Hawke's Bay Health
Consumer Council Meeting

Date: **Thursday, 9 August 2018**

Meeting: **4.00 pm to 6.00 pm**

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

Council Members:

Rachel Ritchie (Chair)
Malcolm Dixon (Co-Deputy Chair)
Dr Diane Mara (Co-Deputy Chair)
Sami McIntosh
Deborah Grace
Jenny Peters
Olive Tanielu
Jim Henry
Sarah Hansen
Dallas Adams
Jemma Russell
Wayne Taylor
Les Cunningham
Gerraldine Tahere
Denise Woodhams

Apologies:

In Attendance:

Ken Foote, Company Secretary (Co Sec)
Tracy Fricker, Council Administrator / EA to Executive Director People & Quality
Debs Higgins, Clinical Council Representative
Linda Dubbeldam, Health Hawke's Bay Representative

Public

Item	Section 1 – Routine	Time (pm)
1.	Karakia Timatanga (Opening) / Reflection	4:00
2.	Apologies	
3.	Interests Register	
4.	Minutes of Previous Meeting	
5.	Matters Arising – Review Actions	
6.	Consumer Council Workplan	
7.	Chair's Report (verbal) – Rachel Ritchie	
8.	Youth Consumer Council Report (verbal) – Dallas Adams	
	Section 2 – Presentation	
9.	HBDHB Annual Plan 2018/19 – Paul Malan	4:30
10.	Primary Care update – Chris Ash	
	Section 3 – Discussion	
11.	Consumer Council Annual Plan 2018/19 Review Annual Plan 2017/18 Review Strategic Context (tabled)	5:00
12.	Clinical Services Plan (Monthly Update) – Ken Foote	5:40
	Section 4 – For Information Only (no presenters)	
13.	Te Ara Whakapiri Next Steps (Last Days of Life)	-
14.	Te Ara Whakawaiora - Access 0-4 / 45-65 years (local indicator)	-
	Section 5 – General	
15.	Topics of Interest – Member Issues / Updates	5:45
16.	**Section 6 – Recommendation to Exclude**	

Public Excluded

	Section 7 – General	
17.	Minutes of Previous Meeting	
18.	Matters Arising – Review Actions	
19.	Karakia Whakamutunga (Closing)	6:00

NEXT MEETING:
Thursday, 13 September 2018 at 4.00 pm. Corporate Boardroom HBDHB

Interest Register

Hawke's Bay Health Consumer Council

Jul-18

Name **Consumer Council Member**	**Interest** **eg Organisation / Close Family Member**	**Nature of Interest** **eg Role / Relationship**	**Core Business** **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
Rachel Ritchie (Chair)	Put the Patient First	Involved when group was active	Advocating for Diabetes Patients	Unsure	Real / potential / Perceived
Jenny Peters	Nil				
Olive Tanielu	HB District Health Board	Employee	Work with Pacific Island children and families in hospital and in the community	Yes	Perceived/potential conflict between employee HBDHB and roles of Consumer
Malcolm Dixon (Deputy Chair)	Hastings District Councillor Scott Foundation HB Medical Research Foundation Inc	Elected Councillor Allocation Committee Hastings District Council Rep		No No No	
James Henry	Health Hawke's Bay Ltd	Facilitator	Part-time role. Improving lifestyles for people with chronic illness.	No	
Sarah de la Haye	Nil				
Sami McIntosh	Eastern Institute of Technology	Student Nurse	Practical placements	No	Perceived potential if applying for work.
Deborah Grace	Isect Ltd	Director	IT Security Awareness	No	
Dr Diane Mara (Deputy Chair)	Napier Family Centre IHC Hawke's Bay Association Pacifica Women's Tiare Ahuriri Branch (Inc)	Chair Chair Branch Chair	Social Service Organisation Disability Intellectual Stakeholder Development Leadership for Pacific Women	Yes No No	Perceived/possible conflict as NFC has a small contract for PND from HBDHB
Denise Woodhams	Nil to declare				
Geraldine Tahere	Nil to declare				
Les Cunningham	Stroke Central Inc	Employee / Field Officer	Working with stroke patients and clients	No	
Wayne Taylor	Nil to declare				

MINUTES OF THE HAWKE'S BAY HEALTH CONSUMER COUNCIL
HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE ON THURSDAY, 12 JULY 2018 AT 4.00 PM

PUBLIC

Present: Malcolm Dixon (Chair)
Dr Diane Mara (Deputy Chair)
James Henry
Olive Tanielu
Deborah Grace
Sami McIntosh
Dallas Adams
Wayne Taylor
Les Cunningham
Gerraldine Tahere
Denise Woodhams

In Attendance: Ken Foote, Company Secretary
Tracy Fricker, Council Administrator and EA to Executive Director – People & Quality

Apologies: Rachel Ritchie, Jemma Russell, Sarah Hansen and Jenny Peters

Guests: Rosemary Marriott, Heather Robertson, Leona Karauira and Terry Kingston

SECTION 1: ROUTINE

1. KARAKIA TIMATANGA (OPENING) / REFLECTION

Malcolm Dixon (Chair) welcomed everyone to the meeting. Jim Henry provided a karakia to open the meeting.

2. WELCOME AND INTRODUCTION OF NEW MEMBERS / FAREWELL TO RETIRING MEMBERS

The Chair welcomed the new members to Council and roundtable introductions took place.

The retiring members shared their experiences and wished the new members well.

The Chair and Company Secretary presented the retiring members with a certificate of appreciation for their service to Council since its inception in June 2013.

3. APOLOGIES

Apologies were noted as above. Apologies were also received from attendee members Kate Coley and Debs Higgins.

4. INTERESTS REGISTER

No conflicts of interest noted for items on today's agenda.

5. MINUTES OF PREVIOUS MEETING

The minutes of the Hawke's Bay Health Consumer Council meeting held on 13 June 2018 were confirmed as a correct record of the meeting.

One minor correction Diane Mara was in attendance at the meeting.

Moved and Carried.

6. MATTERS ARISING AND ACTIONS

Item 1: IS Workshop
This item will be scheduled for a future meeting.

Item 2: Consumers on Projects
Deferred until new Consumer Experience staff in place.

Item 3: Youth Consumer Council
Meeting held with Company Secretary and Consumer Council Chair to look at support for YCC. *Item can be closed.*

7. CONSUMER COUNCIL WORK PLAN

The work plan was provided in the meeting papers.

8. CHAIR'S REPORT

The Chair provided an update for members:

- Youth Consumer Council (YCC) – discussions with the YCC Chair re: support for the YCC.
- Person & Whanau Centred Care - summary from the workshop has been sent out to members.
- Health & Social Care Networks - Wairoa – Te Pare Meihana, Wairoa Health Centre Manager was to attend a meeting to update Council. This is still work in progress and will delayed for a few more months.
- Consumer Experience Vacancies – Interviews were undertaken and offers made to two candidates. One has accepted, the other has since withdrawn her application. A decision was made instead of having a Manager and Advisor role to have two equivalent Facilitator positions. The role will be re-advertised and interviews will take place on 31 August when Kate Coley, Executive Director, People & Quality returns from leave.

9. YOUTH CONSUMER COUNCIL REPORT

Dallas Adams, Chair of the Youth Consumer Council advised there was no major update due to it being mid-semester break at EIT. There are some developments being discussed at the moment and he will provide an update at the next meeting.

The Company Secretary advised that a meeting had been held to look at how best we can support and provide a future path for the YCC. It is important the YCC have a chance to consider the proposal before bringing it to this meeting.

SECTION 2: PRESENTATION

10. VIOLENCE INTERVENTION PROGRAMME (VIP)

The Chair welcomed Dr Russell Wills, Medical Director Patient Safety, and Cheryl Newman, Family Violence Intervention Co-ordinator to the meeting.

Dr Russell Wills provided a background on the history of the Violence Intervention Programme which was first developed in 2002 and is now in 20 District Health Boards. The programme would like advice from Consumer Council on ways to approach/start the conversation with consumers in sensitive and safe ways, around their experience of intimate partner violence, child abuse and neglect.

Cheryl Newman provided a presentation. The key points noted:

- Case studies of victims of assault who were not screen for intimate partner violence, child abuse or neglect
- The importance of screening
- Our community – children want to be with their families; women want choices about the services they receive, how and when
- Men and women frequently carry trauma from childhood which can make it difficult to change
- Families want services that are culturally responsive and to work with people who are respectful and listen to their needs
- Violence Intervention Programme Quality and Improvement actions
- Evaluation of training – between 1 March 2016 and 28 February 2018, 466 staff attended a VIP training programme, screening rates during that same time stagnated to an average of only 36%
- Influences for change and effective change in other organisations due to investment in leadership and dedicated specialist teams, IT systems to support data collection for improvement and culture change

Feedback:

- Visibility of the VIP Champions, who people can talk to and how they can do it in a safe way
- Leadership from churches and community groups, particularly for Pacific, and for Maori Kaumatua saying that this is not okay
- Be careful how to ask the question, pick the right time and use the right language, follow up when they go home and provide advice on who they can contact for help
- Talking with the partner that there is support / help for them to change
- Provide education in schools
- Building relationships and trust would make the conversation easier

Consumer members Gerraldine Tahere, Dallas Adams and Malcolm Dixon confirmed their availability to lend their consumer voice to the VIP.

The Chair thanked Russell and Cheryl for coming to highlight the issue and confirmed that Consumer Council supports the VIP work.

SECTION 3: DISCUSSION

11. USING CONSUMER STORIES

The Company Secretary advised that Rachel Ritchie, Chair had come concerns regarding the paper and has suggested that Council does not chose to adopt the paper today, but to provide feedback only. Rachel Ritchie will then discuss further with Kate Coley, ED P&Q.

The Company Secretary provided background on what patient stories were and the intention for the use within the DHB being for learning and training purposes.

Feedback:

- Consumer stories are good not just for the organisation but for other consumers, works both ways. If it is negative and there has been change consumers will see that as well as staff. They need to be un-doctored where things aren't changed to suit the organisation. The Company Secretary advised that these stories are used for internal purposes only for learning and continuous improvement, due to patient confidentiality the DHB does not share stories publicly
- Using the response to a story first, rather than here is the problem. Focus on the results and change from an issue/complaint raised
- There is always a reason behind a story being told, some consumers are able to come forward to tell their story but some are not. How can we use these stories in a better way for the organisation and consumers to look at better outcomes and service delivery in the future. A lot of stories are not told as consumers have had negative or unpleasant experiences in their journey
- Consumers want something back, how do we respond to the experience that the patient or family has been through
- Question posed which other DHBs use patient stories?

Acton: Kate Coley to advise which other DHBs use consumer stories.

12. CONSUMER COUNCIL ANNUAL PLAN – REVIEW OF 2017/18

A copy of last year's annual plan was provided in the meeting papers.

The Company Secretary advised that last year's plan was provided in the papers to prepare members for a discussion to be had next month. Members to come prepared to discuss the specific objectives for 2018/19 that Council want to achieve.

SECTION 4: FOR INFORMATION ONLY (no presenters)

13. TE ARA WHAKAWAIORA - SMOKEFREE

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

SECTION 5: GENERAL

14. TOPICS OF INTEREST – MEMBER ISSUES / UPDATES

- New week, Diane Mara, Olive Tanielu and the Pacific Leadership Group will take part in a cultural competency training programme/workshop with "Le Va" which focuses on Pasifika

- Concern raised that the Disability Strategy Project is not proceeding the way it was initially thought it would. An update will be provided at a future meeting.

15. RECOMMENDATION TO EXCLUDE THE PUBLIC

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

16. Minutes of joint meeting / workshop with HB Health Consumer Council

17. Clinical Services Plan (first draft)

Moved and carried.

The meeting closed at 5.40 pm.

Confirmed: _____
Chair

Date: _____

5

HB HEALTH CONSUMER COUNCIL - MATTERS ARISING (Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	11/08/17	**IS Workshop** IS Workshop will be delayed as IS will receive output from the Big Listen and CSP workshops prior to enable a constructive workshop with Consumer Council at a future date.	Company Secretary	TBC	Deferred until later in year
2	12/09/17	**Consumers on Projects** List of projects requested by Consumer Members (spreadsheet).	Chair / K Coley	TBC	Deferred until new CE Staff in place
3	12/07/18	**Using Consumer Stories** Advise which other DHBs use Consumer Stories	K Coley	Sep	

Consumer Council Workplan as at 1 August 2018 (subject to change)	**EMT Member**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**HBDHB BOARD Meeting date**
Annual Plan 2018/19 Draft - Presentation	Chris Ash	8-Aug-18	9-Aug-18	29-Aug-18
Clinical Services Plan Monthly Update (aug, sep, oct)	Ken Foote	8-Aug-18	9-Aug-18	29-Aug-18
Consumer Council Annual Plan 2018/2019 discussion on the year ahead	Kate / Ken and Rachel		9-Aug-18	
Te Ara Whakapiri Next Steps (Last Days of Life)	Chris Ash	8-Aug-18	9-Aug-18	29-Aug-18
Te Ara Whakawaiora - Access (Ambulatory Sensitive Hospitalisations) Rates 0-4 / 45-65 yrs (local indicator)	Chris Ash	8-Aug-18	9-Aug-18	29-Aug-18
Primary Care Update Presentation	Chris Ash		9-Aug-18	
Annual Plan 2018/19 - approved tbc	Chris Ash	12-Sep-18	13-Sep-18	26-Sep-18
Clinical Services Plan Monthly Update (aug, sep, oct)	Ken Foote	12-Sep-18	13-Sep-18	26-Sep-18
Matariki Regional Development Strategy and Social Inclusion Strategy update (6 mthly) **Sept**-Mar	Andy	12-Sep-18	13-Sep-18	26-Sep-18
Te Ara Whakawaiora - Breastfeeding (National Indicator)	Andy Phillips	12-Sep-18	13-Sep-18	26-Sep-18
Urgent Care (After Hours) Service Update 6mthly (Sept-Mar-Sept)	Wayne Woolrich	12-Sep-18	13-Sep-18	26-Sep-18
Clinical Services Plan Monthly Update (aug, sep, oct)	Ken Foote	10-Oct-18	11-Oct-18	31-Oct-18
Consumer Engagement Strategy - Implementation Plan (board action June) to consumer the month following	Kate Coley		11-Oct-18	31-Oct-18
National Mental Health Inquiry	Colin Hutchinson/Claire Caddie	10-Oct-18	11-Oct-18	31/10/18
Using Consumer Stories Revised ...	Kate Coley / John Gommans	10-Oct-18	11-Oct-18	31-Oct-18
Collaborative Pathways update (July - **Oct** - Feb - June)	Chris Ash & Mark Peterson	10-Oct-18	11-Oct-18	31-Oct-18
Te Ara Whakawaiora - Alcohol and other Drugs (National and Local Indicators)	Andy Phillips	10-Oct-18	11-Oct-18	31-Oct-18
Te Ara Whakawaiora - Cardiovascular (National Indicator)	Caddie	10-Oct-18	11-Oct-18	31-Oct-18
Te Ara Whakawaiora - Improving Access Indicator	Colin Hutchinson/Claire Caddie	10-Oct-18	11-Oct-18	31-Oct-18
He Ngakau Aotea - Strategic Priorities for MRB -	Patrick LeGeyt	10-Oct-18	11-Oct-18	29-Aug-18
Health Equity Report	Kevin Snee	14-Nov-18	15-Nov-18	28-Nov-18
IS **Presentation** and Discussion (informed by CSP)	Anne Speden	14-Nov-18	15-Nov-18	
Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-May-**Nov18**)	Andy Phillips	14-Nov-18	15-Nov-18	28-Nov-18
Establishing Health and Social Care Localities in HB (Mar 18,**Sept)** -	Chris Ash	14-Nov-18	15-Nov-18	28-Nov-18
Te Ara Whakawaiora "Smokefree update" (6 monthly May-**Nov**) each year Board action Nov 17	Andy Phillips	14-Nov-18	15-Nov-18	28-Nov-18
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) qtly	Andy Phillips	14-Nov-18	15-Nov-18	29-Aug-18
People Plan (6 monthly - **Dec**, Jun)	Kate Coley	5-Dec-18	6-Dec-18	19-Dec-18
Collaborative Pathways update **(July** - Oct - **Feb**- Jun)	Chris Ash & Mark Peterson	13-Feb-19	14-Feb-19	27-Feb-19
Ngatahi Vulnerable Children's Workforce Development - annual progress **Feb 19**	Colin Hutchinson/Claire Caddie	13-Feb-19	14-Feb-19	27-Feb-19
Establishing Health and Social Care Localities in HB (**Mar** 19,Sept**)** 6monthly	Chris Ash	13-Mar-19	14-Mar-19	27-Mar-19
Urgent Care (After Hours) Service Update 6mthly (Sept-Mar-Sept)	Wayne Woolrich	13-Mar-19	14-Mar-19	27-Mar-19
Matariki Regional Development Strategy and Social Inclusion Strategy update (6 mthly) Sept-**Mar**	Kevin Snee	13-Mar-19	14-Mar-19	27-Mar-19

CHAIR'S REPORT

Verbal

YOUTH CONSUMER COUNCIL REPORT

Verbal

HBDHB ANNUAL PLAN 2018/19

Presentation

PRIMARY CARE UPDATE

Presentation

REVIEW OF CONSUMER COUNCIL'S ANNUAL PLAN 2018/19

- Review Council's Annual Plan for 2017/18
- Review Strategic Context (tabled)

HAWKE'S BAY HEALTH CONSUMER COUNCIL
ANNUAL PLAN 2017/18

Purpose	Provide a strong viable voice for the community and consumers on health service planning and delivery	Advise and encourage best practice and innovation in the areas of patient safety, consumer experience and clinical quality	Promote and support the enhancement of consumer engagement
FUNCTIONS	• Identify and advise on and promote, a 'Partners in care' approach to the implementation of 'Person and Whānau Centred Care' into the Hawkes Bay health system, including input into: - Development of health service priorities - Strategic direction - The reduction of inequities • Participate, review and advise on reports, developments and initiatives relating to health service planning and delivery. • Seek to ensure that services are organised around the needs of all consumers	• Identify and advise on issues that will improve clinical quality, patient safety and health literacy. • Seek to enhance consumer experience and service integration across the sector. • Promote equity of access/treatment • .Seek to ensure that services are responsive to individual and collective consumer needs.	• Facilitate and support the development of an appropriate Consumer Engagement Strategy for the Hawkes bay health system • Ensure, coordinate and enable appropriate consumer engagement within the health system - across Hawke's Bay - within the Central region - at National level • Receive, consider and disseminate information from and to HBDHB, Health Hawke's Bay, Consumer groups and communities. • Ensure regular communication and networking with the community and relevant consumer groups. • Link with special interest groups as required for specific issues and problems solving.
STRATEGIES	• Proactively raise and promote issues of importance and/or concern to consumers generally, for consideration and/or resolution by relevant organisations within the health system. • Engage early with project and planning teams, and standing committees, to ensure the consumer perspective is included in all outcomes and recommendations. • Review and comment on all relevant reports, papers, initiatives to the Board.	• Work with Clinical Council to develop and maintain an environment that promotes and improves: - Putting patients / consumers at the centre - Patient safety - Consumer experience - Clinical quality - Health literacy - Equity • Promote initiatives that empower communities and consumers to take more responsibility for their own health and	• Raise the profile and community awareness of Consumer Council and the opportunities / options for enhanced consumer engagement in decision making. • Ensure good attendance and robust discussions at monthly Consumer Council meetings • Co-ordinate consumer representation on appropriate committees and project teams: - Within Hawke's Bay

11.1 Consumer Council Work Plan 2017-18 (Sept 17 Meeting) – March 2016 papers

Purpose	Provide a strong viable voice for the community and consumers on health service planning and delivery	Advise and encourage best practice and innovation in the areas of patient safety, consumer experience and clinical quality	Promote and support the enhancement of consumer engagement
	• Ensure robust complaint/feedback systems are in place and that consumers are well informed and easily able to access these • Consumer Council members to be allocated portfolio/areas of responsibility.	wellness. • Promote a clinical culture which actively engages with patients / consumers at all levels, as 'partners in care'. • Advocate / promote for Intersectoral action on key determinants of health.	- At Central Region and National levels • Engage with HQSC programmes around consumer engagement and 'partners in care'. • Maintain current database and regular communications with all Hawke's Bay health consumer groups/organisations. • Provide regular updates on both the HBDHB and Health Hawke's Bay websites • Ensure Consumer Council members continue to be well connected and engaged with relevant consumer groups and communities
OBJECTIVES 2017/18	• Actively promote and participate in' co-design processes for: - Mental Health, Youth • Participate in the development of Health and Social Care Localities • Initiate work on development of a disability strategy for HB Health Sector • Hold active membership in Clinical Council committees including Patient Experience Committee • Actively participate in Peoples Strategy and Clinical Services Plan development	• Promote and assist initiatives that will improve the level of health literacy within the sector and community. • Facilitate and promote the development of a 'person and whānau centred care" approach and culture to the delivery of health services, in partnership with the Clinical Council. • Promote the provision of consumer feedback and 'consumer stories'. • Monitor all 'Patient Experience' performance measures/indicators as co-sponsor of the 'patient experience Committee' within the clinical governance structure. • Facilitate a focus on disability issues	• Facilitate and support the development and implementation of a consumer engagement strategy and principles in Hawkes Bay • Establish a connection with Youth within the community • Influence the establishment and then participate in regional and national Consumer Advisory Networks.

Portfolios and areas of interest

AREAS OF INTEREST

- Women's health	Sami, Olive, Leona
- Child health	Sami, Malcolm
- Youth health	Dallas, Kylarni
- Older Persons health	Jenny, Heather
- Chronic conditions	Rosemary, Terry, James
- Mental Health	Deborah, Terry
- Alcohol and other drugs	Dallas, Kylarni, Rosemary
- Sensory and physical disability	Sarah, Heather, Tessa
- Intellectual and neurological disability	Heather, Olive, Diane
- Rural health	Leona, Terry, Deborah
- Māori health	Tessa, Leona, James, Sami
- Pacific health	Olive, Sami, Tessa
- Primary health	Jenny, Rosemary
- High deprivation populations	Jenny, Leona

2017-18 PORTFOLIOS

- Co-Design Youth – Dallas, Kylarni
- Co-Design Mental Health – Deborah, Terry & PAG
- Health and Social Care Localities - Tessa, Jenny, Leona, Terry
- Customer Focussed Booking – Tessa, Sarah
- Making the Health System Easier to Understand – James, Leona, Olive
- Person and Whānau Centred Care – Rosemary, Leona
- Disability Strategy – Sarah, Heather, Terry
- Consumer Engagement Strategy - ALL
- Clinical Council Committees and consumer council members on them:
  - Patient Experience – James, Terry, Deborah, Rosemary
  - Professional Standards & Performance – Sami
  - Patient Safety & Risk - Heather
  - Clinical Effectiveness and Audit – Malcolm (Terry as backup)
  - Information Management – Leona

HB Health Consumer Council Members:

Rachel Ritchie (Chair (from 1/9/17) HAVELOCK NORTH	rachel.ritchie@hawkesbaydhb.govt.nz
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11.1

Support:

Operational and Minutes

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11.2

REVIEW STRATEGIC CONTEXT

Paper to be tabled

CLINICAL SERVICES PLAN

12

Verbal Update

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakapiri (Last Days of Life)**
	For the attention of: **HB Clinical Council, HB Health Consumer Council and HBDHB Board**
Document Owner(s)	Patrick Le Geyt, General Manager Maori Health Chris Ash, Executive Director of Primary Care
Document Author	Penny Rongotoa, Portfolio Manager - Integration
Reviewed by	Jill Garrett – Strategic Services Manager, Primary Care
Month/Year	July 2018
Purpose	For information only
Previous Consideration Discussions	MRB endorsed the Te Ara Whakapiri HB Care Plan and toolkit. MRB suggested the paper be shared with other committees, for information only.
Summary	Reviewed by Maori Relationship Board in April 2018, as suggested now circulating to the Council's and the Board
Contribution to Goals and Strategic Implications	Improved equity, communication, co-ordination and integration of services are a major health goal of the New Zealand Government as a means to driving improvements in quality, efficiency and cost control
Impact on Reducing Inequities/Disparities	Māori whānau advise that discussing future healthcare needs and, in particular end of life care can be a tapu (sacred) subject. Therefore, consideration is needed whether patients feel comfortable talking about this subject.
Consumer Engagement	Consultation with team of developers and others MRB feedback
Other Consultation /Involvement	Completed
Financial/Budget Impact	N/A
Timing Issues	Ongoing
Announcements/ Communications	N/A

RECOMMENDATION:

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

1. **Note** the work completed to date that supports the implementation of the HBDHB Last Days of Life - Care Plan and Toolkit

HAWKE'S BAY
District Health Board
Whakawāteatia

Te Ara Whakapiri (Last Days of Life)

Author:	Penny Rongotoa, Portfolio Manager - Integration
Reviewers:	Jill Garrett – Strategic Services Manager, Primary Care
Date:	July 2018

RECOMMENDATION

- Information update ONLY

1.0 Context

This paper responds to feedback from MRB regarding the HBDHB Te Ara Whakapiri HB Care Plan and toolkit

- The need for cultural responsiveness in a local context
- To pilot with Māori
- Include as a resource, tikanga guidelines in respect of the tool.

2.0 Background:

Te Ara Whakapiri HB Care Plan and toolkit was developed for the local setting using the MoH Te Ara Whakapiri Principles and Guidance Tool.

During the establishment phases of the MoH Te Ara Whakapiri Principles and Guidance Tool, the tool went through a robust evaluation of independent reviews of models/stocktake of services, literature reviews based on evident practice/summaries of finding from family/whānau survey. The tool has been designed reflective of Te Whare Tapa Wha.

3.0 Responding to feedback

A small working group was reconvened to work on the approach of the above request. Robust discussion was held and it was clear that when we are talking about the different dimensions that we cannot attempt to put a symptom under one dimension of Te Whare Tapa Wha, for example pain is just not physical and therefore not just under the dimension of Te Taha Tinana.

The working group wanted to ensure there was guidance for nurses and other health professionals. The purpose of the guidance is to align to the Care Plan tool.

As a result Tikanga guidelines have been developed as an additional and integral resource to support the wider Te Ara Whakapiri Tool Kit (TAWTK) - refer Appendix One below.

- A self-review matrix has been developed to assist an organisation or service to self-evaluate and self-design areas for improvement.
- The Matrix is with the communications team for production and publishing
- Users of Te Ara Whakapiri Tool Kit will be provided with the resource once produced.
- The resource was trialled with (5) Aged residential care facilities. The resource and will be promoted to the wider sector once distributed.

Appendix One: Te Ara Whakapiri Tool Kit – Tikanga Guidelines

Traditional Origins[1] e aku Rangatira e whakanui nei i a au, tēnā koutou, tēnā koutou, tēnā koutou – You, my superiors, bidding me welcome, I salute you, Greetings

Traditional Māori origins track back through genealogies from the present, through human generations to the demigod Māui, and further back to guardians, deities, gods and goddesses, and finally to the Skyfather (Ranginui) and Earthmother (Papatūānuku). There is the belief of a single ancestor who became earth and sky from whom all things descend biologically and genealogically;

"Kotahi anō te tupuna o te tangata Māori,
Ko Rangi-nui e tū nei, Ko Papa-tū-ā-nuku
E takoto nei, ki ēnei korero. Ki ta te
Pākehā ki tāna tikanga, na Te Atua anake
Te tangata, me Rangi, me Papa, me ngā mea katoa"

"There is but one ancestor of the ordinary human,
Great Sky Standing above here, and Earth spread surface lying here,
To the Pākehā or European, according to their belief, it is God alone,
Who created people, Sky, Earth, and all things"

Papatūānuku, Earth Mother, or Planet Earth (Gaia) is the ancestress of all things. She and her children are the guardians or the progenitors of everything on and under the earth, sea and skies. The two grandchildren of Papatūānuku, Hineahuone and Hinerauwhārangii were the first to receive human form and were empowered by the guardians and gods to be the receptacles of all knowledge which they then transferred genealogically and genetically through demigods and demigoddesses to Māori. All this encapsulates the holistic connection between whenua (land), humans, gods, guardians and everything in the universe. It underlies the relationship between Māori people and all things.

All this also gives deeper meanings to the word 'Whenua'. For Māori, whenua has an added meaning, being the human placenta or afterbirth. Through various birth ceremonies the placenta is returned to the land, and that results in each Māori person having personal, spiritual, symbolic and sacred links to the land where their whenua (placenta) is part of the whenua (land). The words "nōku tēnei whenua" (this is my land) is given a much stronger meaning because of the above extensions. Having ancestral and birth connections, the above is also translated as "I belong to this land, so do my ancestors, and when I die, I join them so I too, will be totally part of this land".

Assessment:

For Māori, there is sentiment attached to the voice and face-to-face communication *(kanohi ki kanohi);* hence the emphasis is on conversation (1). Whānaungatanga (relationship) is a relationship that develops as a result of sharing whakapapa (kinship links), commonalities and shared experiences which provides people with a sense of connection, belonging and comfort but most importantly, it opens the door to open communication (2). Māori whānau advise that discussing future healthcare needs and, in particular end of life care can be a tapu (sacred) subject. Therefore, consideration is needed whether patients feel comfortable talking about this subject in the presence of kai (food).

Caution should be taken not to make assumptions about whether Maori speak te reo (language), know their whakapapa (heritage, ancestors) or practice tikanga and kawa (cultural practices) (1).

> Most, if not all of the information you need for your assessment can come from a conversation and listening for cues and insights into the person, who they are, where they come from and what matters to them. Direct questions may not illicit the answers you are looking for.

Care Planning:
The table below is intended to illustrate that no careplan issue can be considered from one single dimension of health or wellbeing. Physical well-being is intertwined with spiritual, emotional and family well-being (1). During your assessment and care planning processes, an understanding and consideration of Māori world views and the ways in which tikanga can be incorporated can enhance the relationship with the person and whanau, and the efficacy of the care plan interventions. The following principles provide a foundation for this:

[1] *Hohepa, P, 1995, The Taking into Account of Te Ao Māori in Relation to Reform of the Law of Succession, Law Commission, Wellington, New Zealand*

End of Life – Collective Principles

Tikanga (custom lore)

Custom lore provides the basis of all important decisions for tribal groups as well as individuals. It remains valuable as a guiding principle and a source of wisdom.

Mana (authority, status, prestige)

A person gains authority through displaying the qualities of integrity, generosity, bravery, humility, respect, commitment to the community, using history, stories and legends to explain things, facilitating rather than commanding.

Whakapapa (genealogy)

A common ancestry provides a platform for identity, common histories, and similar understandings of the material world.

Wairuatanga (spirituality)

The spiritual world is important part of reality which is integral to day to day activities and necessary for successful endeavours.

Kaumatuatanga (respect for elders)

Elders play a crucial role in keeping families and the community together and offer both guidance and advice.

Utu (reciprocity and restoring balance)

Maintaining balance and harmony through "give and take", reciprocal obligations, honesty in all things and the exchange of gifts are still essential practices which increase the welfare of the community

Kaitakitanga (the duty of care, for people and the environment)

People should acknowledge their spiritual responsibility to the resources they work with, ensuring health and safety in any endeavour, and pursuing quality and excellence.

Whakawhanaungatanga (family responsibilities)

Family bonds should take priority over all other considerations in deciding what actions we will take.

Manakitanga (generosity and hospitality)

Manaaki is derived from the power of the word as in mana-a-ki and means to express love and hospitality towards people – your contribution, my contribution will provide sufficient for all.

Whakarite Mana (Agreements – contracts)

An agreement is a statement if intention to form a lasting relationship, and the elements of the agreement should be open to review as circumstances change. The objective is to provide long-term satisfaction for both parties, rather than relying on "the letter of the law".

Hui (tribal meetings)

Full and active participation in decision-making is important

Care-Plan Pathways

Focus from Care Plan	**Te Taha Tinana** (Bodily well-being)	**Te Taha Hinengaro** (emotional well-being)	**Te Taha Wairua** (spiritual well-being)	**Te Taha Whanau** (family well-being)
Pain *Mamae/pouri/tangi*	Mirimiri (massage) Visual pain measure Karakia can help a person through painful procedures	Sometimes a reluctance to disclose (private experience to outsiders) (whakama) (3). Pāmamae - be hurt, in pain, feel sad, upset. traumatic, upsetting, distressing.	Pain can be cause by a spiritual unrest and will not be resolved with medication. For some, pain or disease relates to punishment from God or a higher power	May advocate for the patient and tell staff what they see. May need/want to stay with their loved one to protect them and observe treatments or procedures
Agitation *takawairore*	The treatment of physical causes of agitation/ restlessness may impact the person's ability to process spiritual causes	Place of care may impact the person's ability to be at peace	May involve working through/communicating with those that have already passed on – Tohu or symbolic occurrences	Whanau may understand what is happening for their loved one
Respiratory Tract Secretions				
Nausea and Vomiting	The desire to be part of pleasurable whanau dining experience may override nausea or vomiting that occurs as a result			Can affect the person's ability/ desire to eat affecting social relations
Dyspnoea				
Food/Fluids	Food is not passed over the head.		Keeping separate from food anything that comes into contact with the body or body fluids	Often preferred to be a group experience – shared.
Mouthcare				
Bowel Care	The storage of bedpans or urinals should be in designated area	Position of commode may influence if the person uses it. E.g. near to dining area	Tapu	Not always appropriate to ask in front of family/whanau/visitors
Micturition *mimi*		Urinal bags to be kept covered at all times	Tapu	
Medication	Rongoa (treatment, solution, tonics) may be preferred/used alongside			
Mobility/Pressure Area Care		Consult with the tūroro on all aspects of care in relation to his/her body	Consult with tūroro if there is a need to use separate pillows or towels for the lower body and head support	May be preference for a whanau member to wash or care for the person
Psychological Support	Eating, sleeping and carrying out ablutions in the same bed can be a source of distress. The use of te reo is valuable. Correct pronunciation is important – ask if unsure	A Kaumatua or Kuia may be needed as support. Waiata	Taonga (treasure) are extremely important to Māori and have much more significance than just sentimental value. Understanding whakapapa and	Identify a key spokesperson from the whanau and confirm this with the patient. Check in with that person on their well-being regularly. The patient may want someone with them during doctor/nurse visits. Maori express love and respect through visiting in large numbers. Be inclusive in your interactions with tūroro and whānau
Religious/spiritual support	The head is sacred. Privacy of the body is sacred (2)	The person may prefer to keep beliefs private from anyone outside of the whanau, hapu, iwi	May be spiritual and/or religious practices e.g. karakia. Hahi (church). Allow time for the karakia process to occur. Do not rush or interrupt. Waiata	After death, whanau and visitors may use water to cleanse

Tikanga Principles

The major principle is 'tika'. Tika can cover a range of meaning, right and proper, true, honest, just personally and culturally correct or proper to upright. From tika comes the term tikanga – customary, traditional and cultural aspects which are true and honest and just. Tikanga Māori goes beyond Māori culture, or Māori custom, to mean also the true, honest and proper cultural ways. Tikanga Māori encapsulates all accepted Māori principles.
When a person is born, creation binds the two parts of the body and spirit of his/her being together. Only the mauri can join them together. When a person dies, the mauri is no longer able to bind those parts together and thereby give life – and the physical and spiritual parts of a person's being are separated. This is expressed in the following saying:

The heart provides the breath of life, but the mauri has the power to bind or join. Those who die have been released from this bond and the spirit ascends the pinnacle of death. The mauri enters and leaves at the veil which separates the human world from the spirit realm.

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HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora (TAW): Access (Ambulatory Sensitive Hospitalisations) (ASH) Rates 0-4 & 45-64 years** For the attention of: **Māori Relationship Board, HB Clinical Council; HB Health Consumer Council and HBDHB Board**
Document Owner	Dr Mark Peterson, Chief Medical Officer - Primary
Document Author(s)	Marie Beattie, Portfolio Manager - Integration Jill Garrett, Strategic Services Manager – Primary Care
Reviewed by	Executive Management Team
Month/Year	July 2018
Purpose	Provide an update on the Te Ara Whakawaiora priority areas relating to Access (ASH rates 0-4 and 45-64) Māori
Previous Consideration Discussions	Six-monthly update. No previous consideration.
Summary	**ASH rates 0-4**: on track • Respiratory – a targeted approach over the winter period has been implemented. Further considerations are required to sustain this going forward. • Immunisation – despite some challenges this quarter equity in immunisation rates has been maintained. • Oral health – carries free statistics have been sustained over the past 12 months and utilisation of services has improved slightly. Addressing patient experience and engagement with services has been key in shifting the performance within this programme. • Child healthy homes programme – referrals continue into the programme with the addition of external stakeholders providing supplementary services. • Skin Programme – proactive approach to reducing presentations is in progress. Extra support required to close equity gaps in this area- see recommendations. **ASH 45-64**: rates for Māori have improved in the last 12 month period both within our own DHB and the Hawke's Bay District Health Board (HBDHB) performance nationally, however ASH rates for Māori still remain twice the rate of "Other." There is still significant work to be done to address this inequity. • ASH will remain a measure with associated activities as part of the System Level Measure (SLM) Improvement Plan. The focus has been to provide a range of initiatives to support Māori in engaging with a/their primary care provider and having support in place to sustain a good relationship for continuity of care. • There is a need to examine patient journeys in greater depth to understand trends in the utilisation of services, readmission

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

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

Contribution to Goals and Strategic Implications	Focus is on Improving Health and Equity for Māori
Impact on Reducing Inequities/Disparities	Directly aligned to addressing inequity between Māori and Other
Consumer Engagement	(Forms part of each work stream)
Other Consultation /Involvement	Not applicable for this report
Financial/Budget Impact	Not applicable for this report
Timing Issues	Not applicable
Announcements/ Communications	None

RECOMMENDATION:

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

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

   Provide quarterly updates against activities that;

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

HAWKE'S BAY
District Health Board
Whakawāteatia

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

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

OVERVIEW

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

UPCOMING REPORTS

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

Priority	Indicator	Champion	Reporting Month
Access *Local Indicator*	Reducing acute ASH Hospitalisations: 1. 0-4 year olds: dental decay; skin conditions; respiratory; and ear, nose and throat infections 2. 45-64 year olds: heart disease; skin infections respiratory infections and diabetes	Mark Peterson	July 2018

MĀORI HEALTH PLAN INDICATOR

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

ASH reflect hospital admissions for conditions which could potentially be prevented by early access to treatment in primary care. In many countries ASH is used as a means to assess the performance of primary care and to identify potential barriers to access.

However, while ensuring early access to effective primary care is still likely to be of considerable value in reducing ASH, in countries such as New Zealand, where large socio-economic and ethnic disparities in child health exist, a greater emphasis is needed to address those factors, often outside of the health sector, which drive the underlying burden of disease (e.g. household income, housing, nutrition, exposure to second hand cigarette smoke).

What this also emphasises is the necessity for the health system to be working efficiency, effectively, and equitably in every way to ensure that health does not add to the socio-economic burden of ill-health. The HBDHB is committed to non-differential targets and significant inequality is seen in this

indicator. Our work programmes focus on targeting vulnerable populations to reduce hospitalisation, improving the home environment and improving consistency of practice and early access to primary care programmes and reducing inequities.

WHY IS THIS INDICATOR IMPORTANT?

SLMs

The Introduction of the SLMs; targeted performance measures, came into effect beginning 2016-17. The measures include some previous health targets included in the Integrated Performance Incentive Framework and a set of newly introduced, nationally agreed performance measures. ASH rates are included in two SLMs.

- ASH 00-04yrs is reported against under the SLM - ASH
- ASH 45-64yrs is reported under the SLM - Acute Hospital Bed Days.

Each ASH band for total population is divided into; Māori, Pacific, Other[2]. Targets are derived from the DHB ASH rates for the Māori population. The base line rates for the DHB will be compared with national total population rates and targets set accordingly. These are expressed in rates per 100,000. All Māori and Pasifika data reported against for ASH will analysed by Māori vs Other to adequately examine the equity gap.

Targets have been set to work towards eliminating the gap within a two to five year period. Using the base line as a measure, reducing the equity gap by half each year. If below 10% the aim is to eliminate the gap. Rates within 5% would be considered equitable (e.g. HBDHB Māori ASH rates to be at or below national total population rates) [3]

0 – 4 years

For the 2017 year the contributory measures regarding the SLM of Reduced ASH rates for 0-4 years as agreed by Health Hawke's Bay (HHB) and HBDHB are:

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

The 2016 top three ASH conditions for tamariki Māori 0 – 4 years were: dental conditions; asthma and respiratory infections – Upper ENT.

45-64 years

As of September 2016 the Top Three conditions contributing to the ASH rate for 45-64yrs were: cardiac conditions; respiratory (including Chronic Obstructive Pulmonary Disease (COPD) and Pneumonias), and Cellulitis. This is unchanged.

For the 2017-18 year the target areas as identified in the SLM-Improvement Plan are:

Using Health Resources Effectively: Reduce standardised acute hospital Bed Days per 1000 population for Māori to ≤461 (by June 2018).

Contributory Measures

- ASH rates 45-64yrs (Māori)
- Increase the number of Māori and Pasifika and Quintile 5 referred into the high needs enrolment program (PHO)
- Increase the number of referrals into the CPO programme – Hospital Discharge pathway for Māori – Pasifika and Q4 and Q5.

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

1. HAWKE'S BAY DISTRIBUTION AND TRENDS

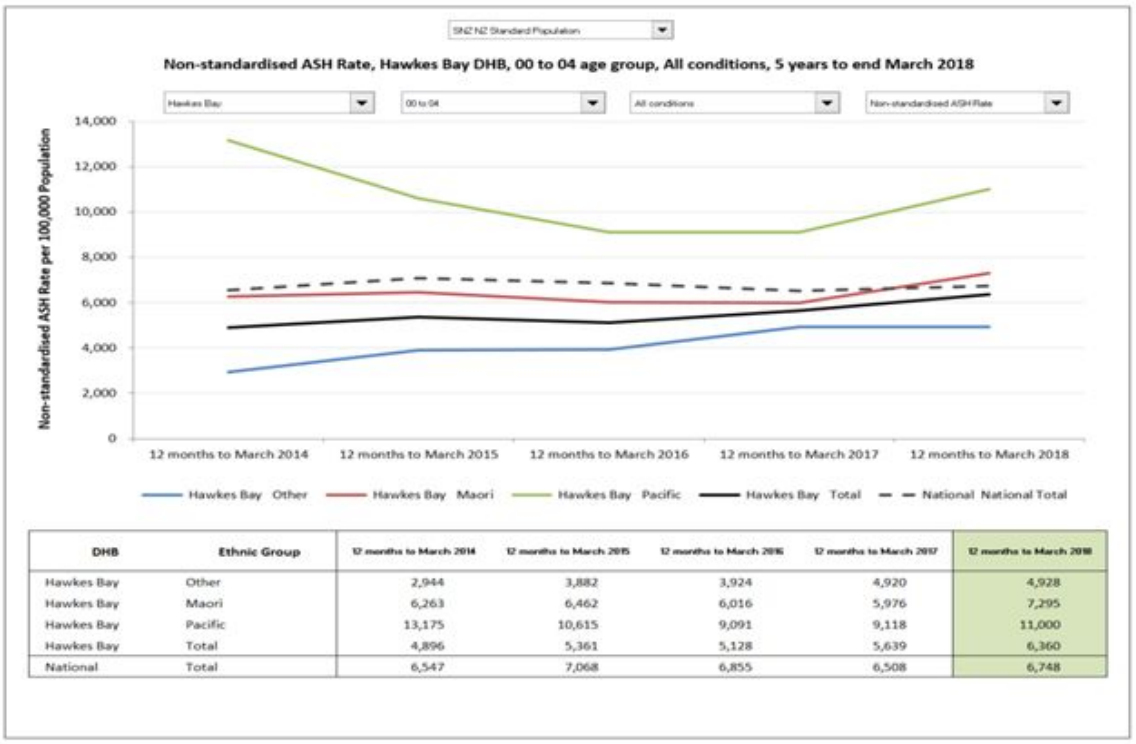
0-4 YEAR AGE GROUP

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

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

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

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



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

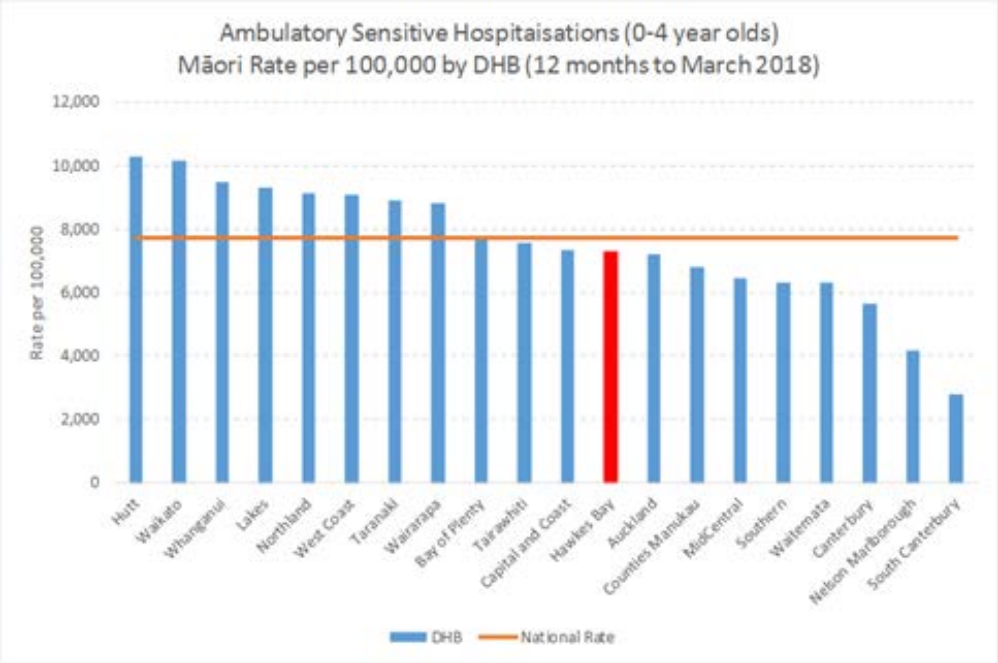
Events

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

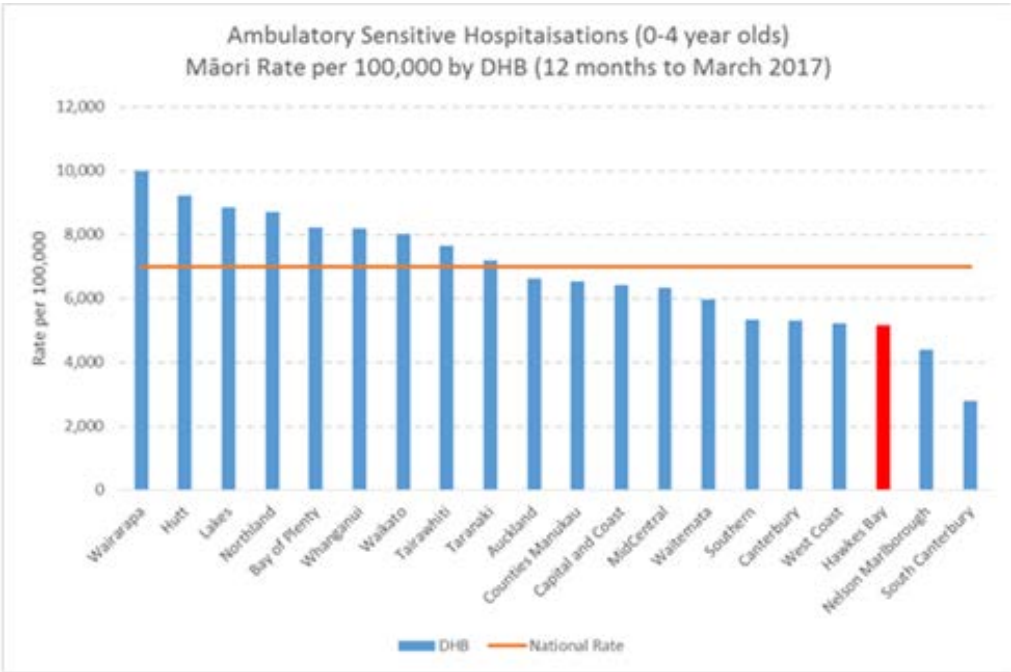
Data Analysis

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

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



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



Data Analysis

In the 12 months to September 2018 the Hawke's Bay Māori rate was 94% of the National Rate which is an improvement from the previous 12 month period of 99.9% of the national rate. We have remained the 9th best performer of all DHB's with Māori rates, in the prior 12 month period we were the 6th best Māori performer in this age group.

Asthma

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

Events

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

Data Analysis

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

Pneumonia

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

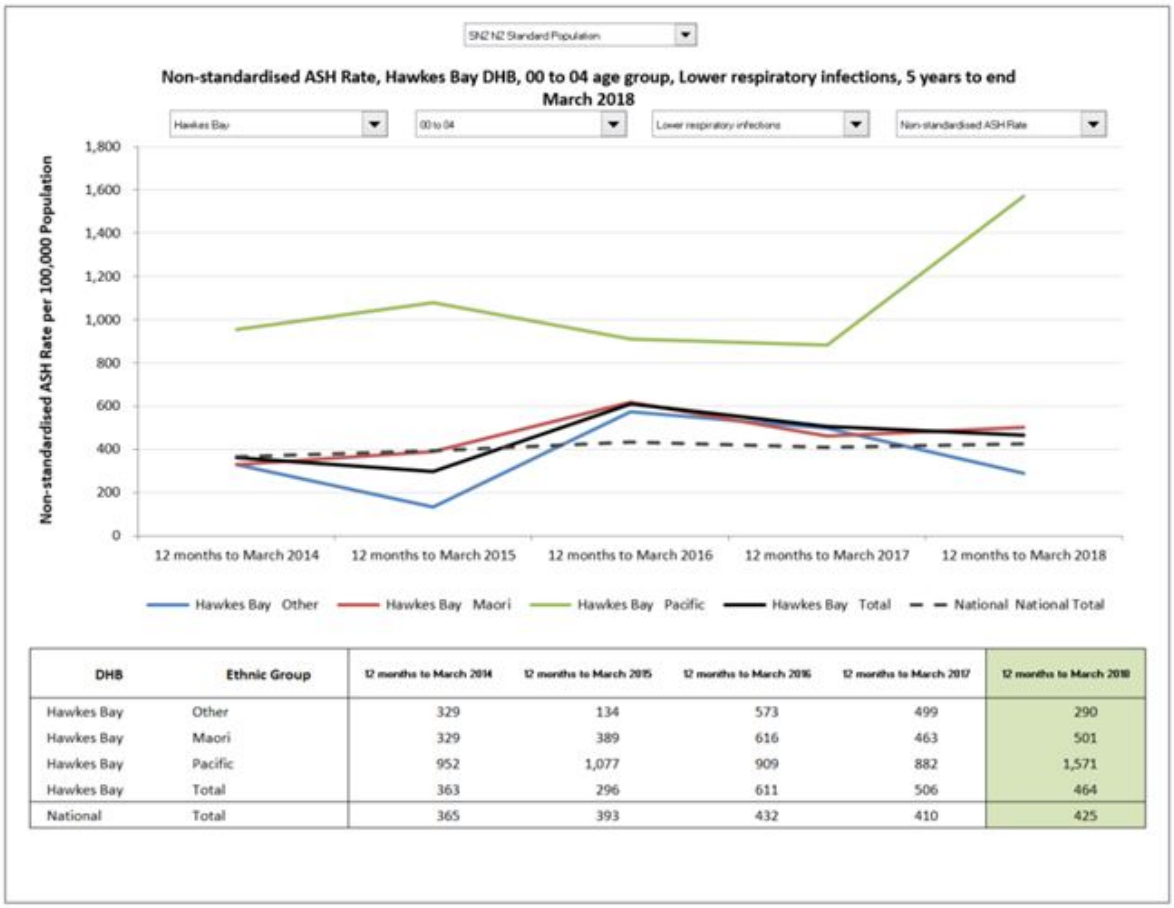
Events

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

Data Analysis

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

Lower Respiratory Infections



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

Events

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

Data Analysis

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

Programme Analysis

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

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

To date, a total of 974 referrals have been received since the inception of the CHHP. Whānau have received a total of 3497 interventions to promote warm dry homes and reduce transmissible diseases. These interventions have included, but not limited to: curtains (320 homes); beds (363); 234 WINZ Full and Correct Entitlement Assessments (FCEA); 177 homes insulated; and, 68 families/whānau supported to relocate to warmer, dryer social or private housing. In addition, all families/whānau receive 'key tip' messages regarding sustaining a warm dry home.

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

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

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

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

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

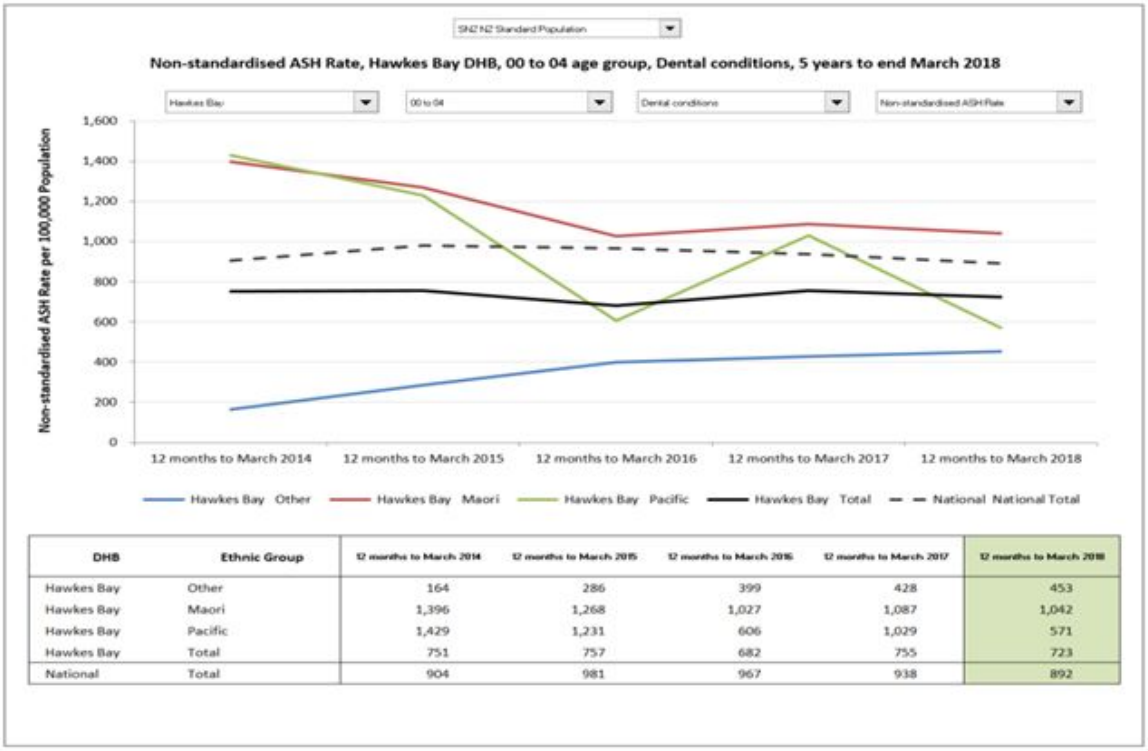
This quarter we have had 15 whānau decline immunisations. All of the above families have had conversations with trusted health professionals or the HBDHB Immunisation team to assist them with their decision-making. Housing is having an impact on finding whānau for the outreach team

[4] Dental programme for children.

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

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

Dental



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

Events

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

Data Analysis

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

Programme Analysis

Oral Health: *Wietske Cloo – Acting Service Director Community Women and Children*
The 'Oral health equity for tamariki 0 – 4 years' project is well underway. This is a five year project from 2016 – 2020. Over the last year, main activities have involved establishing the project, building

relationships with key internal and external stakeholders, and identifying priority areas of focus. Good progress has been made in a number of areas including:

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

- WC/TO providers have been contracted to provide greater emphasis on oral health at Core Health checks. Funded by Māori Health, this service aims to provide whānau with appropriate oral health information and resources, and where appropriate, facilitate access to COHS appointments. There is great collaboration between services. Oral health is now part of WC/TO Quality improvement framework (supported by TAS)

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

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

- The Te Roopu Matua – Māori consumer, community leaders group provide valuable advice to the project group on Māori oral health perspectives and experiences, and appropriate ways to engage whānau Māori to better meet their oral health needs

- Working with Health Hawke's Bay to increase the focus on oral health in the Whānau Wellness Programme, and planning to implement 'Lift the Lip' in two high needs GP practices
.
- The completion of a review of the ASH dental care pathway for tamariki 0 – 4 years. The review examines the interactions and experiences of whānau prior to and after their tamaiti/child's general anaesthetic dental procedure. The final report with recommendations is finalised. Findings indicating quality improvements in early engagement, improved wait-times for children, better follow-up care and support in the community, and appropriate and responsive information and support for tamariki, Māori, Pacific, and children living in deprived areas.

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

Next steps

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

Gastroenteritis/Dehydration

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

Events

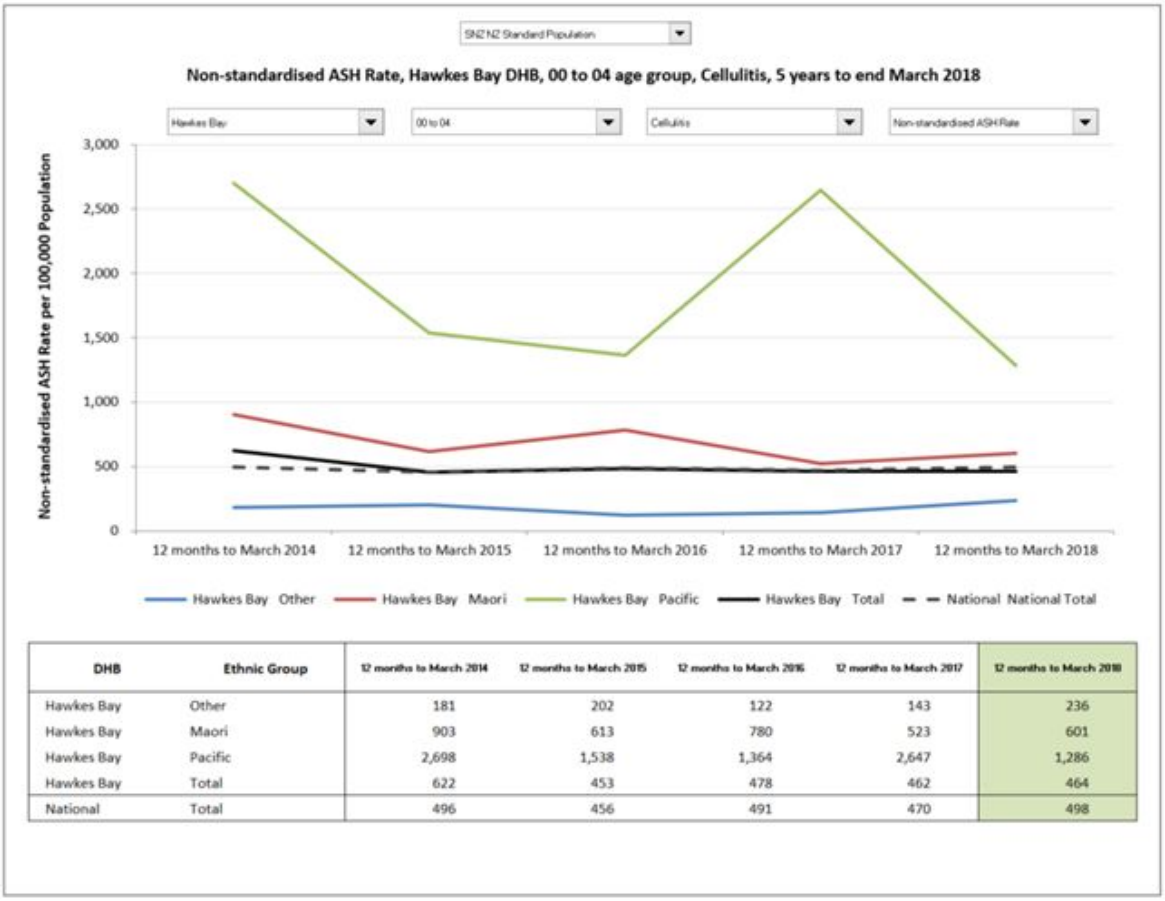
DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	53	79	40	70	72
Hawkes Bay	Maori	38	58	33	47	48
Hawkes Bay	Pacific	7	15	5	8	7
Hawkes Bay	Total	98	152	78	125	127
National	Total	-	-	-	-	-

Data Analysis: **(Peter)**

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

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

Cellulitis



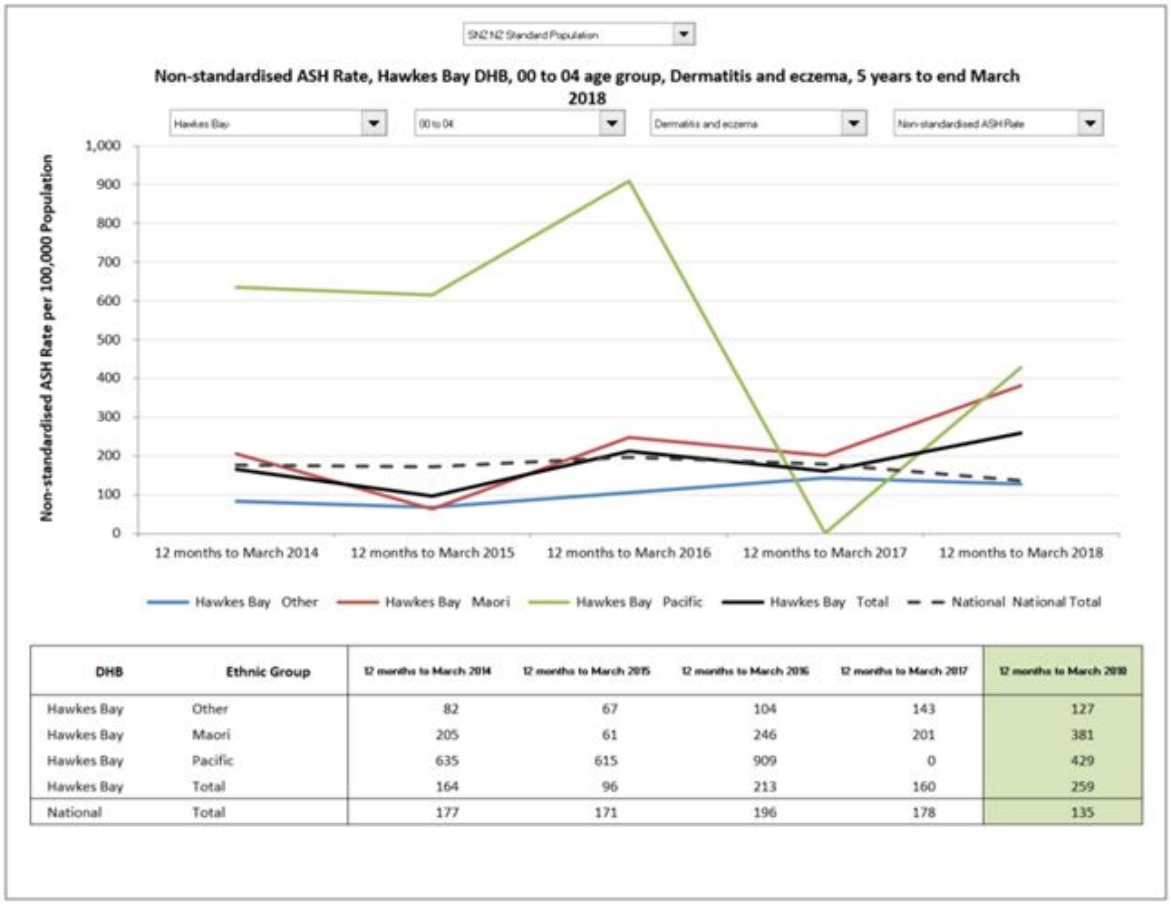
DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	181	202	122	143	236
Hawkes Bay	Maori	903	613	780	523	601
Hawkes Bay	Pacific	2,698	1,538	1,364	2,647	1,286
Hawkes Bay	Total	622	453	478	462	464
National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

Events

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

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

Dermatitis and Eczema



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

Events

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

Data Analysis

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

Programme Analysis

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

The HBDHB Skin Programme aims to raise awareness of skin problems, provide appropriate resources to families/whānau to care for skin, prevent skin infections and infestations, facilitate access to early treatment, and reduce stigma and discrimination for tamariki with skin problems.

During 2017-2018, key activities have included:

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

Going forward in 2018

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

RECOMMENDATIONS: 0-4 yrs

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

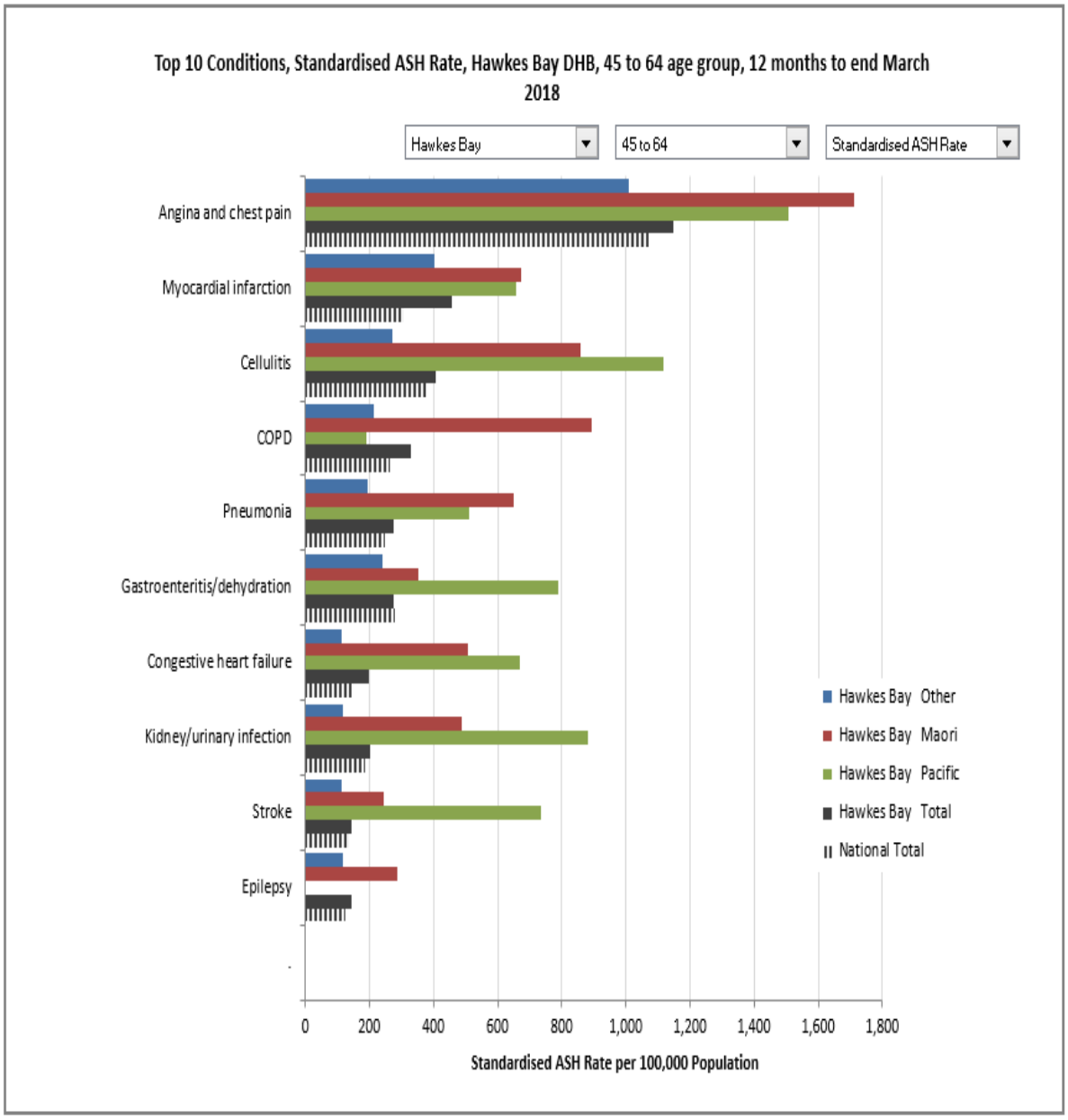
2. HAWKE'S BAY DISTRIBUTION AND TRENDS

45-64 YEAR AGE GROUP

The expectation for ASH 45-64 is that there will be a minimum reduction by half of the equity gap between Māori and national total population base line data over a period of 2.5 years. Within 5% would be considered equity.[5]

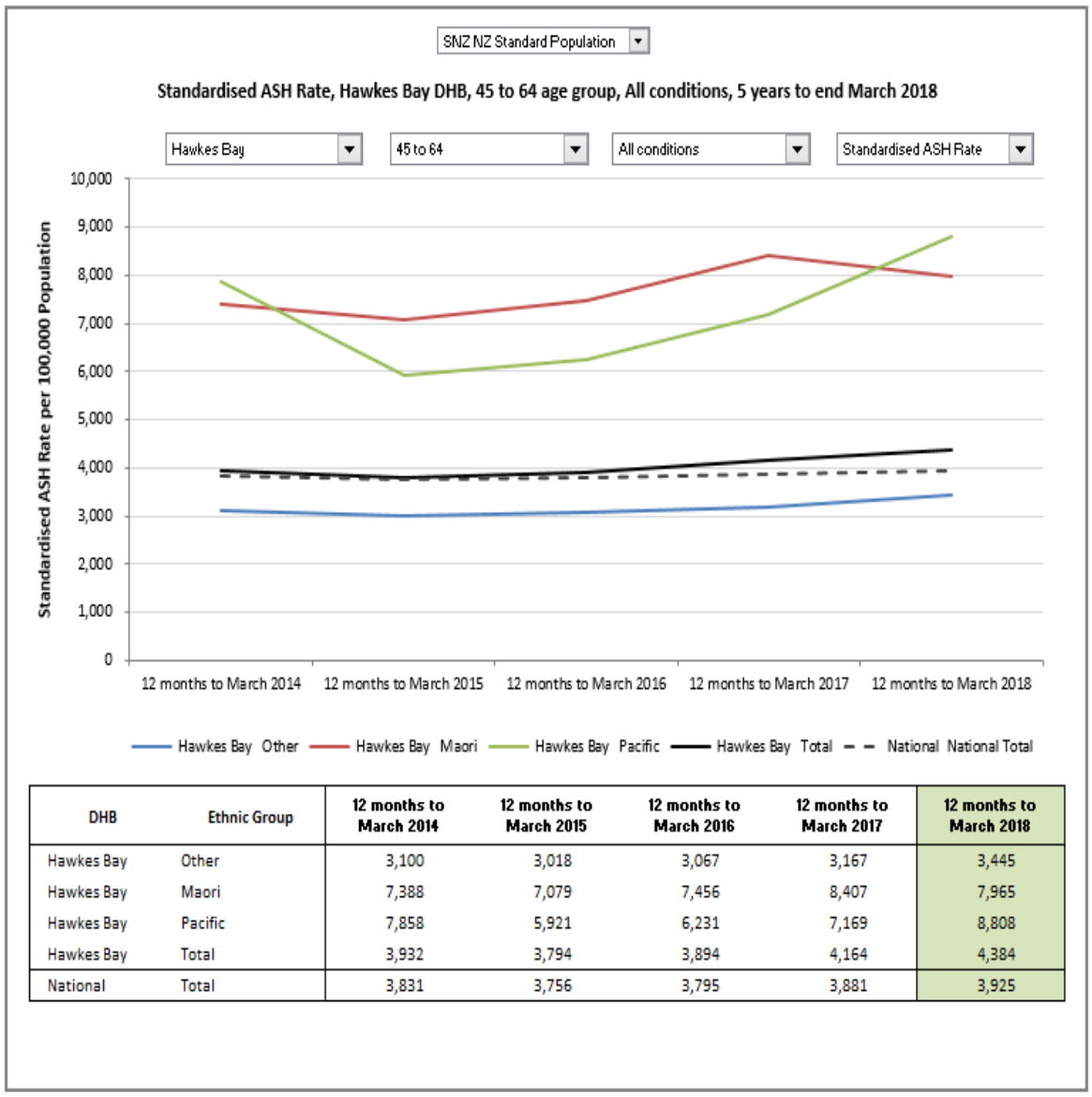
The focus of this report is on progress against reducing: Cardiac; Respiratory and Cellulitis related admissions; the highest contributors to Hawke's Bays top 10 ASH conditions. (See graph 1.0 below)

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



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

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



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

Data Analysis

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

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

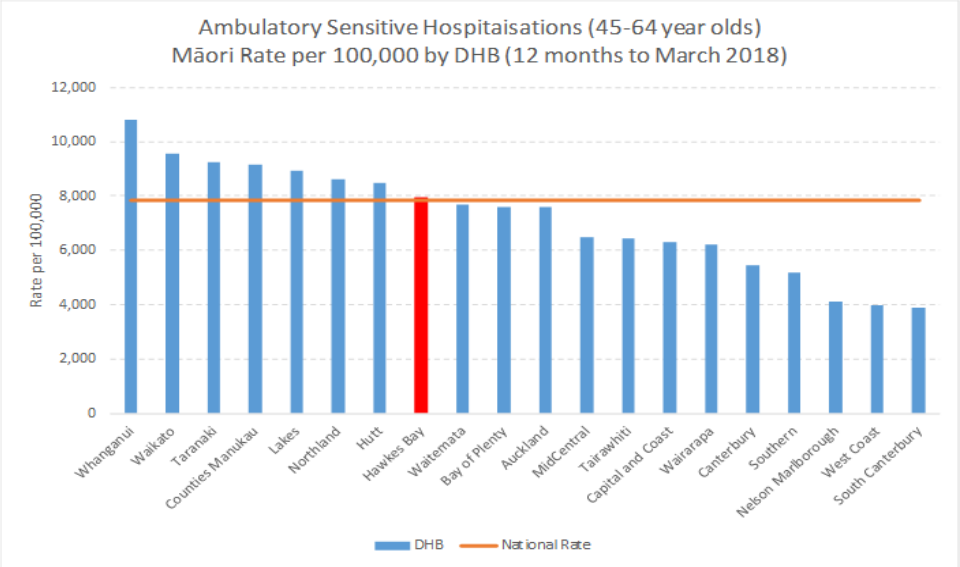
This chart and data is comparing the Māori rate with the Overall National rate, the charts on the next page are comparing the Hawke's Bay Māori rate to the Māori rates of the Other DHB's.

HOW WE COMPARE TO OTHER DHBS

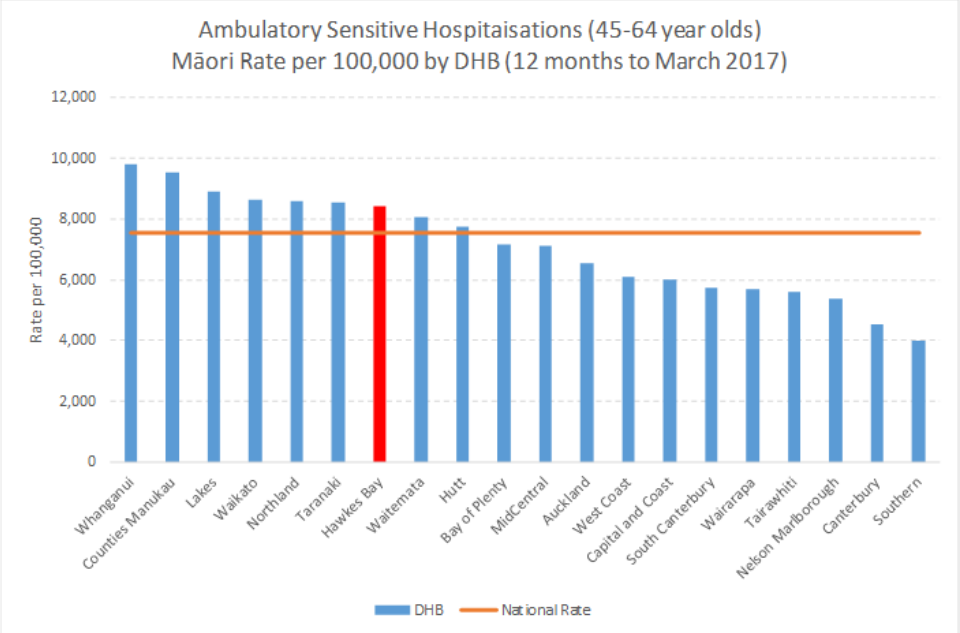
The Māori ranking of HBDHB has improved from seventh highest to eighth highest compared to the other DHB Māori Rates.

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

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



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

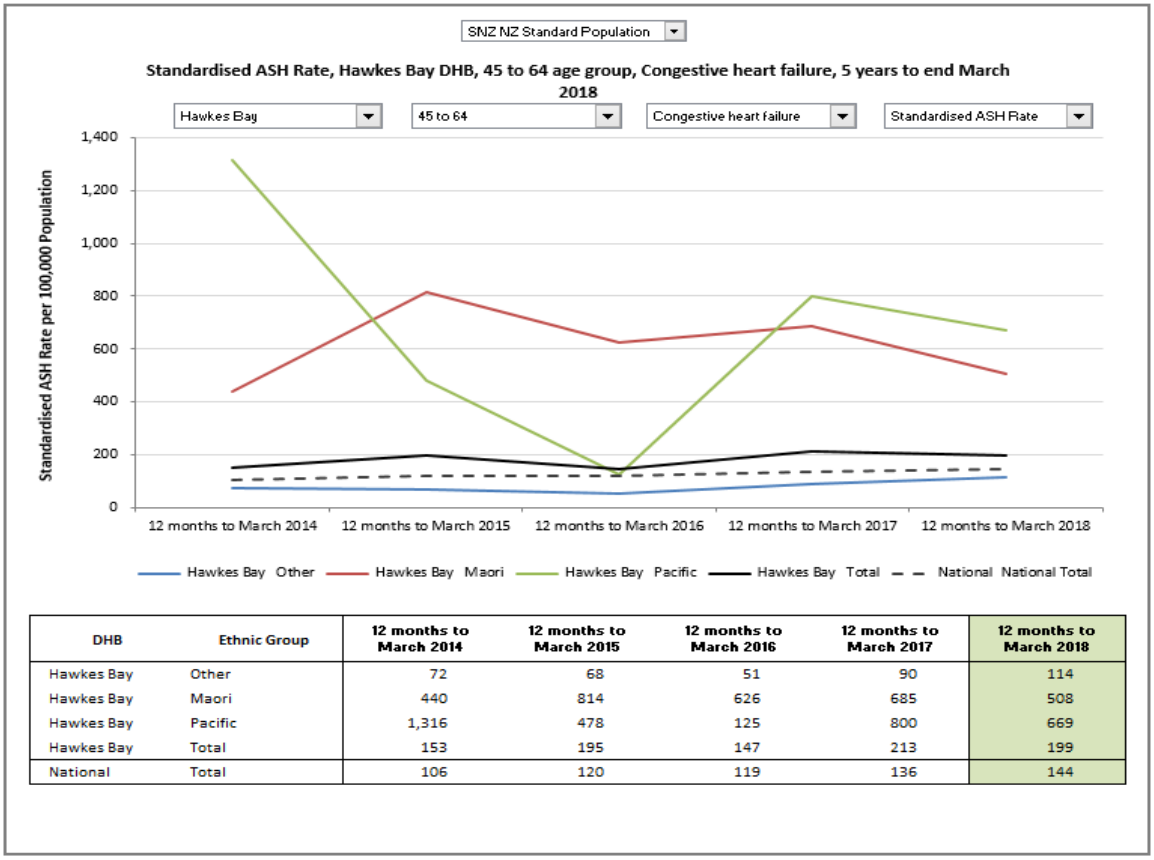


Cardiac and Respiratory Conditions, and Cellutis are the main focus areas for ASH 40-65yrs
The following graphs provide detail on the conditions that have been targeted as part of the 2017-19 SLM Improvement Plan (SLMIP). Each graph is followed by analysis by the Business Intelligence team.

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

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

Congestive Heart Failure (CHF)



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

Events

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

Data Analysis

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

Hypertensive Disease

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

Events

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

Data Analysis

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

Angina and Chest Pain

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

Events

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

Myocardial Infarction rates

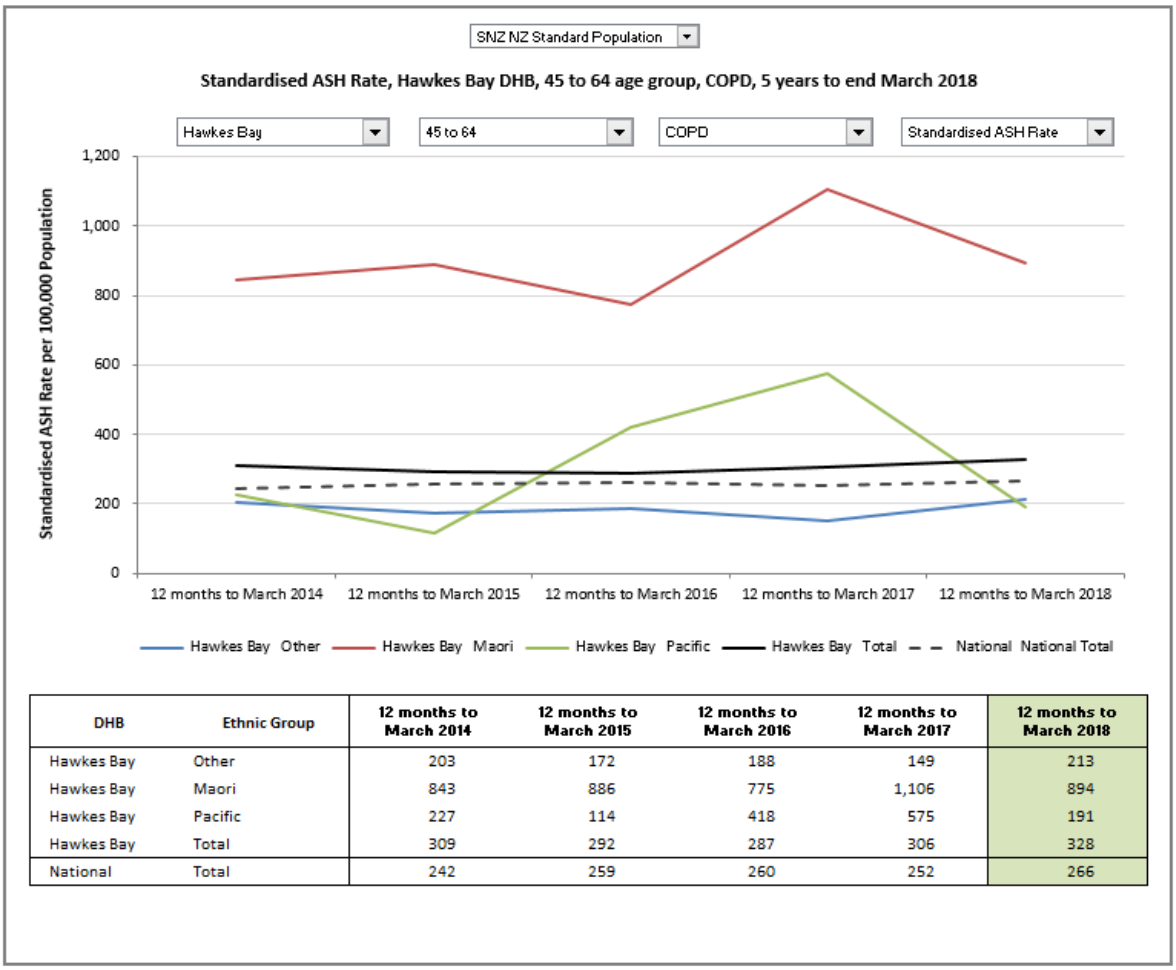
DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	145	142	156	132	149
Hawkes Bay	Maori	48	46	61	60	52
Hawkes Bay	Pacific	4	8	7	9	7
Hawkes Bay	Total	197	196	224	201	208
National	Total	-	-	-	-	-

Data Analysis

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

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

COPD



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

Events

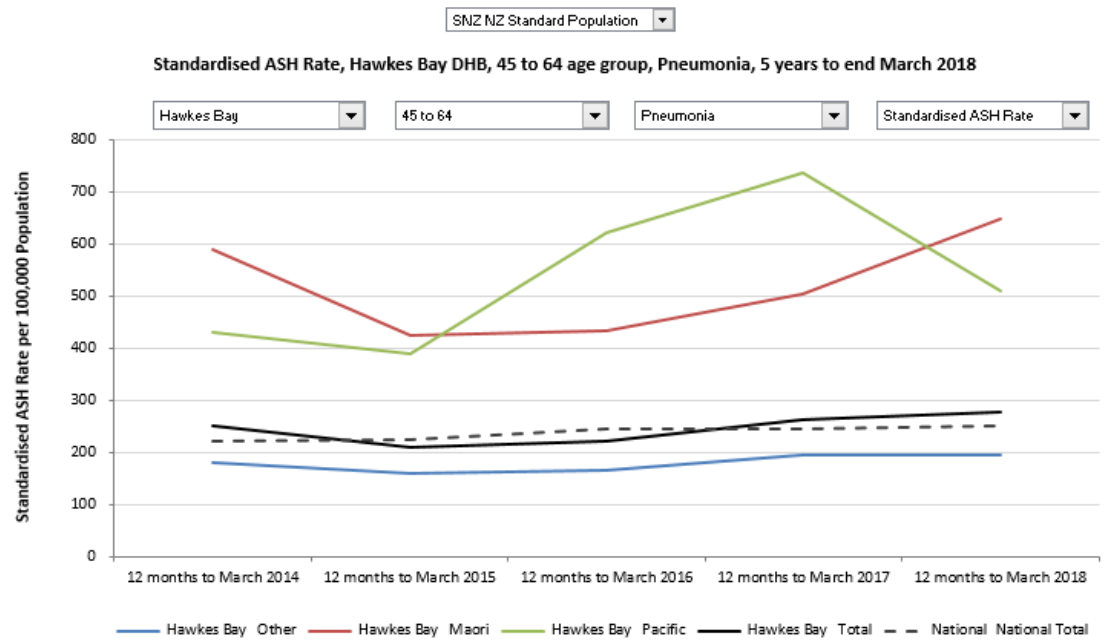
DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	72	63	68	53	77
Hawkes Bay	Maori	60	65	56	80	70
Hawkes Bay	Pacific	2	1	4	5	2
Hawkes Bay	Total	134	129	128	138	149
National	Total	-	-	-	-	-

Data Analysis

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

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

Pnuemonia



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

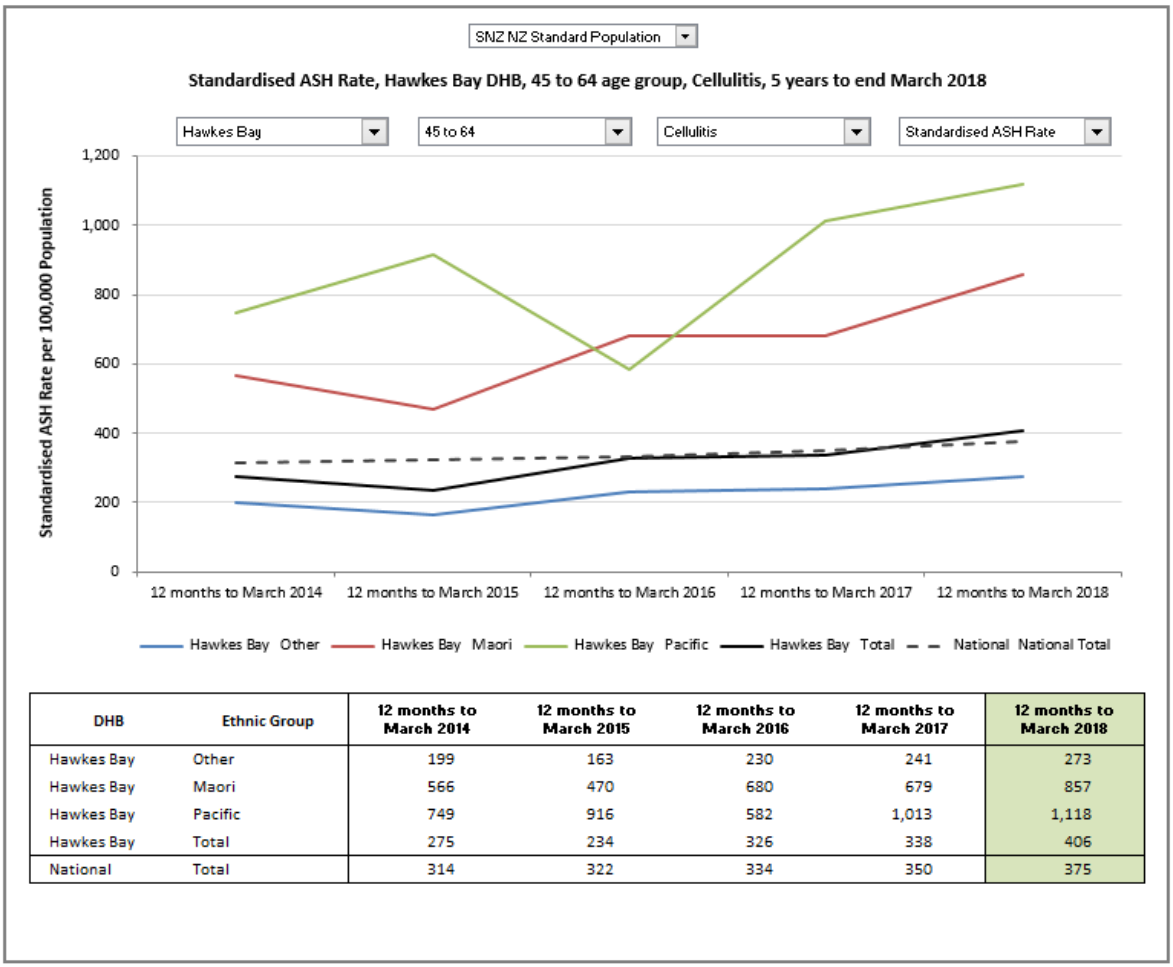
Events

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

Data Analysis

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

The ASH 45-64 Cellulitis



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

Events

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

Data Analysis

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

ACTIVITY TO ADDRESS 45-64 ASH RATES

1. SLM Improvement Plan
Incorporated into the Improvement Plan and aligned to the SLM-Reducing Hospital Bed Days are the following contributory measures and activities and progress towards achieving them:

Increase number of Māori Pasifika and Quintile 5 referred to CPO high needs enrolment programme. Māori Base line 167. Māori Goal 350: Achieved: 91 Māori referrals (44 % of total referrals)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. *Collaborative Pathways*

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

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

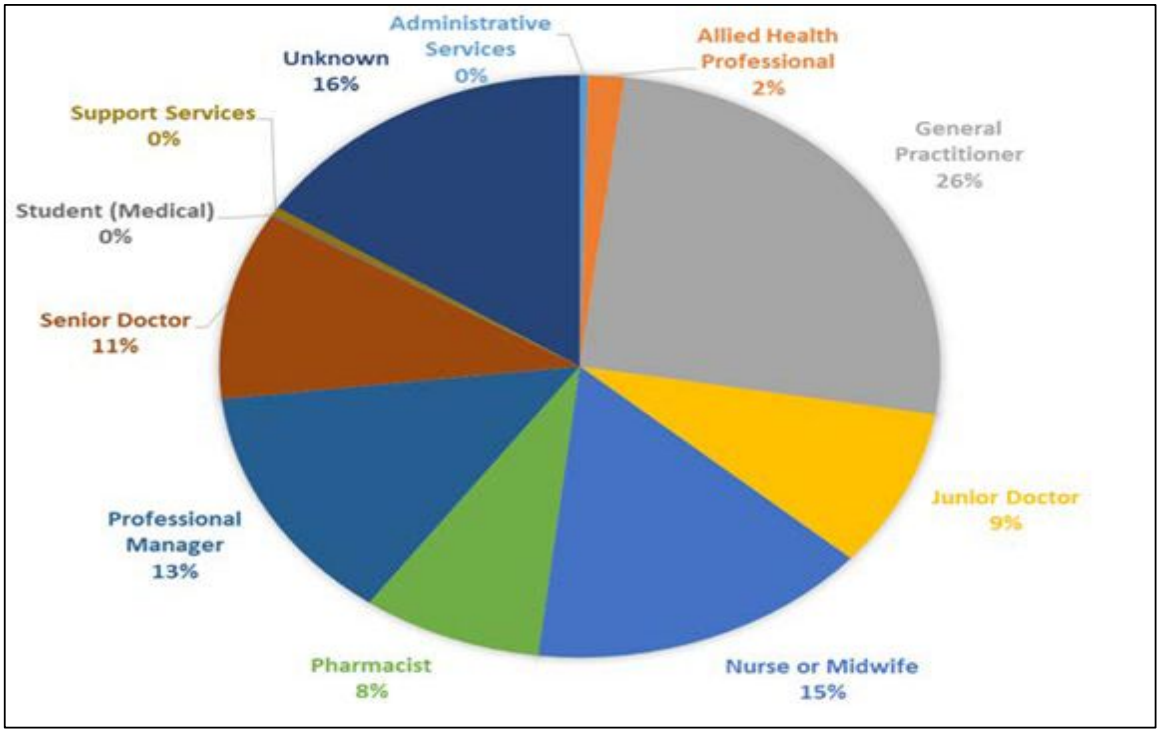
  "Collaborative clinical pathways are essential to the provision of an effective and efficient CPO pathway. Clinical pathways provide the mechanism for guiding adherence to best practice, the ability to inform clinical auditing and provide confidence in services that can be delivered through the CPO Programme.

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

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

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

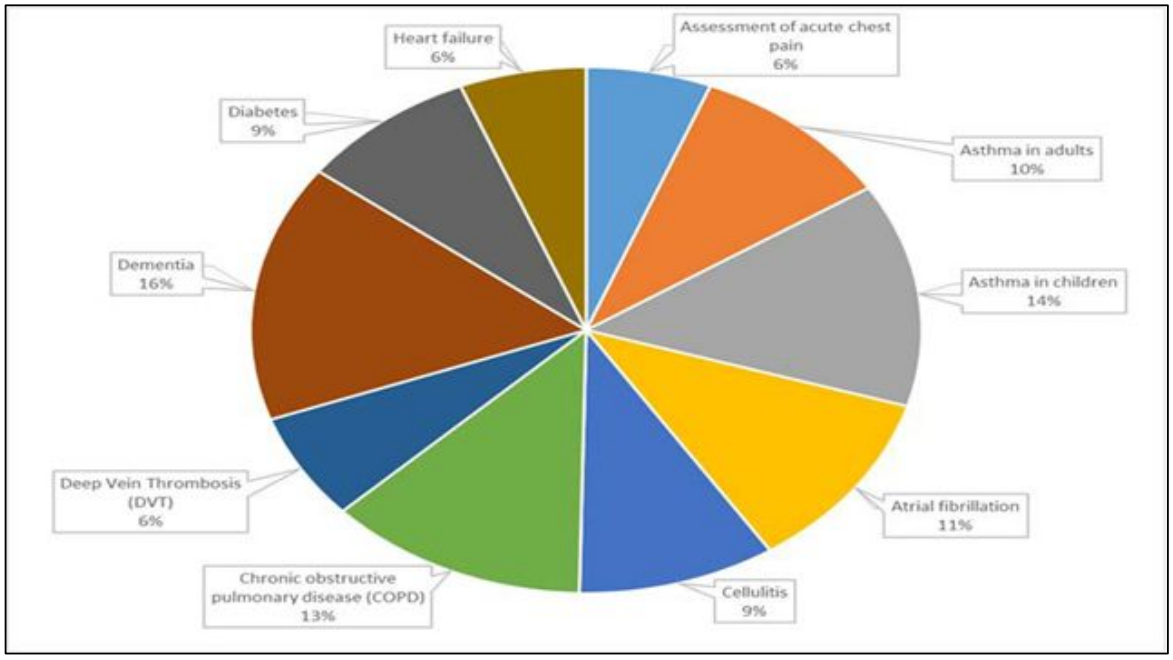
Figure 1.0 – Utilisation of pathways by service provider[8]



Pathways utilised that address the top five contributing conditions to HBDHB ASH rates (Adults):

- Cardiac: Heart Failure (6%), Atrial Fibrillation (11%), Assessment of Chest Pain (6%)
- Respiratory: COPD (11%), Asthma in Adults (10%),
- Cellulitis (9%).

Figure 1.2 – Utilisation rates of current pathways



[8] Not altered since previous report

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

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

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

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

3. Implementation Plan for HBDHB LTCs Framework

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

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

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

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

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

	Key Recommendation	Implementation lead	Champion(s)	Time Frame	Status
1.	Clinical pathways become part of business as usual supported by a sustainable funding resource.	Strategic Services Manager Primary Care LTC Portfolio Manager	CMO Primary CMO Secondary	Dec 2018	DHB commitment to Interim tool for Clinical pathways confirmed. Jan 2019 new platform to be identified
3.	In relation to Cardiac/ Respiratory & Renal/ Diabetes Service plans include: • Workforce development • Care coordination • Transition of care assessed against the LTC Service Review Matrix[9] to demonstrate progress to towards improved outcomes	Head of Planning Strategic Services Manager Primary Care LTC Portfolio Manager	Directorate Leads Chief Nursing and Midwifery Officer	Dec 2018	Not uniform part of service planning as yet Lead Portfolio manager recruitment delay has caused delays
4.	Enhance use of CNS/NP in specific LTC, evidenced by the outcomes achieved to date by Diabetes and Respiratory CNS workforce and engagement with primary care	Directorate leads LTC Portfolio Manager	Chief Nursing & Midwifery Officer	On-going	Newly recruited Portfolio Manager to lead this work.
5.	Increase the weighting that is applied to health award applications in relation to equity.	Clinical Council	ED Equity and Health Improvement	July 2018	Being discussed: Increase weighting in each of the data sections or include in each category "Commitment to reducing Inequities"

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

[9] LTC Service Review Matrix – the evaluation tool designed to assist with implementation of the HBDHB Long Term Conditions Framework

Comments from the Champion for ASH rates

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

Dr Mark Peterson
Chief Medical Officer - Primary

RECOMMENDATION:

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

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

   Provide quarterly updates against activities that;

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

TOPICS OF INTEREST

MEMBER ISSUES / UPDATES

Verbal

15

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

17. Minutes of Previous Meeting (Public Excluded)
18. Matters Arising – Review Actions

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

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