we talk about PWCC, educating our workforce and community about this and ensuring the consumer voice is heard as a powerful reason for the change
2. Document key guides for clinical / operational teams around PWCC
3. Publish a simple Consumer Charter which aligns to the key principles of PWCC
4. Ensure that Relationship Centred Practice (RCP) training is rolled out across the organisation and is identified as mandatory for all staff. A key component of this would be to utilise consumers to deliver and support the training – this would send an exceptionally positive message.
5. Establish a local consumer experience survey (developed in conjunction with this committee, Consumer Council, MRB & Maori Health Services) and put in place a robust system for gathering and sharing all feedback, implementing improvements and reporting back to governance groups and the community about what we've done with that feedback. Based on the feedback gathered, the Consumer Experience Committee would identify the key priorities and improvements that we should implement each quarter.

HAWKE'S BAY District Health Board Whakawāteatia	**Scoping Report - Addictions**
	For the attention of: **Maori Relationship Board (discussion)** **Hawke's Bay Clinical Council and HB Health Consumer Council (for information)**
Document Owner	Chris Ash, Executive Director Primary Care
Document Author(s)	Shari Tidswell; Equity & Intersector Development Manager; Laurie Te Nahu, Health Gains Advisor; and Shirley Lammas, Planning & Commissioning Manager, Integration
Reviewed by	Emma Foster, Deputy ED Primary Care; and Executive Management Team
Month/Year	November 2018
Purpose	Provide information via a map of "meth" use, impact, response and best practice in response to a Board request for information about 'meth' in our communities and how HBDHB are addressing the impact.
Previous Consideration Discussions	None
Summary	The purpose of producing a mapping report is to provide current information about meth and the impacts on the user and their whānau. Overview of services delivered to support user, their whānau and the community impacted. Finally, evidence on what works to address meth and other drug harm. This information will guide the HBDHB Board, those planning HBDHB activities and delivering services. It will also provide some baseline data to measure change and progress in reducing harm for the Hawke's Bay community.
Contribution to Goals and Strategic Implications	Health Equity
Impact on Reducing Inequities/Disparities	Drug use impacts are higher in high deprivation communities. Working with our communities to understand their needs and use this to formulate our response will reduce inequity.
Consumer Engagement	Information from community engagement meetings is included in the report. There was community engagement in Flaxmere and Maraenui
Other Consultation /Involvement	Met with community services providers and attended community meetings. Also used existing consultation documents completed with HBDHB input.
Financial/Budget Impact	Potential impact on reallocating resources

Timing Issues	None
Announcements/ Communications	None

RECOMMENDATION:

It is recommended that Clinical and Consumer Council

1. Note the contents of this report and any feedback can be proviced directly to the document owner.

It is recommended that the Maori Relationship Board

2. Note the contents of this report and discuss and provide feedback.

HAWKE'S BAY
District Health Board
Whakawāteatia

Scoping Report - Addictions

Use, who is working in the area, what is working

Author(s):	Shari Tidswell; Equity & Intersector Development Manager; Laurie Te Nahu, Health Gains Advisor; and Shirley Lammas, Planning & Commissioning Manager, Integration
Date:	November 2018

EXECUTIVE SUMMARY

This map forms part of the response to the HBDHB Board's request – "how we are addressing our community issue of methamphetamine use and wider impacts".

A working group from Māori Health, Population Health and the Primary Care Directorate, sourced information and collated community consultation and key stakeholders engagement, to inform the content of this map.

This map provides an overview of what methamphetamines (meth) are, who is using meth, what communities are saying about their support needs, who is working in the meth space and what is working to reduce harm for meth use in Hawke's Bay[1]. Information and data has been provided by; Police, Housing NZ and the HBDHB. Feedback from community providers is also included[2].

Meth use has increased over the last three years with a number of contributing factors including; availability of other drugs, organised crime involvement and unemployment. There have also been changes in how the drug is being manufactured – from 'meth labs' to the back seat of cars. According to National Health Survey data, adult[3] meth use is at 0.9% with little change. Police identify that there is an increase in meth-related crime and harm, they reference increases in the numbers of seizure of drugs and chemicals that create meth. Health services note that hospitalisations remain static and calls to the drug helpline by whānau and friends of 'meth users" have increased.

There are a number of organisations including: Police, HBDHB and TToH that deliver programmes to support people with addictions with a focus on meth. Indirectly, there are organisations that also address the impact of associated issues, e.g. Family Violence Services, Social Housing, Salvation Army, Mental Health and Addiction Services and income support.

MAP OVERVIEW

The purpose of producing a mapping report is to provide a picture of:

1. Current information about meth and the impacts on the user and whānau.
2. What we know about use of meth in Hawke's Bay.
3. Services delivered to support users of meth and their whānau and the community impacted.

[1] For the purposes of this map, Hawke's Bay is defined as the HBDHB boundaries.
[2] This is sourced from Internal Affairs Report "HB Drug Use Snapshot", CAYAD "Community Meeting – Responding to P", Flaxmere, "Community workshop on P" and Community Alcohol Survey. HBDHB staff engaged in all of the these.
[3] NZ Health Survey 2015

4. Community voice.
5. Evidence on what works to address harm from use of meth.
6. Recommendations for the HBDHB Annual Plan.

This information will guide the HBDHB Board, those planning HBDHB activities and delivering services. It will also provide some baseline data to measure change and progress in reducing harm for the Hawke's Bay community.

What is Methamphetamine?

Methamphetamine is one of a number of amphetamine-type drugs. Some have medical uses and are made by pharmaceutical companies. However, most meth used in New Zealand is made in illegal labs. Meth is a stimulant drug available in pill, powder, crystal or liquid forms. It can be swallowed, snorted or injected but is most commonly smoked in a glass pipe or bong. Meth stimulates the central nervous system to release a large amount of dopamine, a 'feel-good' brain chemical. This can make you feel energetic, alert, talkative, and confident. It can also increase your sex drive and reduce your appetite. Street names include 'P', Crack, Meth, Crank and Ice.

This is not a new drug – it was developed in 1887 and has had a history of being used as a nasal decongestant, treatment for depression, and enhancer for athletic, cognitive and sexual performance. It is a neuro-stimulant, increasing neurotransmissions in the brain and effects norepinephrine and dopamine. The use of Meth significantly increases risk of heart disease. The high doses found in meth are more strongly associated with harmful effects such as; insomnia, agitation, mood swings and hallucinations. Other harmful effects can increase through impaired decision-making, e.g. family violence, unsafe driving, unsafe sex and increased risk of infection via utensil sharing (needles, pipes and spoons).

Addiction is also linked to wider behaviours which support access to the drug. Police information details a link to; dishonesty crimes, shop lifting, drug offenses and violent crime. This increases the risk of a criminal record and incarceration which can act as a further barrier to social inclusion.[4]

The development of Amphetamine Type Stimulant use disorders is associated with a history of:

- Alcohol use disorder (79%)
- Cannabis use disorder (73%)
- Family histories of substance abuse (32%); mood disorders (41%); and Psychosis (20%)
- Imprisonment, homelessness or hospitalisation for substance use or mental health problems (20%)[5]

Who is using methamphetamine?

National Surveys

National drug surveys puts the rate of use for adults in Aotearoa at 0.9%. This is low and has remained at around this rate over a number of years (includes all amphetamines). The average age of a user is 33 years, with higher use amongst males and Māori (compared with females and non-Māori).
The New Zealand Health Survey estimates amphetamine use in the Hawke's Bay region at 1.4% of adults over 18 years, higher than the the New Zealand rate of 0.8%.[6]

[4] NZ Drug Foundation https://www.drugfoundation.org.nz/ East Coast Police "Community Meth Presentation" 2018
[5] Shirley to add
[6] NZ Health Survey https://www.health.govt.nz/publication/regional-results-2014-2017-new-zealand-health-survey

Illicit Drug Monitoring System (2006-2014) noted an average meth user's age at 36 years, male and most likely to be on a health and disability benefit. A worldwide survey in 2015 indicated a similar rate for New Zealand.[7]

Emergency Department data shows a small increase in admissions. Hospital admissions throughout New Zealand related to meth use appear to have been stable over time with 203 people admitted to hospital in 2009, 234 in 2010 and 229 in 2011. The main reasons people were hospitalised for meth use were psychotic disorders or other mental health and behavioural disorders.

Nationwide data for the number of people seeking treatment (in acute care) for problematic meth and Amphetamine Type Stimulants (ATS) use is currently unavailable due to inconsistent data collection. Although flawed, information collected by the Ministry of Health details a general increase in the number of people attending mental health and addiction services with a diagnosis of ATS abuse or dependence.

All nationally compiled data demonstrate an inequity of meth use in our community, based on ethnicity and socio-economic status, with higher prevalence for Māori and high deprivation communities. Overall, there is a consistent description of the user group.

Police information

The seizure rates for meth and products used to make meth have continued to increase. Police collect data on crimes where drugs are referenced. This data indicates a significant increase of crime where meth is referenced - over 200% in two years. Meth and cannabis now have similar levels referenced in criminal activities. An analysis of one month's data for East Coast Region, identified 54 meth users came to the attention of the Police, the most common age was 26/27 years, most were male, a third were unemployed and half were not legally able to drive (forbidden or cancelled driver licenses).

Family violence crime is strongly linked to meth use. This is followed by; child abuse, violence, weapons, drug offences, dishonesty, shoplifting and driving offences. This illustrates the wider impact of drug use with harm to families, community and businesses through crimes.[8]

Meth users are a relatively small group in our community aged in their late twenties to mid-thirties, mostly male, are often on a benefit or in a low income job and involved in other crime. Few are accessing hospital based services. Their behaviour is impacting on a wider group particularly whānau.

Who is working in this space?

Hawke's Bay DHB provide generic addiction services that includes specific nationally allocated beds for people recovering from amphetamine addiction. Services include residential and community based. Including – the Methadone programme, addiction counselling, nursing, clinical care and social work services.

Hawke's Bay DHB plan and support the clinical pathway including phone line support, primary care, school-based services, community providers and secondary services.

[7] Massey University "Recent Trends in Illegal Drugs use in NZ 2006-2014 (2015) https://www.massey.ac.nz/massey/fms/Colleges/College%20of%20Humanities%20and%20Social%20Sciences/Shore/reports/IDMS%202014%20Final%20Report.pdf?38B9C25FBFC4F517CCB03BCA4C7CF64A

[8] Taken from an internal Police Report, compiled in 2016

Community addiction services are delivered via Te Taiwhenua o Heretaunga and MASH Trust. There are residential services specialising in Meth via Odyssey, Nova (including beds allocated under the Compulsory Assessment and Treatment Act) and Salvation Army. Nationally beds allocated for meth treatment have not been filled. Hawke's Bay also receives funding for CAYAD (Community Youth Alcohol and Drug programme) and Safe Community (Central Hawke's Bay, Hastings, Napier and Wairoa) programmes delivering prevention and health promotion. There are a number of community developed programmes for example; Grans against P, Flaxmere Stopping P and community education sessions. Phone line and online supports including; Healthline, Alcohol and Drug Help and Drug Foundation all have been accessed by Hawke's Bay people.

The Alcohol Drug Helpline has reported a change in the pattern of contacts for meth use over the past few years with the largest caller group are family and whānau members concerned about someone else's meth use. This is consistent with an ongoing pattern of whānau members being more likely to seek help for someone's methamphetamine use than the person themselves across a range of services.

There is additional support with community services providing social work and counselling. Work and Income provide income support for those in treatment, primary care providing patient care, Probation Services providing habitation and whānau support. The next layer is the work by Police in reducing supply and responding to incidents involving meth. Justice ensures consequences and Oranga Tamarki responds to child safety issues.

Government departments including Police, Ministry of Health and Justice have strategies for managing drugs which include how they are addressing amphetamines. These strategies have similar themes of reducing harm to our communities. Using the National Drug Policy (developed by the Ministry of Health) the three strategic approaches include:

- Problem limitation (increase accessing support and receiving treatment)
- Demand reduction (having knowledge and options to make informed decisions)
- Supply control (minimising access)

While there is a good range of support and services. There may need to be work to improve user engagement, and greater support or information about for whānau and community. Finally opportunities for more cross agency work that is strategically

What is the Community saying about their support needs ?

There has been a consistent community voice raising concerns about the impact of meth and other drugs. The communities most active in identifying need are Flaxmere, Maraenui and Wairoa. This aligns with the user profile – higher level of use in high deprivation communities. Whānau and community members are managing the associated behaviour of agitation, crime and family violence that stems from meth use.

Whānau are signalling a need for support for example phone line services have seen an increase in calls from those effected by a meth user. A meeting between HBDHB staff and early childhood education providers (2018) identified information about meth as a key need, as they perceived an increased meth impact on children in their services. They have responded to this need through he establishing of community programmes "Nans Against P" and "Flaxmere Stopping P".

"People that access our service are usually not looking for support for their drug issues but primarily for support and advocacy to assist them with the impact it is having on their whanau and themselves." (Te Roopu A Iwi Trust)

Communities are also noting the impact of other drugs including Wairoa identifying the impact of alcohol via a 2016 survey, The Raureka community challenged the license for an off license retailer in their shopping centre noting the negative impact alcohol use has in their community. More recently members of the Maraenui community have highlighted synthetic cannabis use and associated social problems.

"Maraenui is definitely an area where it's (synthetics) extremely accessible" (Whatever It Takes)

Communities are also affected by an increase in crime (e.g. violence, drug driving, theft) linked to drug use and a general reduction in safety. Employers have highlighted the impact of people 'failing drugs tests', resulting in the challenges of recruiting and retaining staff, which intern impacts on business economically growth. Services such as Police, Probation and Courts also note increased workloads. For whānau and community the impact of these behaviours and consequence is economic, social and psychological resulting in community 'despair and depression'.

A community hui facilitated by CAYAD (Community Action for Youth Alcohol and Drugs) was held in June 2017 that discussed possibilities for a "Regional Meth Solution". This hui identified:

- Recovery Whakawaiora - provider list, papatanga, improved services and alternatives (work, walking groups, training opportunities)
- Prevention (address supply, why do people use meth, education about meth, look at Portugal, link to Social Inclusion, provide options, reduce harm, whānau action)
- Politics and funding (petitions, submissions, media, linking government agencies to influence change)[9]

It is important to ensure that communities have a voice, are informed about evidence, know how to access services and support and are supported in their local responses and solutions.

What is working in harm reduction?

National strategies from Ministry of Health, Police and Department of Corrections have similar themes. These themes come through in the NZ Drug Foundations advice on addressing meth and illicit drug use generally. All see merit in agencies working together to support change. The focus on; prevention, intervention and treatment is evident in all approaches.[10]

Cross-sector approaches

Enabling an environment for social inclusive economic growth requires cross sector input and provides the support for prevention, education and effective treatment.

- *Provide intersector strategies to support resilient behaviours and reduce enablers for drug taking.*

For Hawke's Bay this could include supporting Matariki projects to increase employment, school training engagement, changing how social services are funded and deliver, and provide a whānau centric approach to meet whānau needs. A further opportunity could be delivery of cross-sector strategies and plans, including community plans - these would be responsive to community needs

[9] Meeting notes distributed by CAYD June 2017

[10] NZ Strategic Approaches https://www.drugfoundation.org.nz/ https://www.health.govt.nz/publication/national-drug-policy-2015-2020 http://www.police.govt.nz/about-us/publication/illicit-drugs-strategy-2010

and aspirations to support resilience and healthier communities. Local authorities in Hawke's Bay have community plans that could be built on to respond further to community need.

Using holistic approaches such as Whole of Schools Approach including 'Helping Build a Healthy and Supportive Society'. This approach reduces punitive responses and provides effective links to treatment and support. These approaches would support community raised issues i.e. the Community Hui mentioned above identified the need for prevention and treatment responses. Whānau centric approaches e.g. Strengthening Families and Whānau Ora provide whānau with support across a range of agencies. There is an opportunity for the HBDHB to apply this holistic approach in the planned review of Mental Health and Addictions Services.

Prevention

Reduces the number of people mis-using drugs and the level of harm. Prevention includes supporting people to be drug free through increasing resilience i.e. employment, meeting needs and creating safe environments. Early intervention is also important to reduce harm i.e. education, access to support services.

- *Ensure children and young adults stay engaged in school and education.*

This is key to building resilience. Developing career pathways with links to training/qualifications and jobs can be delivered via Matariki Social Inclusion and the Regional Economic Development Strategy.

- *Support engagement in employment through programmes and socially responsible employers*

Being engaged in employment develops resilience, reducing harm and preventing drug use. Programmes that support people into employment are most effective for people on benefits and experiencing barrier to employment (i.e. low or no qualifications, no driver's license, criminal record or past history of substance abuse). Supporting employers to become socially responsible will also help increase opportunity for employment and the support to retain employment.

- *Supporting safe homes where children are not exposed to drug misuse.*

Ensure children, youth and adults have a relationship with a good adult role model, their basic needs are met (safety, food, sleep and care) and opportunities provided for learning. One-third of meth users in treatment have a family history of drug abuse. Those living in a deprived households have higher rates of drug misuse.

- *Address family violence, prevention and respond with support pathways and interventions.*

This would require multiple agencies working collaboratively including advanced community engagement. More than half of meth associated crime is related to family violence. Supporting whānau with interventions to address family violence would increase children's resilience to reduce future drug use as well as addressing adult meth use. Additional effective interventions include supporting peoplewho "fail drug tests", when they apply for benefits or are picked up for traffic offences. An effective first step is to ensure Police, Work and Income and employers have the right information and skills to refer people to support services.

Education and Community Support

Education is an enabler to prevent drug misuses and reduce harm if it is non judgemental and community based.

- *Support community education programmes, provide accurate information delivered in a non-judgemental manner with clear links to support and treatment services.*

Information needs to include how to reduce harm e.g. from no-use to the safest way to use. There is some support for providing a service that assesses drugs being used so users are aware of what ingredients are in drugs and the level of risk.

Education is beneficial when it covers all drugs and is not targeted at specific drugs; has clear messaging on harmful drugs and provides accurate information. Scare tactics and abstinence messaging have been proven not to be effective. Drugs covered should include tobacco, alcohol and illicit drugs.

Providing a safe place and key people to talk to should include being; non-judgemental, prepared and able to follow-up. Key people need to have the skills to notice change and ask questions to support and engage. Resiliency research also supports the benefit of a significant adult helping people make beneficial choices and develop skill to manage challenges.

Treatment

Treatment must be available when requested with no waiting lists. Programmes have to respond in a way that provides effective recovery from the drug used i.e. methamphetamine.

A recent meth research and treatment literature review confirms the information and recommendations contained in the Interventions and Treatment for Problematic Use of Methamphetamine and Amphetamine-Type Stimulants (ATS). Specifically the literature confirms that:

- No pharmacology has been consistently identified as being effective in helping people reduce and or stop the use of ATS
- No pharmacology has been identified as being particularly useful to help withdrawal management
- The stepped care model of treatment remains appropriate as an intervention pathway

Clear clinical pathways for meth users with a range of accessible referral points is essential. Accessible support and information for whānau and community is also invaluable.

Prevention approaches start early in life with safe homes, engagement in school and education, employment and developing resilience. Providing people with information to base decisions on is more effective than ignorance. Treatment needs to be accessible and responsive to the needs of a user's. Good harm reduction approaches are effect for all drugs.

SUMMARY

Methamphetamine is a neuro stimulant and most meth produced in New Zealand is illegal. Meth is used by a relatively small proportion of the population (between 0.8% and 1.4% of people over 18 years), however Māori, beneficiaries and low wage earners have the highest rate of use. Meth use is also linked to other offending, particularly family violence and to heart disease in the user.

There are a wide range of services from clinical to community, however there could be gaps particularly for whānau and community affected by a meth user. Improvements in access to information should provide consistent messaging and opportunities for those working across all sectors.

Community and best practice are very closely aligned with a focus on cross-agency approaches, prevention, education and treatment. These actions support a drugs harm reduction approach rather than a focus on a single drug or category. Prevention strategies have the ability to address the wider determinants of health and wellbeing including education, employment, reducing family violence and safe communities.

There is a ripple effect moving out from the meth user to their whānau and community. This requires layers of responses to support all those affected including; empowering communities, responding to whānau needs, educate, prevention strategies and treatment. A cross-sector response to ensure users, their whānau and the community are able to reduce the harm from meth use.

RECOMMENDATIONS

Key Recommendation	Description	Responsible	Timeframe
Include in the Mental Health and Addiction review	Include meth and other drug treatment, community responses and the other recommendations from this paper, in the review of mental health and addiction services review.	Shirley Lammas	2019
Engage with whānau and community to understand their needs and provide appropriate support	Investigate ways to link whānau and community with support and information. Including using co-design approaches.	Shirley Lammas	2019
Take a Cross sector approach	Support a cross sector approach as part of the Matariki Strategy and Tripartite programme of work i.e. employment, family harm reduction and whānau centric approaches.	Shari Tidswell	Ongoing
Establish clear clinical pathways	Establish clear clinical pathways and communicate these with a wide range of referral points including whānau, to maximise intervention opportunities.	Addictions Services Managers	July 2019

HAWKE'S BAY District Health Board Whakawāteatia	**Best Start: Healthy Eating and Activity Plan - Healthy Weight Strategy**
	For the attention of: **Māori Relationship Board, Pasifika Health Leadership Group, HB Clinical Council and HB Health Consumer Council**
Document Owner	Andy Phillips, Executive Director Health Improvement and Equity
Document Author(s)	Shari Tidswell, Equity and Intersector Development Manager
Reviewed by	Phil Moore (Clinical Lead) and Executive Management Team
Month/Year	November 2018
Purpose	The Board requested six monthly progress reports. This report provides an overview of the progress and changes impacting the Best Start Plan's delivery.
Previous Consideration Discussions	Reported six monthly.
Summary	*Work delivered is part of the Best Start Plan that includes; supporting healthy eating environments, delivers prevention programmes, provides intervention pathways and supports health leadership in healthy weight. In the last six months we have worked with early childhood services, developed a pre-pilot for the 8 year old measure, worked with schools to support healthy weight environments and set priority areas for Plan delivery in the next 12 months.*
Contribution to Goals and Strategic Implications	Health equity – Healthy weight is the second highest contributor to wellbeing for people in Hawke's Bay. Transform and Sustain – increasing focus on prevention. Improving health outcomes for Māori and Pasifika peoples.
Impact on Reducing Inequities/Disparities	Directly aligned to addressing inequity for Māori and Pasifika.
Consumer Engagement	Delivered by the Best Start: Healthy Eating and Activity Plan Development and Delivery, consumer/stakeholder/community engagement are noted in all programme development and delivery.
Other Consultation /Involvement	Ongoing - as part of all delivery and programme development.
Financial/Budget Impact	Not applicable
Timing Issues	Not applicable
Announcements/ Communications	Not applicable

RECOMMENDATION:
It is recommended that the Maori Relationship Board, HB Clinical Council, HB Consumer Council and the HBDHB Board:
1. **Note** the content of the report.
2. **Endorse** the next step recommendations.

14

HAWKE'S BAY
District Health Board
Whakawāteatia

Best Start: Healthy Eating and Activity Plan - Healthy Weight Strategy

Author(s):	Shari Tidswell
Designations:	Intersector Development Manager
Date:	**November 2018**

OVERVIEW

In 2015 the Healthy Weight Strategy and in 2016 the Best Start: Healthy Eating and Activity Plan were endorsed by the HBDHB Board. These documents responded the areas identified as most impacting wellbeing in the Health Equity Report (2015). These documents guides the HBDHB's work in increasing the number of healthy weight people, with a focus on children. Work is delivered across HBDHB and other sectors including primary care, councils, education, workplaces and Ngati Kahungunu Iwi Inc.

Childhood healthy weight is also being reported to the HBDHB Board via Te Ara Whakawaiora performance programme and nationally through the Raising Healthy Kids target. These reports share information and the Best Start Plan provides the direction and overview for work.

REPORTING ON PROGRESS

Below is a summary of the highlights for each of the Plan's four objectives. Appendix one provides further detail of the progress on the Plan's activities to date.

1) ***Increasing healthy eating and activity environments***
   Resource in development for early childhood settings to support healthy conversation, identifying additional resources to support education opportunities and engage whānau. Schools programme support role is being established so that school's healthy weight plans can be facilitate and monitored.

2) ***Develop and deliver prevention programmes***
   Programmes are now at the embedding stage with key messages going to wāhine and whānau during pregnancy; via Mama Aroha – messaging is consistently provided to new parents/whānau; Healthy First Foods programme is part of Well Child Tamariki Ora and Plunket services; Healthy Conversation and BESMARTER Tools are used by health professionals engaging with 2-4 year olds and "Water is the Best Drink" messaging is consistently being used from 2 to 10 years.

   An evaluation is underway to identify improvements in how we communicate about healthy weight with whānau. This is to engage with whānau to complete their child's Before School Check. These findings will be used to improve working with whānau.

The 8-year old measure is being pre-piloted this term, with a pilot to be delivered in Term One 2019. Kimiora, Marewa, Irongate and Henry Hill Schools are participating in the pre-pilot. The aim is to measure 90% of 8-year olds in decile 1-4 schools annually; providing information for schools about their school population's healthy weight, impact of their healthy weight activities and ability to feedback to their whānau. A pathway will also be provided to support the child and their whānau if they are identified as obese. We can also now monitor change over three measurement points; 4-year olds (B4SC), 8-year olds (decile 1-4 schools) and 13-year olds (completing HEADDSS assessments in decile 1-4 secondary schools)

To increase the rate of breastfeeding for Māori pēpē we are trialling increased midwife visits for whānau engaged with community midwives. This is to provide extra support with breastfeeding in the first 6-weeks. Data will be collected to assess the impact on breastfeeding rates. There has also been a review of services from 6-weeks to 6-months to improve support whānau are receiving.

3) Intervention to support children to have healthy weight

HBDHB continues to meet the Raising Healthy Kids target six months earlier than the target date and has now achieved 100% of children identified at a B4 School Check in the 98th percentile weight being referred to a primary care assessment. Further supportive pathways and tools have been developed to support whānau to make lifestyle changes which support healthy weight. This includes; Active Families under Five and the BESMARTER goal setting tool.

A programme is being established that will provide support for schools through Public Health Nurses accessing referral pathways to Active Families programmes. This is also linked to the 8-year old measure.

4) Provide leadership in healthy eating

The HBDHB continues to provide leadership across sectors to provide advice and support to implement healthy weight programmes, activities and sharing of information. The DHB have provided feedback on the Child Poverty measures and are contributing feedback on the draft Child and Youth Wellbeing Strategy.

WIDER CONTEXT FOR CHILD HEALTHY WEIGHT

Obesity is the second leading risk to population health outcomes in Hawke's Bay. Medium and long-term costs of not addressing obesity are very high, as obesity leads to a range of diseases with high health sector costs. A third of our adult population are obese; 48% and 68% for Māori and Pacific adult populations respectively. Childhood weight is a significant influence for adult weight and changing behaviours to increase healthy weight are more effective during childhood years.

The national target (Raising Healthy Kids) has been in place for 18 months and Hawke's Bay performs well in our consistent achievement of this target. There is wider work being undertaken nationally including the Child and Youth Wellbeing Strategy and Child Poverty Reduction work programme. Both of these will impact on childhood healthy weight and the DHB are engaging with the development, including providing submissions and feedback on the strategy.

HB Community Fitness Trust held a key stakeholder workshop, which the DHB participated in. Meeting have also occurred with key research staff from Auckland University engaging with the Trust.

NEXT STEPS

1. Trial the conversation tool in early childhood settings and collect feedback from whānau and educators.

2. Complete a process review of the pre-pilot and apply findings to the pilot design. Deliver the pilot in term one 2019.

3. Monitoring the impact of the increased visits and breastfeeding support for whānau.

4. Engage 10 primary schools over the next 12 months to implement a healthy weight environment. Establish a baseline with current practice and monitor implementation of change.

5. Identify and develop leadership opportunities promote healthy weight messaging, increase healthy weight environments and support national changes which influence healthy weight.

RECOMMENDATIONS

Key Recommendation	Description	Responsible	Timeframe
Develop a pilot programme for in-home support for breastfeeding	Completed a review of the trial and make recommendations for future programme delivery.	Jules Arthur/ Shari Tidswell	July 2018
Develop a pilot for monitoring and measuring children at 8-years	Engage decile 1-4 schools to participate in the pilot, develop tool and supporting clinical pathways for the pilot. Evaluate the pilot.	Child Health Team/ Shari Tidswell	April 2019
Identify and implement leadership opportunities	Engage with nationally led developments to support Hawke's Bay healthy weight gains. Supporting healthy weight messages.	Best Start Advisory Group	July 2019

RECOMMENDATION:

It is recommended that the Maori Relationship Board, HB Clinical Council, HB Consumer Council and the HBDHB Board:

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

Appendix One

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

The data we have is improving, there will be a survey completed by June 2018 for all primary schools and data for the school environments has been collected with Auckland University (Informas) and reported.

Activity to deliver objective one				
	What	**How**	**Progress**	**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 and regional messages • Supporting the implementation of programmes and plans i.e. i Way, Active Transport, Sport HB and Ngāti Kahungunu Iwi Incorporated plans	• School water only policies reviewed by PHNs, all primary schools have policies and two secondary schools. Support is being developed for ECEs with MoH licensing staff. Four churches engaged, two are working toward reducing sugar. Hasting District Council is going sugar sweeten beverage free at their facilities. • Water only messaging promoted in schools, under 5 Healthy Food messages • DHB rep on Active Transport group, supporting Ngāti Kahungunu Iwi Inc. events to provide health messages and supplying water.	July 2017
New actions	• Support education settings to implement healthy eating and food literacy- early childhood, primary schools secondary schools,	• 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	• Schools are being engaged via Public Health Nurses and to support this a new resource is being established in the Child Health Team. • Best Start Advisory Group has been meeting monthly to support coordination and the development of	Reported annually to 2020

Activity to deliver objective one				
	• 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	• 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	resources/programmes/project. Includes: Health HB, Child Health, Oral Health, Maori Health, Population Health, Pasifika Health, Paediatrics, Primary Care Directorate. Current work is looking at delivering an 8 year measurement for weight • Pre-piloting an 8 year old measure to monitor impact acorss the lifespan. Food Environment data collection complete and report shared with stakeholders. • Working with Boyd Swinvurn from Auckland University to look at a HB research project. • Presented Healthy Weight Strategy to Hastings and Napier Council.	

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 72% for total population, 66% Māori and 82% Pasifka (December 2015 Ministry of Health), these show slight increases
- 67.8% of Hawke's Bay four year olds are healthy weight, 62.7% Māori and 55.7% Pasifika (2016 Before School Check data, Health Hawke's Bay), this is 2016 data. Most recent data is obesity data with 13% of Māori, 26% Pasifika and 5.8% other four year old children in the 98th percentile for weight (June –Dec 2017 B4SC)

Actions and Stakeholders				
	What	**How**	**Progress**	**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	• Complete • Complete • Information and resources shared • Meeting HPS coordinators, attended workshop with other providers. • Training is completed for Tamariki Ora and Plunket staff, LMCs and B4SC nurses. Training plan being delivered for ECEs. • Maternal Nutrition and Physical Activity programme being delivered in Wairoa – great response and across HB	July 2017
Next actions	• Extend the Maternal Nutrition programme developing programmes in ECE and resources to support B4 School Check providers	• 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	• Active Families contracts in place and delivered by Iron Māori and Sport HB. Tamariki Ora and Plunket staff trained and delivering Healthy First Foods programmes. Trial programme being delivered via	Reported annually until 2020

Actions and Stakeholders				
	• 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	• 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	Maternity Services to provided increased support for breastfeeding. • Resource developed with early childhood providers and resources to support healthy weight messages for whānau and children – expert group completed this. • Healthy conversation tool implemented and evaluated – this includes BE SMARTER whānau plan, B4 Schools Check nurses • Working group developing the survey for all primary schools and tool to support design and delivery of healthy weight schools. • Schools programme facilitated via Child Health Team, with additional resource to support this work.	

Objective 3: Intervention to support children to have healthy weight

Indicator 3a: Increase referrals to programmes which support healthy lifestyles and whānau engagement for 4 year olds with a BMI in the 98th percentile

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

- 119 Hawke's Bay children were identified with BMI in the 98th percentile, of these, 90 accepted a referred to a primary care follow, 2 already in care and 27 declined at referral. 98% Māori, 100% other and 100% Pasifika children received a referral to primary care. (Dec 2017 B4 School Check reported Data - MoH)
- 100 participants attended breastfeeding support training, 23 Well Child staff attended First Foods Trainer Workshops, 83 health professionals attended Gestational Diabetes updates (2015 HBDHB Maternal Nutrition Report to MoH) and 45 practice nurses attended CNE session on Raising Healthy Kids Target and whānau conversation tool/plan. 63 early childhood teaching attended an information session

Activities and Stakeholders				
	What	**How**	**Progress**	**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	• Monitoring provided via HBDHB Board and MoH. Raising Health Kids target has been met. • Active Families under 5 is funded and DHB has received additional funding from MoH • Majority of referrals are to Active Families which has 80% of children increasing healthy eating and activity.	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	• Support training for health professionals completing screening - maternal, Well Child/Tamariki Ora and B4 School Checks.	• Completed WellChild/Plunket Health First Foods training, B4 School Check Conversation Tool training	Annually until 2020

Activities and Stakeholders				
	• 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	• 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	• Active Families – delivered by Iron Māori and Sport HB. New contracts in place from Oct 2017. • Clinical pathway for B4 School Check complete. Working with diabetes pathway • Training in healthy conversation completed in 2016. Delivered the Healthy Food conversation tool 2017. Complete. • 8 year old measure includes a referral pathway to support whānau with children identified as obese. This includes clinical and family support.	

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 has been updated and aligns with MoH guidelines and an implementation plan is in place, endorsed by EMT June 2016. Auckland University review of the policy has HBDHB ranked 3rd most effective policy for DHBs. Healthy Weight Strategy have been presented to the Intersectorial Forum, Napier and Hastings Councils, MoE East Coast, Priority Population Committee (Health HB) and internally across the DHB. Intersector Group has been established

Activities and Stakeholders				
	What	**How**	**Progress**	**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 work plan	• 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 work plan	• Strategy and Best Start Plan shared with - Sport HB, Mananui, Napier and Hastings Councils, HB Community Fitness Centre Trust, DHB staff and placed on DHB website. Communication Plan developed to increase awareness • Policy complete	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	• Equity assessment written and finding used to refine this plan to improve response to equity • Cross-sector activity includes a sugar reduction focus • Framework/process implemented for cross-sector approach and inter-agency activity reported	• All contracts have targets for Māori and Pasifika, resources are tested with Māori and Pasifika whānau and equity lens was applied to funding. • Water only and healthy food has been delivered in event planning, Pasifika churches, workplaces and education. • Shared Healthy Eating Strategy with Intersectorial Forum – Intersector Group	Ongoing until 2020

Activities and Stakeholders				
	• 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	• 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	establish and setting out leadership activities • Messaging is "water is the best drink" and promoting the MoH Nutrition Guidelines • We have worked with the Te Matatini steering group and promoted water and healthy food choices (with a reduction in high fat, sugar and salt foods). The Healthy Events – Food guide material has been reviewed by Ngāti Kahungunu Iwi (events and comms staff), available on DHB website. • Completed submissions and providing feedback on national work including Child Poverty and Child and Youth Wellbeing Strategy. • Partner agencies have delivered policies – HDC has "no fizzy" at the venues, Sport HB is working clubs and code to implement "water is the best drink" and healthy food options.	

HAWKE'S BAY District Health Board

Clinical Portal Implementation (CP) – EMT/FRAC Project Progress Report

Project Name	Clinical Portal & Radiology (RHIP)	Date	18 / 10 / 2018
		Prepared by	Lyle Chetty
Project Manager	Lyle Chetty		

Description: The Clinical Portal (CP) project is moving clinical information from a customised Patient Administration system (ECA). ECA will remain for patient administration while clinical information will migrate to Orion Health's Clinical Portal as part of a regionally hosted solution, in-line with a region wide agreement.

HBDHB Clinical Portal Implementation Project

OVERALL PROJECT STATUS & TREND – to date ending 18/10/2018

Status	Trend	Rationale
G	▶	**Status = Green** • Encounters data migration commenced and will continue through October and November 2018. **Trend = Amber** • After extensive analysis, data migration speed will be limited by platform constraints; CP team working with clinical SMEs to safely reduce volume of data to be migrated (i.e. 10 years' history, no deceased patients are options) to decrease time to migrate;

Planning & Activities – to date ending 31/10/2018

Progress To Date
- Primary Care Record integration scheduled for end of October;
- Work item 'Note to GP' testing commenced;
- Encounters data migration commenced;

Upcoming Activities
- Planning for Q1 2019 delivery;
- Historical 'data migration value' paper for Clinical Council to be drafted (i.e. to confirm decision on minimum safe data to migrate);
- Meeting with PHO to incorporate GPs into DHB engagement model.

Budget
- Capital & operational expenditure for 2018/19 within budget

Progressive Rollout Out Dates

- April – Hawke's Bay clinicians can view Regional data – complete
- From end August - Hawke's Bay can view Regional and HBDHB Demographic data migration (was July but nurses strike delayed these activities) - complete
- Through to December 2018 – Progressive rollout to be planned in consultation with stakeholders – rollout options being developed (for example, migration up to 10 years' initially to give clinicians value sooner)
- Through to June 2019 – progressive roll-out of value-add functionality aligned with available data.

Issues	Mitigating actions underway
• Complexity of data preparation has added more effort to data migration activities • Analysis of ECA data has identified a number of data inconsistencies • Patient Safety is a high risk area	• Working with SMEs to deliver value-added 'stream' of work in parallel with data migration to provide more functionality to users in shorter time-frame • Issues scoped & actions underway to remediate ECA source data to required quality, but adds significant effort/time • Engaged with People & Quality and Patient Safety teams to assess ECA-to-CP changes & build mitigations

Governance Report Overview

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora - Smokefree**
	For the attention of: **Māori Relationship Board, HB Clinical Council; HB Health Consumer Council and HBDHB Board**
Document Owner	Andrew Phillips, Executive Director, Health Improvement and Equity
Document Author(s)	Johanna Wilson, Smokefree Programme Manager
Reviewed by	Shari Tidswell, Intersectoral Development Manager and Executive Management Team
Month/Year	October 2018
Purpose	To provide an overview of the six months implementation progress on the Smokefree plan for discussion.
Previous Consideration Discussions	Reported six monthly.
Summary	**Smokefree** ***95% of all patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking.*** • HBDHB achieved 96.7% in Quarter 1. Health practitioners in secondary care continue to achieve the 95% target of all patients who smoke aged 15 years and over, are offered brief advice and offered support to stop smoking. ***90% of PHO enrolled patients who smoke have been offered help to quit by a health care practitioner in the last 15 months.*** • Rates Ethnicity 30/09/2018 Total population 84.7% Asian 84.0% Māori 81.6% Other / Unknown 88.0% Pacific 80.8% • Health Hawke's Bay down 5.5% from this time last year. 13 of 25 practices decreased during the month. All ethnicities decreased. Māori and Pacific both decreased by 1.3 % compared to 0.4% for other. ***90% of pregnant women who identify as smokers upon registration with a Lead Maternity Carer are offered brief advice and support to quit smoking.*** • HBDHB achieved 90.5% with Māori achieving 94.4% in Quarter 1. LMCs and DHB midwives have received ABC Smokefree training and education with an emphasis on D – Documentation.

16

	We note data issues for the following: ***90% of young pregnant Māori women were referred to cessation support.*** • Data collection was based on all Māori women. • Data provided by the DHB employed midwives for the period 1 July–30 September 2018 identified 33 events, with 18 Māori women were smokers. Seventeen (94.4%) received smoking brief advice, fifteen, (88.2%) were offered support to quit smoking and seven (46.7%) were referred to cessation support services. ***95% of pregnant Māori women who are smokefree at 2 weeks postnatal.*** • Data collection is based on women smokefree status at discharge by DHB midwives. There is inadequate data available for pregnant Māori women who are smokefree at two weeks at this time and we will provide data in the next report.
Contribution to Goals and Strategic Implications	Improving health outcomes for pregnant women and their whānau. Health equity – smoking at time of registration and at two weeks postnatal is more common among Māori women. Transform and Sustain – increasing focus on prevention.
Impact on Reducing Inequities/Disparities	Directly aligned to addressing inequity for Māori women and their whānau.
Consumer Engagement	Not applicable.
Other Consultation /Involvement	Not applicable
Financial/Budget Impact	Not applicable
Timing Issues	Not applicable
Announcements/ Communications	Not applicable

RECOMMENDATION:

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

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

HAWKE'S BAY
District Health Board
Whakawāteatia

Te Ara Whakawaiora - Smokefree

Author:	Johanna Wilson
Designation:	Smokefree Programme Manager
Date:	October 2018

OVERVIEW

Following concerns from the National Māori General Managers (Tumu Whakarae) about the slow pace of progress on some indicators in reducing health disparities for Māori, the Hawke's Bay DHB Executive Management Team (EMT) decided to establish a championship role in 2013 for each of the indicators to spur faster traction on implementation. The Champions were tasked to provide the Board with six monthly Te Ara Whakawaiora (TAW) exceptions based report drawn from AMHP quarterly reporting highlighting the implementation progress on these indicators along with recommendations for improvement towards achievement of the annual targets and reducing health disparities. This report is from Kevin Snee, Champion for Smokefree Indicator.

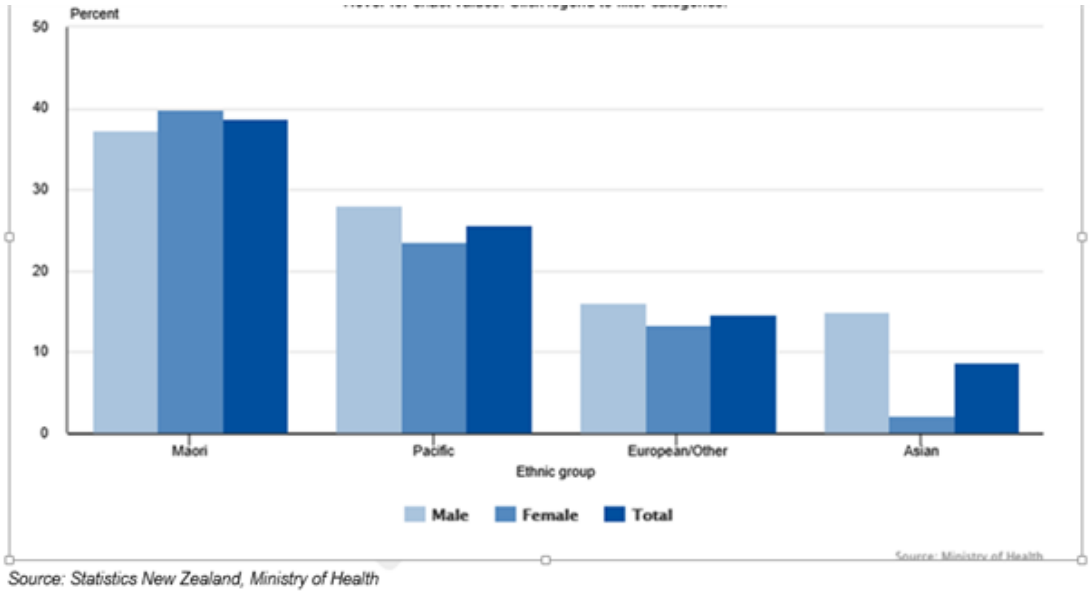
MĀORI HEALTH PLAN INDICATOR: Smokefree

- 95% of all patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking
- 90% of PHO enrolled patients who smoke have been offered help to quit by a health care practitioner in the last 15 months
- 90% of pregnant women who identify as smokers upon registration with a Lead Maternity Carer are offered brief advice and support to quit smoking
- 90% of young pregnant Māori women are referred to cessation support
- 95% of pregnant Māori women who are smokefree at 2 weeks postnatal

WHY ARE THESE INDICATORS IMPORTANT?

80% of smokers want to quit and there are immediate and long-term health benefits for those who do. The risk of premature death from smoking decreases soon after someone quits smoking and continues to do so for at least 10 to 15 years. These are interventions that can be routinely provided in both primary and secondary care.

Figure 1: Proportion of population who currently smoke tobacco



Source: Statistics New Zealand, Ministry of Health

As shown in the National Health Survey (Figure 1), the rates of tobacco smoking are higher among Māori than non-Māori with highest rates of smoking among Māori women (36.5%). This smoking behaviour among women continues even when they are pregnant. While rates of tobacco use have declined over the years, the rates for Māori are not declining fast enough to reach equity levels let alone meeting the national 2025 smokefree target of less than 5%[1].

CHAMPION'S REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THESE INDICATORS

95% of all patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking

Table 1: Quarter 1 (1 July–30 September 2018) percentage of people who receive smoking brief advice and support

	Events Coded	No. of people who smoke	No. of people given advice /support	Smoking rate	% of people who smoke given advice /support
ALL	8861	1649	1594	18.6%	**96.7%**
Māori	2212	843	818	38.1%	**97.0%**
Pacific	307	64	61	20.8%	**95.3%**

Health professionals in the secondary care settings have continued to achieve the 95% target of all patients who smoke aged 15 years and over, are offered brief advice and help to stop smoking.

The DHB Smokefree Team includes a Smokefree Liaison Nurse whose primary role is to support health professionals and clinicians to offer brief advice and support to quit smoking. This involves smokefree education and training to new staff, regularly meeting with clinical lead managers and liaising with pharmacy and other health services i.e. DHB coding staff for accuracy in smoking brief advice and cessation support documentation.

[1] Regional Tobacco Strategy for Hawke's Bay update, 2015 – 2020 presented at the MRB, HB Clinical and HB Health Consumer Council, November 2016, update.

90% of PHO enrolled patients who smoke have been offered help to quit by a health care practitioner in the last 15 months

		Target	Total	Māori	Pacific	Other
2018/19	Q1	90%	84.7%	81.6%	80.8%	88.0%
	Q2					
	Q3					
	Q4					

As at 30 June 2018 Health Hawke's Bay had a smoking brief advice coverage of 89.1% (Data Source: Karo Management). Twelve practices met the 90% target and nine practices were within 10% of the 90% target.

During the first quarter (1 July–30 September 2018) Health Hawke's Bay have reviewed and restructured its health services to include a new Clinical Performance and Support Lead who commences in November. Through this time of readjustment, the primary care better help for smokers to quit health target has decreased 5.5% from this time last year. All ethinicities have decreased. Māori and Pacific have both decreased by 1.3% and 13 of 25 practices have also decreased.

Health Hawke's Bay will continue to provide a twenty hour a week clinician to contact eligible people for updating records, brief advice and cessation support with a focus on high needs population. This includes after hours and weekend calling to people who cannot be contacted during normal working hours.

90% of pregnant women who identify as smokers upon registration with a Lead Maternity Carer are offered brief advice and support to quit smoking

Whole of DHB

Number of events (a)	Number of Smokers	Brief advice given	Offered cessation support	Referred to cessation support	Smokers' gestation (weeks) (b)	% offered brief advice	% offered advice and support to quit	% accepted cessation support	Smoking prevalence (c)
46	21	19	16	7	16.6	90.5%	84.2%	43.8%	45.7%

Māori

Number of events	Number of Smokers	Brief advice given	Offered cessation support	Referred to cessation support	Smokers' gestation (weeks)	% offered brief advice	% offered advice and support to quit	% accepted cessation support	Smoking prevalence
33	18	17	15	7	16.6	94.4%	88.2%	46.7%	54.5%

(a) Number of events: number of pregnancies
(b) Smokers gestation: average for all events (pregnancies) included in the table
(c) Smoking prevalence is for the pregnancies that their data is included here

HBDHB continues to provide smokefree training for LMCs and midwives during education and study days, the importance of capturing ABC and D (documentation).

The HBDHB Smokefree Service developed a project plan and a three month pilot in Wairoa called CO-free Homes. All midwives (5) in Wairoa have received the Maternity Smokerlyzer and training to complete the following tasks:

- CO readings of all pregnant women (smokers and non-smokers)
- Smokefree conversations with smokers
- Referrals to the Wahine Hapu Increasing Smokefree Pregnancy Programme (ISPP).

This pilot is from 1 September to 30 November. Regular meetings with the midwives during this period to assess progress and iron out any problems prior to an evaluation of the pilot in December. It is our intention to then roll-out a further 10 Maternity Smokerlyzers to LMCs and midwives working in Napier and Hastings with high Māori women case load from February 2019. To date there has been an increase in Wahine Hapu referrals in Wairoa.

90% of young pregnant Māori women are referred to cessation support

The communities where young Māori women live, socialise and belong is also the community in which they learn to smoke, keep smoking and try to quit. The relationships young Māori women have with their whānau and friends influence their smoking. Smoking can be a big part of a young woman's life as many of her whānau, friends, school mates, workplace and social circles smoke. In many instances young Māori women start smoking because their whānau and friends smoke and when socialising, the smoking increases as the two often go together.

In June 2018, HBDHB and Choices Kahungunu Health Services made adjustments to the Wahine Hapu ISPP (the programme) to align with the stop smoking services reporting template to the Ministry of Health and the challenges experienced by the Stop Smoking Practitioners and their clients. The programme includes the following:

- 8 week programme
- Carbon Monoxide testing at the initial assessment then 1, 2, 4, 8 weeks (5 readings documented)
- $50.00 grocery voucher at weeks 1 and 8. The grocery voucher at week 1 will be banked and given at week 8, making this a total of $100.00. NB: if the client is not smokefree at week 2 then the grocery voucher will be forfeited
- Nappies will also be provided at 1, 2, 4, 8 weeks
- $30.00 grocery vouchers at 1, 2, 4, 8 weeks are offered to whānau members who live in the same household or are regular visitors

To date, we have seen an increase in referrals to the programme, with wahine hapu completing the programme.

The following data does not distinguish between young pregnant Māori women and others.

Wahine Hapu ISPP referrals from 1 January to 31 July 2018

Total referrals	**185**	NZ Māori	NZ European	Pacific	Other
Ante Natal referrals	144	97	41	4	3
Post Natal referrals	15	9	5	1	
Whānau	26	10	12	3	

Wairoa Wahine Hapu ISPP referrals from 1 January to 31 July 2018

Total referrals	**26**	NZ Māori	NZ European	Pacific	Other
Ante Natal referrals	16	14	2	0	0
Post Natal referrals	3	3	0	0	0
Whānau	7	6	1	0	0

95% of pregnant Māori women who are smokefree at 2 weeks postnatal

There is inadequate data available for pregnant Māori women who are smokefree at two weeks at this time and we will provide data in the next report.

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

Hospital Smokefree Target

1. The DHB Smokefree Team will continue to provide smokefree education sessions for all staff as required.
2. Clinical staff continue to be encouraged to complete the MoH online e-learning tool 'Helping People Stop Smoking' every three years and complete the Nicotine Replacement Therapy Module via Ko Awatea. It is important for all clinical staff to review and receive up-to-date knowledge of smokefree to improve practice and increase confidence with cessation.
3. The Smokefree Team will continue to triage all hospital patients who smoke and want help to quit smoking.

Primary Health Organisation Smokefree Target

1. All clinical staff in GP practices continue to be encouraged to complete the MoH online e-learning tool 'Helping People Stop Smoking' and complete a refresher every three years.
2. The Smokefree Team will continue to provide Wāhine Hapū ISPP and The Top Five to help my baby thrive resources and Te Haa Matea business cards to all GP practices.
3. The Smokefree team will meet with GP Smokefree Champions in the next quarter to evaluate the use of smokefree resources in practices.

Maternity Smokefree Target

1. CO-free Homes pilot in Wairoa will be completed at the end of November. Meetings with the Wairoa Maternity services continue to progress the pilot. An evaluation of the pilot will be completed mid-December for extending out to the rest of Hawke's Bay by February 2019.
2. The Smokefree Team has completed an audit on the unknown categories of the Women Smokefree status at Booking and Discharge by LMC to identify smokefree missed opportunities. The Maternal and Child Health Smokefree Coordinator will make recommendations to address outstanding issues.
3. The Wahine Hapu ISPP has been reviewed and changes made to increase referrals to the programme.
4. The Smokefree Team will develop a programme in schools and alternative education to support young Māori women to stay smokefree.

NEXT STEPS

1. Smokefree Team to evaluate the CO-free Homes project to extend to rest of Hawke's Bay.
2. Link in with the new Whanake te Kuri – Pregnancy and Parenting Education and Information Programme, providing a referral pathway to the Wāhine Hapū Programme.
3. Identify all ante-natal programmes offered in Hawke's Bay to provide a referral pathway to the Wāhine Hapū Programme.

Key Recommendation	**Description**	**Responsible**	**Timeframe**
Ante-natal programmes in Hawke's Bay	1. Link in with the new Whanake Te Kuri – Pregnancy and Parenting Education and Information Programme providing Wāhine Hapū resources and Te Haa Matea business cards and a referral pathway to the Wāhine Hapū programme. 2. Identify all Ante-natal programmes in Hawke's Bay providing Wāhine Hapū resources and Te Haa Matea business cards and a referral pathway to the Wāhine Hapū programme	Johanna Wilson/ Smokefree Team	October 2018 – On Target
Audit patient files	Select a number of 'Unknown' patient files to determine missed opportunity		

	for Smoking Brief Advice from Quarter 3 data (1 January – 31 March) - Women Smokefree Status at Booking and Discharge by LMC data.	Johanna Wilson/ Smokefree/ Maternity Services/ Medical Records	October 2018 – On Target
Review / evaluate the Wāhine Hapū (Increasing Smokefree Pregnancy Programme)	Conduct an internal review of the Wāhine Hapū programme and action the recommendations.	Johanna Wilson/ Smokefree Team/ Choices Kahungunu Health Services	September 2018 - Completed
Equip LMCs the Maternity Smokerlyzer (Carbon Monoxide Monitor)	• Meet with Maternity Services • Develop Logic Model • Identify smoking status of all pregnant women at booking • Promote Wāhine Hapū (Increasing Smokefree Pregnancy Programme) to increase referrals to be smokefree	Johanna Wilson/ Smokefree Team/ Maternity Team	November 2018 – On Target

RECOMMENDATION:

It is recommended that the Māori Relationship Board, HB Clinical Council, HB Health Consumer Council and HBDHB Board:

Note the content of the report.

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora (TAW): Access (Ambulatory Sensitive Hospitalisations) (ASH) Rates 0-4 & 45-64 years**
	For the attention of: Executive Management Team; Māori Relationship Board; Clinical Council; Consumer Council; and, HBDHB Board
Document Owner	Dr Mark Peterson, Chief Medical Officer - Primary
Document Author(s)	Jill Garrett, Senior Commissioning Manager, Primary Care Directorate Marie Beattie, Planning and Commissioning Manager, Primary Care Directorate
Reviewed by	Patrick Le Geyt, GM Māori - Māori Health; Chris Ash, Executive Director Primary Care and the Executive Management Team
Month/Year	November 2018
Purpose	Provide a quarterly update on progress against data and activities identified within the System Level Measures (SLM) Improvement plan that relate to ASH rates for 0-4 yrs and 45-64
Previous Consideration Discussions	The TAW access report to have quarterly updates rather than 6 monthly as had been previously
Summary Comments	**ASH rates 0-4**: • **Data:** No improvement over baseline in headline indicator. No improvement across all ethnicities in the contributory measures • **Activities:** Activities aligned to this indicator are in their initial stages or are about to begin. Some temporary activities were in place over winter to assess the resource demand and scope feasibility and sustainability. **ASH 45-64**: • **Data:** Improvement over base line in headline indicator. No shift in contributory measures indicators to date. • **Activities:** Majority of activities aligned to this indicator are underway. Good progress being made in the area of readmissions, and engAGE extension to the rurals. Too early to be seeing a shift in data in the contributory measures as a result. Teams working closely with business intelligence to ensure uniform and robust data in place for these indicators. **Progress on previous recommendations 45-64** • Completed or on track for completion
Contribution to Goals and Strategic Implications	Focus is on Improving Health and Equity for Māori
Impact on Reducing Inequities/Disparities	Directly aligned to addressing inequity between Māori and Other
Consumer Engagement	(Forms part of each work stream)

Other Consultation /Involvement	Not applicable for this report
Financial/Budget Impact	Not applicable for this report
Timing Issues	Not applicable
Announcements/ Communications	None

RECOMMENDATION:

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

1. **Note** the content of the report and progress against recommendations.

HAWKE'S BAY District Health Board
Whakawāteatia

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

Summary: Below is a summary of the current data and activities within the System Level Measure improvement plan relating to ASH 0-4 and 45-64yrs.

ASH 0-4yrs

1. Keeping Children Out of Hospital

Headline Measure 1	ASH 0-4 years				
Milestone	20% reduction in the inequity gap over 5 years will eliminate inequity. This equates to 19 children per year = Maori 6,320				
	Base line	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Māori	6,693	7,490			
Pasifika	10,000	12,535			
Other	4,824	5,498			
Total	6,000	6,843			
Equity Gap - Māori and Other	-1,869	-1,992	0	0	0

Contributory Measure: 1.1	Reduced ASH 0-4 yrs due to Dental				
Aim	**20% reduction in the inequity gap over 5 years will eliminate inequity. This equates to 5 children per year = Maori ≤784**				
	Base line	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Māori	**882**	1,096			
Pasifika	**556**	1,408			
Other	**390**	461			
Equity Gap - Māori and Other	**-492**	**-635**	**0**	**0**	**0**

Contributory Measure: 1.2	Decreased hospitalisations (Māori and Pasifika) due to Respiratory				
Aim	**20% reduction in the inequity gap over 5 years will eliminate inequity.This equates to Maori ≤3404**				
	Base line	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Māori	**3,625**	4,243			
Pasifika	**4,931**	7,605			
Other	**2,518**	2,749			
Equity Gap - Māori and Other	**-1,107**	**-1,494**	**0**	**0**	**0**

Summary Comments:
There has been a deterioration in the equity gap overall for ASH and across all ethnicities. Dental results have increased on baseline which may be an indicator of heightened screening and awareness as the lift the lip initiative is about to begin and awareness has been raised. Respiratory data reflects similar trends.

Activities:

1.Keeping Children Out of Hospital	ASH 0-4 years		Activities Plan Progress Green, Amber, Red
Activities	**LEAD**	**Contributory Measure 1.1**	**Narrative by Leads** **Quarter 1**
Develop a pathway for community oral health service referrals to secondary care to ensure the child's appropriate primary care practitioner is informed of the child's health status.	Susan Barnes	ASH relating to Dental	A named dental therapist, supported by a dental assistant has been identified to lead a specific workstream as part of the over arching 0-5 year old Dental Equity Project, to develop a care & support package for all children & their families/whanau who have been referred for treatment under general anaesthetic. This package will include notifying the families GP/primary care provider.
Pilot General Practice 'Lift the Lip' at 15-month Immunisation Visit.	Primary Care Innovation Lead		Delayed start as awaiting the arrival of the Clinical Programme and Support Lead in November
Activities	**LEAD**	**Contributory Measure 1.2**	**Narrative by Leads** **Quarter 1**
Develop a respiratory pathway to standardise follow up of tamariki, post admission, by general practice	Charrissa Keenan	ASH relating to Respiratory	Temporary measures were implemented over the winter months this year to ensure follow-up and support to Tamariki 0-4 and their whanau who were admitted to hospital as a result of a respiratory illness. In response, a scoping exercise is being undertaken to ascertain the feasibility and sustainability of these measures within current resourcing. The model, yet to be decided will provide support and education for 0-4 year olds and their whanau to improve understanding of the illnesses and actions to mitigate readmissions and remain well.
Provide community based respiratory support for targeted tamariki and their whānau during peak winter months	Charrissa Keenan		
Work with the Child Health Team to distribute the skin care resource to early childhood centres, Kohanga Reo and Punanga Reo/language nests, taking a population health approach to promotion and socialisation of the resource.	Liz Read		Te Reo and Samoan translation of the resource completed. Resource will be promoted at Early Childhood Education/Te Kohanga Reo/Te Punavai hauora hui at Pukemokimoki Marae early November

Summary Comments:

Temporary measures were implemented and as a result of responses to those in regard to respiratory a scoping exercise is being undertaken to ascertain the feasibility and sustainability of these measures. Addressing respiratory wellness from a whanau vs individual perspective across the age bands is forming the thinking around contract reconfiguration and service design modelling. This is underway.

ASH 45-64 yrs

2. Using Health Services Effectively

Headline Measure 2	Acute Hospital Bed Days				
Milestone	**20% reduction in the inequity gap over 5 years will eliminate inequity. This equates to 1712 beds p.a. or 33 beds per week (Target = Maori ≤530)**				
	Base line	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Māori	570	588			
Pasifika		494			
Other	336	364			
Total	378	407			
Equity Gap - Māori and Other	-234	-224			

Contributory Measure: 2.1	ASH rates 45-64				
Aim	**20% reduction in the inequity gap over 5 years will eliminate inequity. This equates to 75 admissions p.a. = Maori ≤7159**				
	Base line	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Māori	**8,092**	8,302			
Pasifika		7,954			
Other	**3,404**	3,435			
Total	**4,370**	4,414			
Equity Gap - Māori and Other	**-4,688**	**-4,867**	**0**	**0**	**0**

Contributory Measure: 2.2	Acute readmissions to hospital - Diabetes				
Aim	***Establising Baseline indictor with Business intelliegence team***				
	Base line	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Indicative base line only	**12.5%**				

Contributory Measure: 2.3	In patient average length of stay				
Aim	**To achieve ≤ 2.3**				
	Base line	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Quarter 3 2017	**2.39**	2.4			

Summary Comments:

Small reduction in the equity gap in the headline indicator. Quarter 1 results will show little shift for the contributory measures as activities for aligned to these are only in their early phases of implementation. Focus on the actual reduction number p.a. quantifies for sector leads the size of the task to make an impact on this measure. This make the work that sits under the measure more tangible.

Activities:

2. Using Health Services Effectively	Headline Measure: Acute Hosp. Bed Days Per Capita		Activities Plan Progress Green, Amber, Red
Activities	**LEAD**	**Contributory Measure 2.1**	**Narrative by Leads**
			Quarter 1
Identify through the Whānau Wellness Resource Programme, those at risk of respiratory issues / concerns and actively screen through the respiratory programme.	Programme Delivery Lead	ASH 45-64yrs	Work has commenced but will become more evident inthis in the October quarter as we have a full compliment of staff.
Evaluate the effectiveness of the High needs enrolment programme and work with NGOs, Maori health providers, secondary services, and other stakeholders to increase the understanding, uptake and effectiveness of the high needs enrolment programme.	Clinical Support and Performance Lead		Delays dues to waiting new Clinical Performance and Support person to start.
Work with general practice and Hastings Hospital staff to promote and encourage increased use of the Hospital Discharge Programme with a particular emphasis on admissions associated with Diabetes, Respiratory and Cardiac Disease.	Programme delivery Lead		Work has commenced but will become more evident in the October quarter as we have a full compliment of staff.
Work with general practice to investigate the feasibility of undertaking different models of patient care with the view of increasing capacity.	Group Manager - Health Services and innovation		Work has commenced but awaiting arrival of Group Manager - Health Services and innovation.
Health Hawke's Bay to review the new urgent care model.	Group Manager - Corporate Services		Met, completed submitted to committees at HHB and UC Governance Group - for further discussion.
Scope extension of the Co-ordinated Primary Care Options (CPO)	Jill Garrett		Proposal to proceed to business case approved by EMT
		Contributory Measure 2.2	**Narrative by Leads**
			Quarter 1
Eaxamine readmission rates in relation to diabetes, trageting those with 1-3 readmissions and work up a plan to address	Wietske Cloo	Acute Readmission rates	Working group has formed- Tackling Readmissions rates. Multidisciplinary and cross sector. Action plan (3 areas) to be developed end Nov
		Contributory Measure 2.3	**Narrative by Leads**
			Quarter 1
Increase utilisation of intermediate care beds by reviewing acceptance criteria.	Allison Stevenson	In patient average length of stay for acute admissions	Work is commencing in this area and extending engage to the rural areas has also commenced
Introduce Geriatric Evaluation and Monitoring (GEM) beds in the AT&R to expediate the acute hospital journey for frail and older people	Nikki Ryniker-Doull		AMBER – this work has progressed and patients are being brought directly from ED/AAU under the GEM pathway. The pathway is currently in draft and we are working with the relevant parties to ensure the patients are safely managed under GEM.

Summary comments:
Good progress in the majority of activities aligned to this indicator. Collaboration across the five top medical long term conditions areas to address care coordination and transitions of care well underway. Work in the health of older person, extending engAGE to the Rurals on track.

Status of Recommendations (45-65 yrs)

	Key Recommendation	Implementation lead	Champion(s)	Time Frame	Status
1.	Clinical pathways become part of business as usual supported by a sustainable funding resource.	Strategic Services Manager Primary Care LTC Portfolio Manager	CMO Primary CMO Secondary	Dec 2018	Paper going to EMT and Clinical Council proposing local solution to pathways
3.	In relation to Cardiac/ Respiratory & Renal/ Diabetes Service plans include: • Workforce development • Care coordination • Transition of care	Head of Planning Strategic Services Manager Primary Care LTC Portfolio Manager	Directorate Leads Chief Nursing and Midwifery Officer	Dec 2018	Completed See item 8
4.	Enhance use of CNS/NP in specific LTC, evidenced by the outcomes achieved to date by Diabetes and Respiratory CNS workforce and engagement with primary care	Directorate leads LTC Portfolio Manager	Chief Nursing & Midwifery Officer	On-going	Completed See item 8
5.	Increase the weighting that is applied to health award applications in relation to equity.	Clinical Council	ED Equity and Health Improvement	July 2018	Deferred by coms till 2019 round
6	Retain ASH 45-65 as contributory measure with activities to address within the SLM Improvement Plan	Medical Directorate Leads Portfolio Manager – Integration Innovation and Dev Mgr PHO	Exec. Director Primary Care	Quarterly	In place
7	Present CPO scoping paper to committees and support a focus on addressing equity as the top line priority.	Emergency Department and Medical Directorate Leads Snr. Commissioning Mgr. Innovation and Development Manager - PHO	Exec. Director Primary Care	December 2018	Scoping paper completed. Service redesign and business case to be developed for budget round 2019
8	LTC Framework implementation plan to include formalised use of medical directorate clinical leads to influence activities directly relating to reducing ASH	Medical Directorate Leads Portfolio Manager – Integration Innovation and Dev Mgr PHO	Mark Peterson, CMO Primary	On confirmation into roles (Sept 2018)	LTC cross sector group established. , Action plan stage to address readmission rates top 5 LTC.

RECOMMENDATION:

It is recommended that Māori Relationship Board; HB Clinical Council; HB Consumer Health Council; and the HBDHB Board:

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

Hawke's Bay Clinical Council dates for 2019

Wednesday	Meeting	Time (s)	Venue
13 February 2019	Hawke's Bay Clinical Council	3.00-5.30pm	HBDHB Board Room
13 March 2019	Hawke's Bay Clinical Council	3.00-5.30pm	HBDHB Board Room
10 April 2019	Hawke's Bay Clinical Council	3.00-5.30pm	HBDHB Board Room
8 May 2019	Hawke's Bay Clinical Council **part with Consumer Council**	12.30pm-5.30pm	*Venue to be confirmed*
12 June 2019	Hawke's Bay Clinical Council	3.00-5.30pm	HBDHB Board Room
10 July 2019	Hawke's Bay Clinical Council	3.00-5.30pm	HBDHB Board Room
14 August 2019	HB Clinical Council – **Annual Meeting**	12.30pm-5.30pm	*Venue to be confirmed*
11 September 2019	Hawke's Bay Clinical Council	3.00-5.30pm	HBDHB Board Room
9 October 2019	Hawke's Bay Clinical Council	3.00-5.30pm	HBDHB Board Room
13 November 2019	Hawke's Bay Clinical Council	3.00-5.30pm	HBDHB Board Room
11 December 2019	Hawke's Bay Clinical Council **part with Consumer Council**	1.30pm-6.00pm	*Venue to be confirmed*

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HAWKE'S BAY
Whakawateatia

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:

20. **Minutes of Previous Meeting (Public Excluded)**
21. **Matters Arising – Review of Actions**
22. **Radiology Facility Development Business Case**
23. **Election of Chair / Co-Chair**
24. **Topics of Interest – Member Issues / Updates**

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).