Māori Relationship Board Meeting

Date:	**Wednesday, 13 June 2018**
Meeting:	**9.00am to Noon**
Venue:	**Te Waiora (Boardroom), District Health Board Corporate Office, Cnr Omahu Road & McLeod Street, Hastings**

Board Members:

Ngahiwi Tomoana (Chair)
Heather Skipworth (Deputy Chair)
George Mackey
Na Raihania
Kerri Nuku
Lynlee Aitcheson-Johnson
Trish Giddens
Ana Apatu
Hine Flood
Dr Fiona Cram
Beverly Te Huia

Apologies:

In Attendance:

Member of the Hawke's Bay District Health Board (HBDHB) Board
Members of the Executive Management Team
Member of Hawke's Bay (HB) Consumer Council
Member of HB Clinical Council
Member of Ngāti Kahungunu Iwi Inc.
Member of Health Hawke's Bay Primary Health Organisation (HHB PHO)
Members of the Māori Health Service
Members of the Public

Our vision

HEALTHY HAWKE'S BAY

TE HAUORA O TE MATAU-Ā-MĀUI

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

Our values

Tauwhiro – delivering high quality care to patients and consumers

Rāranga te tira – working together in partnership across the community

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

Ākina – continuously improving everything we do

PUBLIC MEETING

Item	Section 1 : Routine	Time
1.	Karakia	9.00am
2.	Whakawhanaungatanga	
3.	Apologies	
4.	Interests Register	
5.	Minutes of the Previous Meetings held 9th May 2018	
6.	Matters Arising - Review of Actions	
7.	MRB Workplan	
8.	MRB Chair's Report	
9.	Acting General Manager's Monthly Māori Health Report	
10.	Clinical Council Verbal Update	
	Section 2: Presentations and Discussion	
11.	HBDHB Youth Strategy Implementation update inclusive of Zero Fees 13-17 – Jill Garrett	09:20
12.	People Plan – Kate Coley	09:50
13.	Implementing the Consumer Engagement Strategy – Kate Coley	10:00
14.	Recognising Consumer Participation - Policy Amendment – Ken Foote & Kate Coley	10:10
	Section 3: Monitoring – for Information	
15.	Clinical Services Plan verbal update – Ken Foote	10:25
16.	Te Ara Whakawaiora - Oral Health (National Indicators) – Dr Robin Whyman	10.30
	Section 4: General Business	
17.	He Ngakau Aotea – Strategic Priorities report preparation	10.50
	Karakia Whakamutunga (Closing)	Noon

NEXT MEETING:

Wednesday, 11 July 2018, Boardroom, HBDHB Corporate Office
Cnr Omahu Road & McLeod Street, Hastings

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Māori Relationship Board Interest Register - 28 May 2018

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict (if any)	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Declared
Ngahiwi Tomoana (Chair)	Active	Chair, Ngati Kahungunu Iwi Incorporated (NKII)	Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The HBDHB Chair	01.05.08
	Active	Uncle of Tiwai Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Tiwai Tomoana is employed by HBDHB and is a Kitchen Assistant in the Food and Nutrition Department at Hawke's Bay Hospital.	All employment matters in relation to Tiwai Tomoana are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Uncle of Iralee Tomoana	Iralee Tomoana is employed by HBDHB and works in the Radiology Department as a clerical assistant.	All employment matters in relation to Iralee Tomoana are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Brother of Numia Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital.	Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital.	The HBDHB Chair	01.05.08
	Active	Involved with Waitangi Claim #2687 (involving Napier Hospital land) sold by the Government	Requested that this be noted on the Interest Register	Unlikely to be any conflict of Interest.	The HBDHB Chair	28.03.18
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract; and the Mobility Action Plan (Muscular Skeletal)	Will not take part in any discussions or decisions relating to any actions or contracts with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15 29.03.17
	Active	Director of Kahungunu Asset Holding Company Ltd	The asset portfolio of the company in no way relates to health, therefore there is no perceived conflict of interest.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	26.10.16
Kerri Nuku	Active	Kaiwhakahaere of New Zealand Nurses Organisation	Nursing Professional / Industrial Advocate	Will not take part in any discussions relating to industrial issues	The Chair	19.03.14
	Active	Trustee of Maunga HaruruTangitu Trust	Nursing Services - Clinical and non-Clinical issues	Will not take part in any discussions relating to the Trust	The Chair	19.03.14
George Mackey	Active	Wife, Annette Mackey is an employee of Te Timatanga Ararau Trust (a Trust aligned to Iron Maori Limited)	The Trust Holds several contracts with the HBDHB	Will not take part in any discussions relating to the Trust	The Chair	19.03.14
	Active	Wife Annette is a Director and Shareholder of Iron Maori Limited (since 2009)	The company is aligned to a Trust holding contracts with HBDHB	Will not take part in any discussions relating to Iron Maori Limited	The Chair	04.08.16
	Active	Trustee of Te Timatanga Ararau Trust (a Trust aligned to Iron Maori Limited)	The Trust Holds several contracts with the HBDHB	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.06.14
	Active	Director and Shareholder of Iron Maori Limited (since 2009)	The company is aligned to a Trust holding contracts with HBDHB	Will not take part in any discussions or decisions relating to the Contract aligned to Iron Maori Limited).	The Chair	04.08.16
	Active	Employee of Te Puni Kokiri (TPK)	Working with DHB staff and other forums	No conflict	The Chair	19.03.14
Lynlee Aitcheson-Johnson	Active	Chair, Maori Party Heretaunga Branch	Political role	Will not engage in political discussions or debate	The Chair	19.03.14
	Active	Trustee, Kahuranaki Marae		No conflict	The Chair	14.07.16
	Active	Treasurer for Ikaroa Rawhiti Maori Party Electorate		No conflict	The Chair	04.07.17
Na Raihania	Active	Wife employed by Te Taiwhenua o Heretaunga	Manager of administration support services.	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.03.14
	Active	Member of Tairawhiti DHB Maori Relationship Board		Will not take part in any matters that may to any perceived contracts with Tarawhiti	The Chair	19.03.14
	Active	Employeed as a Corrections Officer		No conflict	The Chair	19.03.14
	Active	Mother in law, Jenny McQueen, Chaplain at Te Matau a Maui		No conflict	The Chair	14.02.18
	Active	Niece, Albie Raihania attending on the NeSP program		No conflict	The Chair	14.02.18
	Active	Board member of Hauora Tairawhiti	Relationship with Tairawhiti may have contractural issues.	Will not take part in any matters that may to any perceived contracts with Tarawhiti	The Chair	27.03.17
Ana Apatu	Active	CEO of U-Turn Trust (U Turn is a member of Takitimu Ora Whanau Collective) The U-Turn Trust renamed /rebranded "Wharariki Trust" advised 30-8-17	Relationship and and may be contractural from time to time	No conflict	The Chair	12.08.15
	Active	Chair of Directions	Relationship and contractual	Potential Conflict as this group has a DHB Contract	The Chair	12.08.15
Hine Flood	Active	Member, Health Hawkes Bay Priority Population Committee	Pecuniary interest - Oversight and advise on service delivery to HBH priority populations.	Will not take part in any conflict of interest that may arise or in relation to any contract or financial arrangement with the PPC and HBDHB	The Chair	23.02.17
	Active	Councillor for the Wairoa District Council	Perceived Conflict - advocate for the Wairoa District population and HBDHB covers the whole of the Hawkes Bay region.	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	23.02.17
Dr Fiona Cram	Active	Board Member, Ahuriri District Health Trust	Contribution to the health and wellbeing of Māori in Napier, as per the settlement under WAI692.	Declare and interest and withdraw from any discussions with respect to any contract arrangements between ADHT and HBDHB	The Chair	14.06.17

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict (if any)	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Declared
	Active	Adjunct Research Fellow, Women's Health Research Centre, University of Otago, Wellington	Health research involving data and/or participant recruitment from within HBDHB.	Declare a potential conflict of interest, if research ethics locality assessment requires MRB input.	The Chair	14.06.17
	Active	Director and Shareholder of Katoa Limited	An indigenous research organisation that undertakes research and work for organisations by Maori for Maori.	Declare any potential conflict of interest, prior an discussion on work undertaken for HBDHB and/or health service organisations.	The Chair	11.04.18
Trish Giddens	Active	Trustee, HB Air Ambulance Trust	Management of funds in support of HB Air Ambulance Services	Will not take part in discussions or decisions relating to contracts with HB Air Ambulance Service.	The Chair	19.03.14
	Active	Member Heatlh HB Priority Population Health	Health Advisors	Will declare intertest prior to any discussions relating to specific topics	The Chair	1.01.17
	Active	Committee Member, HB Foundation		No conflict	The Chair	1.01.17
	Active	Committee Member, Children' Holding Foundation		No conflict	The Chair	1.01.17
	Active	Trustee, Waipukurau Community Marae		No conflict	The Chair	1.01.17
Beverley TeHuia	Active	Trustee and employed by Kahungunu Health Services	Kahungunu Health Services currently contracts with HBDHB with a number of contracts. Mother and Pepi, Cervical and Breast screening, # Whanau and smokefree pregnant wahine.	Will not take part in discussions about current tenders that Kahungunu Health services are involved with and are currently contracted with.	The Chair	7.11.17
	Active	Employee of Totara Health	GP Practice providing heatlh services	Will declare intertest prior to any discussions relating to specific topics	The Chair	7.11.17
	Active	Committee Member of the Priority Population Committee (PPC)	Health Advisors		The Chair	7.11.17
	Active	Nga Maia O Aotearoa Chair person	The current Chair of Maori Midwives organisation of New Zealand. Providing Cultural Competency to all Midwives and child birth organiser in New Zealand. DHB employed and independent.	Will not take part in discussions about cultural training required of maternity services	The Chair	7.11.17
	Active	Iwi Rep on Te Matua a Maui Health Trust		Will not discuss or take part of discussions where this trust is or interest.		28.05.18
	Active	Claimant of Treaty Health Claim currently with the Tribunal; Wai #2575	Is yet to be heard by the Waitangi Tribunal	Unlikely to be a conflict		28.05.18

MINUTES OF THE MĀORI RELATIONSHIP BOARD
HELD ON WEDNESDAY 9 MAY 2018, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 9.05AM

PUBLIC

Present:	Heather Skipworth (Deputy Chair) Ngahiwi Tomoana Ana Apatu Hine Flood George Mackey Na Raihania Trish Giddens Dr Fiona Cram
Apologies	Beverly Te Huia Lynlee Aitcheson-Johnson Kerri Nuku
In Attendance:	Peter Dunkerley (HBDHB Board Member) Patrick Le Geyt (Acting General Manager, Māori Health HBDHB) Chris Ash (Executive Director Planning and Funding, Primary Care) Ngaira Harker (Director of Nursing – Māori Health) Kevin Snee (Chief Executive Officer HBDHB) *part* Ken Foote (Company Secretary) *part* Tiwana Aranui (Kaumatua for Māori Health) John Barry Heperi-Smith (Senior Advisor Cultural Competency)
Minutes:	Brenda Crene

KARAKIA AND INTRODUCTIONS

Patrick LeGeyt opened the meeting with a Karakia followed by an introduction of those present for the benefit of Tiwana Aranui and John Heperi-Barry Smith

Ngahiwi advised of succession planning and indicated he would be stepping down as Chair of the Māori Relationship Board (MRB), with Heather Skipworth taking on the role.

APOLOGIES

Apologies were noted from those above.

INTEREST REGISTER

No changes to the interests register were advised on the day, however Beverly TeHuia and Na will provide interests for inclusion. **Action**

No member advised of any interest in the items on the Agenda.

ADDITIONAL ITEM

Hine requested an additional item be placed on the agenda entitled "Trip to Alaska"

5. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the MRB meeting held on 11 April 2018 were approved as a correct record of the meeting

Moved: Na Raihania
Seconded: Ana Apatu
Carried

The minutes of the MRB Workshop held on 18 April 2018 at Mihiroa was approved as a correct record of the meeting.

Moved: Trish Giddens
Seconded: Na Raihania

Carried

6. MATTERS ARISING FROM PREVIOUS MINUTES

It was advised the matters arising ie, previous which had not been provided to the meeting, were to be updated.

7. MRB WORK PLAN

The Work Plan was noted.

Planning:

Once the direction of MRB has been ascertained, members will review the workplan going forward.

It was noted that the 5 year strategy is where the focus and this would be carried forward to the Workshop discussion. **

It was advised the HBDHB Board were holding a Workshop the following week (16th May) on the "Annual Plan and Prioritisation Setting. Chris Ash (ED Primary Care) conveyed this was occurring in the absence of a confirmed funding envelope or a letter of expectations describing requirements/targets to DHBs.

The National Budget was to be announced on Thursday 17 May by Finance Minister, Grant Robertson.

8. MRB CHAIR'S REPORT

The report was received taken as read. Noted that Health and Local Care Localities in HB should carry forward to the discussion under general business at 11am **

9. ACTING GENERAL MANAGER MĀORI HEALTH REPORT

Patrick LeGeyt's report was received which included an overview of: the Kaupapa Health Enquiry WAI 2575; Prioritisation of Te Ara Whakawaiora Reports for 2018/19; Sexual health and well-being; Pregnancy and Parenting Information and Education Programme; Te Hiringa Tamariki – Māori Child Wellbeing Framework; Māori Maternal health programme; Health Workforce New Zealand (HWNZ) and Tūruki Funding Rounds; and Matariki Living Taonga Awards 2018.

Ngaira Harker (Nurse Director) introduced herself and handed around the "te karere Māori Nursing Newsletter" which was very well received. She advised we celebrate Māori nurses as huge resource for HB, noting Sonja Smith's success in growing the rural nursing workforce. Nursing generally is focusing on wider scope and broader skill sets. Māori nurses speak from a kaupapa base and Ngaira is impressed with the unique differences they offer. It was anticipated that the Newsletter will be produced three times per year, and there are a lot of stories we need to capture including profiling Māori nurses in mainstream to show what others can work towards.

There was general discussion about wider circulation of this newsletter including preparing and providing videos in strategic locations.

Action: a) It was recommended that the CEO be approached and asked to issue the 'te karere Māori Nursing Newsletter' in conjunction with a CEO's Newsletter, focusing on "Māori Workforce Development".

Anton Blank's Child Wellbeing Framework was discussed. A draft had recently been presented in Wellington. The first draft appeared to be a circular wellbeing framework and internally contradictory however it was early days.

It was asked what was Ngati Kahungunu's (NKII's) definition of wellness and whanau – does that work in? This is a framework for Child Wellbeing – given what Fiona said it was noted we have a half completed definition of what wellbeing means to Māori and this needs to be completed. This would be further discussed under general business at 11am **

Action: b) Fiona Cram would circulate her Wellbeing paper to members for information.

10. CLINICAL COUNCIL VERBAL UPDATE

Ana Apatu having attended recent Clinical Council meetings felt the role of observer was invaluable and has a real purpose. She advised she was willing to substitute as MRB Observer for Kerri Nuku. In discussion it was understood Kerri had a large workload and that it was sensible for Ana to attend for a longer period.

Members agreed for Ana Apatu to become the observer at Clinical Council meetings for one year, and thanked her for volunteering.

Actions:
- **a) Clinical Council to be advised that Ana Apatu will replace Kerri Nuku as observer until April 2019.**
- **b) In April 2019 the MRB observer on Clinical Council would be included on the MRB agenda and reviewed.**
- **c) The Chair, Heather Skipworth will contact both Kerri and Lynlee to ascertain their availability to attend MRB meetings in the next year, and advise Kerri directly of Ana's appointment.**

It was noted that information was always available to MRB members as Council and HBDHB Board were on the website prior to each meeting http://www.hawkesbay.health.nz/

Clinical Service Plan (CSP) Workshops

Ana and Trish had attended a Hui at Taiwhenua one of the four CSP Workshops.

Key points noted:

- Good representation of Pasifika advising of their difficulties accessing GPs, with a sad consumer story shared as an example.
- The three top priorities were:
  - More focus on health and wellbeing of young families.
  - Need for preparation to ensure responsive workforce.
  - Moves to ensure primary care work better together
- The evening was very well facilitated, was really positive and everyone across the sector knew it was a time for change.
- Noted a problem with different interpretations/understanding of the Māori terminology ie, taking Māori concepts and relaying them into European concepts! This needs to be discussed further.

PRESENTATIONS AND DISCUSSION

11. CLINICAL SERVICES PLAN – PLANNING FOR CONSULTATION

The report was received from Ken Foote who updated on the workshop held the prior week. Information/feedback from each workshop is collated and brought together to develop options. These will go through to the workshop being held on 31 May which will bring all together and commence framing up the options for the future to form the framework of the CSP. There needs to be a tidy up on some of the outcomes. He advised that a clinical team was being pulled together to road test concepts from the three workshops held also.

A draft will be developed and provided to MRB for review in July. This will be a reality check more than a debate on the outcomes.

At the meeting Ken sought feedback and input into the papers provided around "Planning for Consultation" with no preconceived views.

Summary of points raised:

- How do we ensure interpretations are correct and add value?
- It was generally felt the use of Māori terminology would be good to encompass Pasifika cultures as well ie, a universal language that crosses barriers.
- This is all about helping the people and if we think from the mind and heart then we can't get it wrong.
- There may be some reluctance to nominate presenters without understanding what that final shape looks like?
- Ken Foote conveyed this would be in the form of a "concept". In July – we can change if need be but cannot leave things until the last minute.

  This is about "selling the concept of change". We need to change and need to involve people in that change. We want better health outcomes for all people. The thinking is to go out to as many groups and present in some form (hopefully by the end of July). Need to decide who is best to take this out to stakeholders/whanau in the best possible way to get true engagement.

  Action: Members to email Patrick LeGeyt with suggestions and will advise Ken Foote.

12. MATERNAL WELLBEING MODEL OF HEALTH

Charrissa Keenan provided presented providing an overview to this partnership approach by way of presentation and a paper (tabled at the meeting). Want to see good Māori maternal and child health outcomes. It is proposed that HBDHB develop a kaupapa Māori maternal health programme ('the Programme'). The intent of the programme is to overcome barriers to access to maternal health care, eliminate inequities in maternal and child health, and improve maternal and child health outcomes. This paper outlines the approach to develop the programme, and identifies key actions and timeframes to deliver the programme. This is about taking services to culture.

The paper tabled explained further including doing away with the number of service providers visiting homes and asked why do we need the Kaupapa Māori maternal health programme?

Whole of service receiving training. Do have a key focus on how we make our environment welcoming in a meaningful cultural way. Developing a community based programmes to make a difference.

Proposing to:
- Partnership approach with Maternity and Population Health
- Strategic direction from a Community-HBDHB Steering Group

Key points raised:
- This is a service wrap around approach.
- Great to do an evaluation on this as outcomes must be positive
- This presentation was an example of how presentations should come to MRB
- Asked why focusing just on Māori? We need to push Māori improvements, then everything changes because across the board there will be no losers as there will be cultural infusion.

The Recommendation to note the contents of the report and approve the development of a Kaupapa Māori Maternal Health Programme and proposed next steps was **carried.**

Action: It was noted the paper should be amended and the "Inequities" section of the report header completed, prior to being issued to the Board

Wellbeing Framework revisited:
- Charrissa Keenan was questioned about her views on Anton Blank's Wellbeing Framework. She advised this had been the first opportunity he had to take the draft to the sector and there had been a lot of discussion on the concepts and positioning within Te Ara Māori. Depending on where this sits would depend on applications. Anton will continue meeting and obtaining feedback and would surely be happy to come to this way.
- Fiona commented on administrative data and data sovereignty – it is risk focused and does not really measure things such as wellbeing. Data tells us what risk means, but not about vulnerability.
- This topic will remain on MRBs radar.

MRB noted the contents of the report and supported the development of a Kaupapa Māori Maternal Health Programme and proposed next steps.

13. NATIONAL BOWEL SCREENING ROLL-OUT PRESENTATION

Dr Malcolm Arnold provided an excellent presentation on the Bowel Screening Programme Roll-Out, with Lynda Mockett, Project Manager in attendance.

The presentation:

a. The Bowel Screening Pathway was explained and those eligible to participate in the programme would receive an invitation letter dependent on birthday (based on odd / even birth dates). Free test kits then sent out, with tests being completed at home and samples returned.

b. The results and next steps were explained. Once the samples had been tested, those needing to be contacted would be. Called up 2 years later.

c. The eligible population for this testing is those in the community between 60-74 years of age. This is not a two tier system, the same applies for all.

d. The numbers within the HB community being contacted in this rollout include:

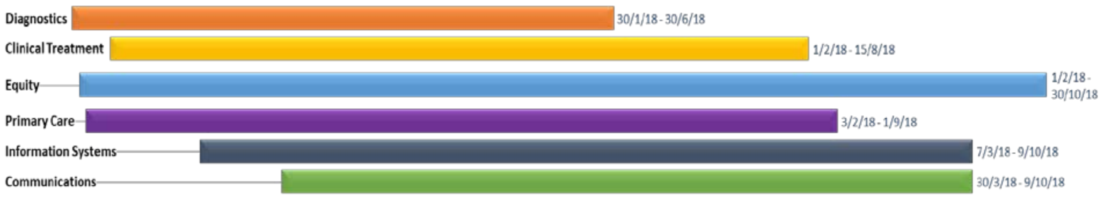
Other:	23,160
Māori:	3,550
Asian:	700
and Pacific:	430

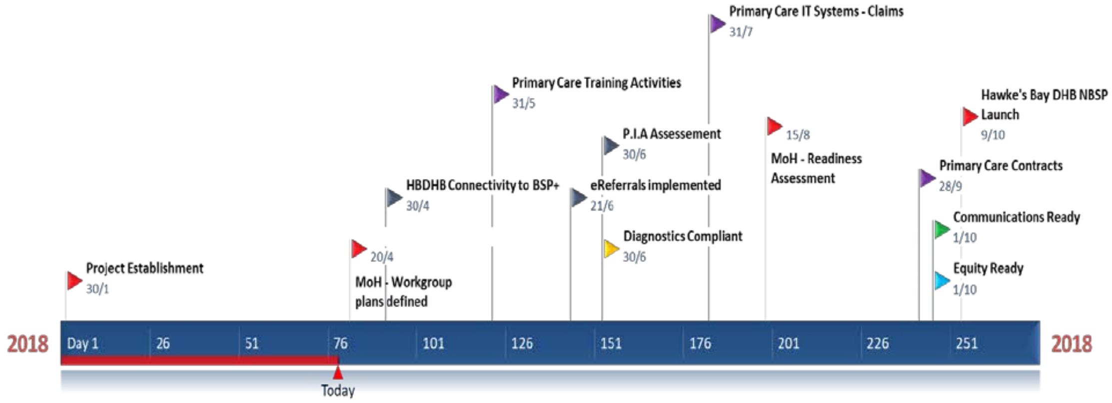
e. MoH's key deliverable dates for self-assessments is 27 July; readiness assessment 15 August; with go-live date being 9 October 2018

f. Working Groups within this project include: Primary Care led by Linda Dubbeldam; Information Services led by Kelly Emus; Clinical Treatment led by Mandy Robinson; Diagnostics led by Di Vicary; Equity led by Jenny Cawston; Communication led by Anna Kirk.

g. Risks and Assurances

h. HBDHB Delivery Plan – timelines:





Key points:

- This is a national rollout and must meet MoH criteria.
- Cannot cure the disease, Ideal to catch early and you do not know if you have a bowel issue until tested.
- Māori affected less than 35.6 per 100,000; others are 42 per 100,000.
- The national roll-out commences those from 60 to 74 years.
- Asked ideal age to pick test? In response, 50 years was noted as ideal
- Noted that the MoH have been lobbied to commence screening proactively from 50 years of age.
- Advised there are very few gastroenterologists in the country to do this work.
- Nurses were being training nationally to undertake screening.
- Tracking people's movements is of concern, as is tracking those with mental or other disabilities.
- Will there be transport grants as part of this package? If centrally controlled Māori lose out.
- Those with symptoms need to seek medical advice. Noted that those with GP debt is of concern.
- HB have learned from experiences at Hutt Valley DHB.
- Realise this is great for the community as it is all about saving lives.

Members discussed recommending to the HBDHB Board to make strong representation to the MoH to lower the starter age to 50 plus years for Māori. It was advised other DHBs nationally were lobbying for an earlier screening age.

RESOLUTION

That MRB recommend that the HBDHB Board

1. Strongly lobby the Ministry of Health to lower the starter age for bowel screening to 50 years and over.

Moved: **Na Raihania**
Seconded **Hine Flood**

FOR INFORMATION ONLY (NO PRESENTERS)

14. HBDHB PERFORMANCE FRAMEWORK EXCEPTIONS Q3 (Jan-Mar 2018)

The report was received but not discussed at the meeting.

15. TE ARA WHAKAWAIORA – IMPROVING ACCESS INDICATOR (Local Indicator)

Formerly referred to as "Did not Attend"

Action **The report had been amended and would be re-issued to members.**

16. BEST START HEALTHY EATING & ACTIVITY PLAN

The report was received but not discussed at the meeting.

17. THE PLACE OF ALCOHOL IN SCHOOLS – Young people and under-age exposure

It was noted the drug and alcohol policy is being reviewed by Population Health. The report was received but not discussed.

18. HEALTH SECTOR LEADERSHIP FORUM REPORT

The report was received but not discussed.

GENERAL BUSINESS

Topics outlined for discussion included:

STRATEGIC PRIORITIES – the way forward for MRB

CEO Kevin Snee joined the meeting.

This document entitled "**He Ngakau Aotea"** (having an open heart and mind) that had been provided to MRB members in draft form prior to the meeting, was considered and discuss following an introduction by George Mackey.

The key driver was the Nuka Model with the pilot being Wairoa. Need to ascertain the approach and have the right people around the table.

Following general discussion the CEO Kevin Snee spoke, advising this was a step in the right direction and will make a different to the health of Māori. The areas highlighted were in-line with the aspirations of the Board. If you take lessons from the NUKA model – yes it is an indigenous system and very validly based, driven by organisations and drives health improvement thinking. It is very focused on relationships and that between a patient and clinician. It is not just an indigenous system – we can all learn from Nuka. We are to make changes to primary care across HB. The model will be the same but will need to be "shaped" differently in Wairoa compared to Taradale as the needs of the people are different, therefore delivery will be different.

Chris Ash who was in attendance is working towards revolutionising Primary Care. We need to be very deliberate and shift resources into Primary care – which is hard. Hopeful the new Government will focus in this area. Have a great deal of respect for MRB wanting to push forward and commended them for this.

In 2019 there will be a progressive change in primary care which will draw heavily on lessons from NUKA as a lot of the elements are similar but other examples will also be drawn on.

Clearly, we are all saying the same thing which is not too dissimilar to that relayed at the Leadership Forum.

Key points in discussion included:

- Vulnerable children, turn it on its head and ask what does a healthy NKII child look like?
- Trying to say who we are and trying to say what we want. Discussion document would be helpful to ensure we are journeying together.
- What is our TOOL – what do we want to use when we pass our lens over. Do it implicitly – if we could articulate that – keeps us more at a governance level!
- Be mindful of the audience when writing the paper.
- Presentations: impressed with the way the Maternal paper was presented using Māori analogies.
- Apply measures to monitor expectations against the DHBs annual plan and hold accountable to the benchmarks set.

- To further discuss a Workshop will be planned for Tuesday 22nd May at 9am at the Mahiro Whare. The output from this discussion would be a paper for consideration at the June MRB Meeting and would be required for issue on 5 June.
- Is this position paper number one, with other papers to follow?
- Reiterated by Patrick that the focus will be on the 5-year strategy which will pave the way.

MRB agreed they had learnt from delving too deep into detail and not coming up for air. Having learned from this experience we now need move forward and be more focussed on strategic big picture areas.

Meetings / Actions and Timeframes

a) To finish off He Ngakau Aotea in timely manner, another Workshop will be arranged for 22nd May at 9am at the Mihiroa Whare.

b) Ensure the following are considered when fianlising the paper:

- **Ensure alignment with MRB Terms of Reference**
- **Ensure to align expectations against the Five Year Strategic Plan**
- **Apply measures to monitor expectations against DHB's Annual Plan**

c) Ensure He Ngakau Aotea is on the agenda for discussion at the MRB Meeting on 12 June 2018

d) Following this meeting, the paper needs to be finalised for issue by Friday 29 June 2018

e) Request time at the Clinical and Consumer Council meetings on 11 and 12 July to discuss – as a courtesy.

f) Schedule time at the HBDHBs Board Meeting on 25 July 2018.

It was noted the Trip to Alaska noted as an extra item by Hine Flood, had not been discussed.

There being no further general business, the meeting closed at 12.07pm

Signed: ______________________________

Chair

Date: ______________________________

6

MAORI RELATIONSHIP BOARD MEETING
MATTERS ARISING (Public)

Action #	Date Issue first Entered	Action to be Taken	By Whom	Month	Status
1	12 May 16	**Review form and function of MRB including a Youth Representative:** NKII and MRB to review MRBs composition giving consideration to a Youth Representative.	CEO NKII	Sept 2017	A reminder sent 28/5. Outstanding
2	7 Sept 17	**Nuka Model Wānanga:** Wānanga at a later date to put forward input into the Nuka Model process.	MRB members		Outstanding
3	9 Aug 17	**Te Ara Whakawaiora - Mental Health (National And Local Indicators):** Mental Health Services to develop proposal, including whānau and community groups, to have greater input into whole of sector approaches, i.e. the Intersectoral Forum.			A review of Alcohol and Other Drugs (AOD) is underway locally and nationally.
4	9 May 18	**Interest Register changes** Beverly TeHuia to advise changes Na Raihania's interests included.	 Beverly Admin		 Actioned Actioned
5	9 May 18	**Acting GM Maori Health Report** **a) te karere Maori Nursing Newsletter** Approach the CEO Kevin Snee and ask to issue the Newsletter in conjunction with his CEO's Newsletter, focusing on "Maori Workforce Development" **b) Fiona Cram's Wellbeing paper** to be issued to members for information.	 Patrick and Ngaira Fiona		 Update at meeting
6	9 May 18	**Maori Relationship Board attendance and representation on Hawke's Bay Clinical Council** a) Clinical Council to be advised that Ana Apatu will replace Kerri Nuku as observer until April 2019. b) In April 2019 the MRB observer on Clinical Council would be included on the MRB agenda and reviewed. c) The Chair, Heather Skipworth will contact both Kerri and Lynlee to ascertain their availability to attend MRB meetings in the next year and advise Kerri directly of Ana's appointment.	 Admin Admin Heather		 Clinical Council advised – remove action Added to workplan for April 2019 – remove action Actioned

Action #	Date Issue first Entered	Action to be Taken	By Whom	Month	Status
7	9 May 18	**Clinical Services Plan – Planning for Consultation:** Selling the concept of change and involving people in that change. Need to decide who is best to take this out to stakeholders in the best possible way to get true engagement. Suggestions to be provided to Patrick who in turn to advise Ken Foote	MRB members Patrick		Verbal update at meeting No feedback provided
8	9 May 18	**Maternal Wellbeing Model of Health:** noted the paper provided should be amended and the inequity section on the report header updated prior to being issued to the HBDHB Board.	Charissa		Actioned, amended version issued to May Board meeting.
9	9 May 18	**Recommendation to HBDHB Board** insist the DHB strongly lobby the MoH to lower the starter age for bowel screening to 50 years of age.	Admin		Actioned. Included in MRB's Report to Board 30 May
10	9 May 18	**Te Ara Whakawaiora – Improving Access Indicator:** The report had been amended and would be re-issued to members	Admin		Actioned and issued to members and the Board
11	9 May 18	**Strategic Priorities:** a) To finish off **He Ngakau Aotea** in timely manner, another Workshop will be arranged for 22nd May at 9am at the Mahiro Whare. b) Ensure the following are considered when finalising the paper: - Ensure alignment with MRB Terms of Reference - Ensure to align expectations against the Five Year Strategic Plan - Apply measures to monitor expectations against DHB's Annual Plan c) Ensure He Ngakau Aotea is on the agenda for discussion at the MRB Meeting on 12 June 2018 d) Following this meeting, the paper needs to be finalised for issue by Friday 29 June 2018 e) Request time at the Clinical and Consumer Council meetings on 11 and 12 July to discuss – as a courtesy. **f)** Schedule time at the HBDHBs Board Meeting on 25 July 2018.	Patrick LeGeyt MRB Members MRB Members Heather / Patrick Admin		Actioned Work in Progress " " " Actioned, included on Workplan " " "

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Maori Relationship Board Workplan as at 6 June 2018 - subject to change		**EMT Member**	**MRB Meeting Date**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**BOARD Meeting date**
Alcohol Positon Statement INTERNAL and Strategy *for EMT consideration* (board action August 2017) now July		Kevin Snee	11-Jul-18	11-Jul-18	12-Jul-18	25-Jul-18
Policy on Consumer Stories		Kate Coley / John Gommans	11-Jul-18	11-Jul-18	12-Jul-18	25-Jul-18
Te Ara Whakawaiora "Smokefree update" (6 monthly)		Kevin Snee	11-Jul-18	11-Jul-18	12-Jul-18	27-Jun-18
Annual Plan 2018/19 Draft (June) (DRAFT DUE TO MoH 16 JULY)		Chris Ash	11-Jul-18	11-Jul-18	11-Jul-18	25-Jul-18
Clinical Services Plan verbal update (May June **July**)		Ken Foote	11-Jul-18	11-Jul-18	12-Jul-18	25-Jul-18
He Ngakau Aotea - Strategic Priorities report preparation (MRB only)		Patrick LeGeyt	11-Jul-18			
Mobility Action Plan Update **Presentation**		Andy Phillips	11-Jul-18	11-Jul-18	12-Jul-18	
Te Ara Whakawaiora - Access 0-4 / 45-65 yrs (local indicator)		Kevin Snee	8-Aug-18	8-Aug-18	9-Aug-19	29-Aug-18
Matariki Regional Development Strategy and Social Inclusion Strategy update from Feb 2018		Kevin Snee	8-Aug-18	8-Aug-18	9-Aug-19	29-Aug-18
HBDHB Performance Framework Exceptions Q4 Feb/May/**Aug 18**		Kevin Snee	8-Aug-18			29-Aug-18
Establishing Health and Social Care Localities in HB (Mar 18,**Sept)** - update on activity planned Board action March18		Chris Ash	12-Sep-18	12-Sep-18	12-Sep-18	26-Sep-18
Heatlh Equity Report		Sharon Mason	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Te Ara Whakawaiora - Breastfeeding (National Indicator)		Kevin Snee	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Annual Plan 2018/19 - approved Minister timing open		Chris Ash	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Te Ara Whakawaiora - Alcohol and other Drugs (National and Local Indicators)		Kevin Snee	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
Te Ara Whakawaiora - Cardiovascular (National Indicator)		Kevin Snee	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
Te Ara Whakawaiora - Did not Attend (local Indicator)		Kevin Snee	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
Te Ara Whakawaiora "Smokefree update" (6 monthly May-**Nov**) each year Board action Nov 17		Kevin Snee	14-Nov-18	14-Nov-18	15-Nov-18	28-Nov-18
HBDHB Performance Framework Exceptions Q1 **Nov 18** Feb 19 /May/Aug 19 Just in time includes Maori and Pasifika		Kevin Snee	14-Nov-18			28-Nov-18
People Plan (6 monthly - **Dec**, Jun)		Kate Coley	5-Dec-18	5-Dec-18	6-Dec-18	19-Dec-18

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HAWKE'S BAY
District Health Board
Whakawāteatia

MĀORI RELATIONSHIP BOARD
CHAIR'S REPORT

HAWKE'S BAY District Health Board Whakawāteatia	**Monthly Māori Health Report**
	For the attention of: **Māori Relationship Board**
Document Owner:	Patrick LeGeyt, Acting General Manager (GM) Māori Health
Month:	June 2018
Consideration:	For Information

RECOMMENDATION

That the Māori relationship Board:

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

NEW POUAHUREA AND SENIOR ADVISOR CULTURAL COMPETENCY

In May 2018, HBDHB welcomed Tiwana Aranui (Ngāti Pahauwera) and Hawira Hape (Ngai Te Rangikoianake) as the new Pouahurea (kaumatua) and John Barry Heperi-Smith (Ngai Te Kikiri o Te Rangi) as the new Senior Advisor Cultural Competency.

INTERNATIONAL NURSES DAY AND HBDHB AWARDS

International Nurses day celebrated the collective work and contribution of the nursing workforce. It was also an opportunity to recognise two HBDHB nurses for their contribution to nursing or midwifery. This year's winners were Tungāne Kani (The Tūruki Award for Services to Māori Nursing or Midwifery), and Donna O'Sullivan (Services to Nursing or Midwifery). Both of these health professionals are leaders in their respective fields, and are particularly acknowledged for the way they incorporate tikanga Māori within their practice.

(Pictured: Tungāne Kani, Amanda Martin, Janine Palmer, Kate Davis, Kirsten Bailey, Jennifer Quinn, Donna O'Sullivan, and Anna Walter. Absent: Heather Cormack).

CLINICAL SERVICES PLAN – UNDERSERVED POPULATIONS WORKSHOP

On 2 May 2018, a workshop was held at Te Taiwhenua o Heretaunga to bring key stakeholders together and produce a list of actions for the future design and delivery of clinical services for whānau with unmet health and social needs in the Hawkes Bay district. This workshop was one of four workshops supporting the development of the Clinical Services Plan, including Aging/frail Population, Primary Care, and the Future Hospital.

The Underserved Populations workshop objectives were to:

- Build consensus of the current state issues, including what whānau have already told us
- Agree actions to get develop services that meet whānau needs
- Build consensus of the enablers and barriers to progress

The workshop participants were broken up into 6 groups and each group were asked to consider and report back on the following:

1. What have whānau told us about current services?
2. What have whānau told us about what they want future services to look like?
3. What are the key actions and enablers to get to the future state?

A prioritisation process was subsequently implemented where each participant was given two selections on their top priorities. The following three actions were selected by workshop participants as the top priorities:

1. Services should be prioritised and designed specifically to meet those populations who currently experience the poorest health and social status, i.e. the most disadvantaged poor young families
2. Up-skilling of clinicians/health professionals, with particular regard to relationship centred practice, cultural competence, mental health and addictions, wellness focus, and family violence.
3. Multidisciplinary approaches in primary care which more holistically consider and address health and social needs and aspirations for families.

The outputs from this workshop will feed into the combined Integrative Workshop May 2018

WHANAKE TE KURA

On 18 May 2018, Te Taiwhenua o Heretaunga launched Whanake te Kura, the new HBDHB funded pregnancy and parenting education programme (previously known as ante-natal classes). The programme is currently running in Hastings and Napier, with classes planned for Central Hawkes Bay and Wairoa. There has been some resistance from the maternity and wider community sectors toward the new programme as a shift in focus on prioritising Māori, Pacific, families from high deprivation backgrounds, young mothers, and second language speakers has occured. Te Taiwhenua o Heretaunga, with support from HBDHB, will continue to strengthen relationships with the maternity and primary care sectors to ensure whānau/families are informed and can access the programme.

KAUPAPA MĀORI MATERNAL

In May 2018, the committees supported the development of a kaupapa Māori Maternal Health Programme. A Steering Group has been established, and a meeting held. Current activities underway include: the development of an intervention logic based on HBDHB core values, a scan of current programmes and services available to hapū women and their whānau, a brief review of relevant reports and literature that focus on indigenous and Māori pregnant women and mothers, and based on the above activities, a developmental design of what a kaupapa Māori maternal health programme might look like. The Steering Group is scheduled to meet every 6 weeks.

HAUORA TAMARIKI INITIATIVES

Māori Health have developed a package of health initiatives to provide added support to tamariki Māori via Well Child Tamariki Ora Services. These health initiatives include: a community based Māori lactation service, oranga niho education and facilitating access to dental care, and a new respiratory support service. Well Child Tamariki Ora Services are well positioned to deliver such support because of their relationships with whānau/families, and strong linkages across the health and education sectors. Underlying this package of health initiatives is HBDHB's commitment to reduce inequities in hospital admissions for tamariki Māori aged under 5 years and to improve child health outcomes for these tamariki.

MĀORI WORKFORCE ACTION PLAN

Initial development of a Māori workforce strategy has been approved by DHB Clinical Council, Consumer Council, Māori Relationship Board and DHB Board. The strategy will be aligned with the Turuki workforce development activities to support operationalizing identified areas for growth and development.

NGĀTAHI PROJECT

Planning for the Ngātahi Forum is underway. Workshops progressing within each area and development of the workshops to be approved at upcoming steering group meeting (June). Workshops will include:
Poutama 1: Foundational Knowledge - Mauri Ora cultural competency engagement
Poutama 2: Ngātahi Competency and application of knowledge
Poutama 3: Leaders of Practice

PRESENTATIONS OF NZNO

On the 3rd May the NZNO Ahuriri regional conference took place. The focus of the day was 'How to protect minority interests in a majority rule democratic society'. The conference provided an opportunity to network and whanaungatanga with NZNO members in Hawkes Bay. Work conditions and current focus on salary equity were key discussions at the forum. Key presenters and topics included:

- Kerri Nuku: providing strong leadership within the NZNO and future nursing developments, roles and responsibilities
- Shannon Bradshaw (Midwife consultant Maori, HBDHB): discussed her role and future projects to improve Māori midwife numbers.

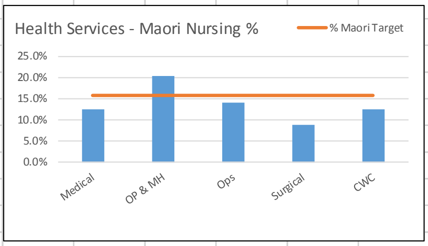
HBDHB NURSING STRATEGY

The Hawkes Bay DHB Nursing and Midwifery strategy requires an update. A new 5 year plan will be developed and will align with the new strategic plan for the HBDHB workforce and diversity strategy currently in development. Ngaira Harker, Director of Nursing Māori will lead this update and will:

- Engage with nursing groups within the rohe to review and discuss the vision and needs;
- Form focus groups with Directors of Nursing / Clinical Nurse Managers and Nursing groups to identify view in line with developments;
- Prepare timeframe for completion; and
- Liaise with wider groups to support alignment with other strategies currently in progress

Current Statistics
April 2018
Nursing workforce Statistics April 2018.
Note % Māori Nursing slightly down from March 12.9%

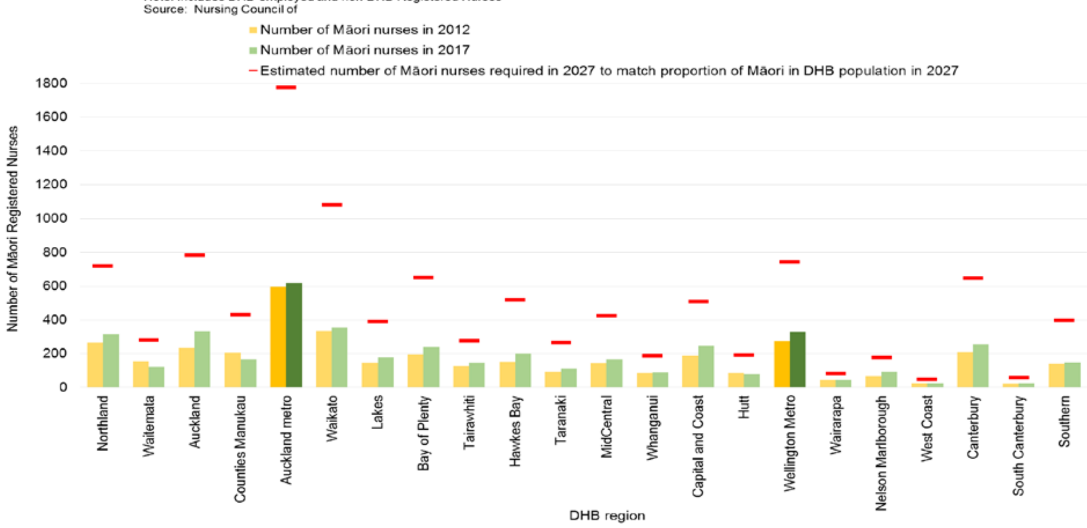
Nursing	Maori	Total	% Maori	% Maori Target	Gap
Health Services - Maori Nursing %					
Medical Directorate	57	453	12.6%	15.68%	14
Facilities	0	0	0.0%	15.68%	0
Old Person, MH, AH & Options	31	153	20.3%	15.68%	-7
Operations Directorate	42	296	14.2%	15.68%	4
Surgical Directorate	29	326	8.9%	15.68%	22
Communities, Women & Children	47	372	12.6%	15.68%	11
Health Services - Maori Nursing % Total	**206**	**1600**	**12.9%**	**15.68%**	**44**



May 2018
Nursing workforce Statistics May 2018.
Note % Māori Nursing slightly down from March 12.9%
Nil results as yet to be published June 1.

National Māori Nursing workforce projection

Figure 2: Number of Māori Registered Nurses by DHB region in 2012 and 2017 and number of Māori required in nursing workforce to match proportion of Māori in DHBs in 2027
Note: Includes DHB-employed and non-DHB Registered Nurses
Source: Nursing Council of



TŪRUKI MAORI WORKFORCE DEVELOPMENT

The Tūruki funding round is complete. This round saw 37 of 38 applicants receive funding. The successful applicants are completing training at Otago, Massey, Waikato, and Victoria Universities.

On May 22 the upgraded Tūruki webpage went Live! Registrations for the HWFNZ funding round opened on May 21st and close June 20th. Eleven applicants have successfully registered for funding.

TŪ KAHA CONFERENCE

Registrations for the 2018 Tū Kaha conference July 11- July 13 are now open. Tū Kaha is the Central Region (District Health Boards') Māori health conference that fosters collaboration, innovation and overall excellence in Māori health. Tūruki have recruited six rangatahi to attend Pecha Kucha – Health Professionals talking with Rangatahi workshop.

TAW CHAMPION PAPER - DNA

The Māori Health Service collaborated with the Hospital Provider Services team in the preparation and presentation of the Te Ara Whakawaiora paper on " Improving FSA Access Local indicator" to the Executive Management Team and governance committees.

DNA FSA SUPPORT

The Monthly FSA DNA (ESPI Specialities) rate was **10.3%**.
The following is a breakdown of DNA support provided for the month:

Pre-emptive Calls – **232**
Confirmed Appointments – **141**
Re-scheduled Appointments – **12**
Home Visits – **40**
Messages Left – **65**
Not Contacted – **22**

SAFE SLEEP PROGRAMME

HBDHB continues to fund a Safe Sleep Programme. Key activities of the programme are:
- Purchase and distribution of wahakura/pēpi pods
- Promote safe sleep messages
- Train the workforce in the delivery of safe sleep messages.

For the month of May:

- 21 wahakura were distributed
- 3 training sessions were delivered
- 0 pēpi-pods were distributed.

Most recent data shows that from 1 July 2017 to 31 March 2018, 257 pēpi pods, and 176 wahakura were distributed. Whānau Māori made up 70% of referrals to the programme in Quarter 3, with 54.83% of māmā who gave birth in Quarter 3 receiving a pēpi-pod or wahakura.

ENGAGING EFFECTIVELY WITH MĀORI

Engaging Effectively with Māori has undergone a revitalisation through the core value lenses - Recognising the philosophical relevance of the HBDHB Core Values to their respective roles and apply this knowledge in everyday clinical and non-clinical settings;

Ākina / Continuous Improvement:
- Best practice aligned with Māori concepts of wellbeing.
- Reflect own practice and behaviour, identify strengths and weakness to help plan areas for self-development.

Raranga te tira / Partnership:
- Whanaungatanga – to build and maintain meaningful relationships, relationships of trust, respect and honesty as well as accessible, ongoing communication and information.

Tauwhiro / Care: - High quality care:
- Strengthen staffs understanding of the Māori worldview that supports the development of an ethic of care for Māori, for all consumers.
- Promote and create whānau friendly user's environment within the organisation.

He Kauanuanu: - Respect:

- Demonstrate respect for each other and respecting, acknowledging, supporting and recognising notions of difference as well as our diversity including that of staff, patients, whānau and ourselves.

Learning Outcomes:

By the end of this workshop, HBDHB workforce participants will:

- Strengthen staffs understanding of the Māori worldview that supports the development of an ethic of care for Māori
- Know a little more about local history and the local landscape here in Ngāti Kahungunu, Hawkes Bay;
- Recognise the philosophical relevance of the HBDHB Core Values to their respective roles and apply this knowledge in everyday clinical and non-clinical settings;
- Have more capacity to engage in culturally responsive practice and be prepared to apply cultural competencies within their respective workplace areas.

NATIONAL BOWEL SCREENING PROGRAMME

Māori have a lower incidence of colorectal cancer, higher background mortality and are likely to have lower screening coverage compared to non-Māori. This would almost certainly result in an increased disparity in cancer outcomes. The national bowel screening programme would improve total population health and result in health gains for both Māori and non-Māori cancer health gains which are likely to be larger. The net effect is that the disparity between Māori and non-Māori cancer health outcomes would increase. Māori are often diagnosed with bowel cancer at a more advanced stage than non-Māori, and treatment options are more frequently complicated by a greater co-morbidity burden. Māori, therefore, have more potential to benefit from prevention, earlier detection, more simple treatment options, and better survival outcomes for early stage disease that result from a screening programme.

The eligible population currently stands at 27,480 people (60 – 74 years) for the bowel screening programme in Hawkes Bay DHB. 13% of this eligible bowel screening population are Māori 2% Pacific, 3% Asian and 83% other. Over half (52%) of the current eligible population are female. The eligible population is expected to increase on average 2% per annum over the next 10 years from 27,840 in 2017/18 to 33,020 by 2027/28. However the Māori eligible population is projected to increase by an average of 4% per year over the next 10 years from 3,550 in 2017/18 to 5,060 by 2027/28. The Pacific eligible population is projected to increase by nearly 5% per year over the same period from 430 people in 2017/18 to 680 by 2027/28;

Ethnic group	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Asian	700	750	820	890	940	1,000	1,040	1,140	1,200	1,260	1,320
Maori	3,550	3,700	3,890	4,060	4,240	4,400	4,570	4,720	4,860	4,960	5,060
Other	23,160	23,780	24,320	24,850	25,220	25,460	25,700	25,840	25,880	25,900	25,960
Pacific	430	440	470	480	520	550	570	590	610	650	680
Total	**27840**	**28,670**	**29,500**	**30,280**	**30,920**	**31,410**	**31,880**	**32,290**	**32,550**	**32,770**	**33,020**

Just over 27% of the eligible population live in areas classified as socio-economically deprived. Hawke's Bay DHB Māori and Pacific population is particularly impacted by socioeconomic disadvantage with 56.8 % of Māori and 73.6 % of Pacific peoples living in areas classified as high deprivation areas (NZdep2013 Quintile 5-CAU weighted).

To initiate development of the Equity Plan, the Health Equity Assessment Tool was employed. The assessment identified the existence of common inequalities for Māori and Pacific populations in terms of access to treatment and primary care. Households were transient, and while whānau connection was important, there was a disconnect from cultural identity and language. In addition, geographic inequalities exist for Wairoa and Central Hawke's Bay populations with regard to accessing clinical services sited in Hastings. It is noted that attitudes amongst rural populations, specifically males, may hinder participation in screening.
Realising this, the Māori Health Improvement team is a key participant in driving equity. Targeted approaches will be utilised to reach Māori as priority populations through awareness raising and improving health literacy, with special emphasis on vulnerable and transient populations and those not enrolled in the PHO. Māori specimens that report a positive result will have access to transport and support to attend colonoscopy and treatment appointments if required. Our approach is designed to;

- Intensify our engagement with Māori providers in the community to work in a more collaborative way to engage in common with patients and whānau.

- Develop a training/education regime with HBDHB bookers to better engage and communicate with Māori and their whānau
- Establish and strengthen our relationships with Māori Health Services kaitakawaenga to better engage directly with Māori whānau.
- Make referrals directly with Māori Health Services DNA Kaitakawaenga making contact with Māori whanau when appointments are due.
- Strengthen Article 3 of Te Tiriti o Waitangi to support and embed the HBDHB's obligations when working with whānau.
- Adhere to the 'Engaging Effectively with Māori undertaken by Māori Health Services.
- Further down the track, engage with PSGEs (Post Settlement Governance Entities) to communicate our intentions with respective registered members.
- Improve understanding of literacy brochures and relevant information using imagery and kupu Māori to increase engagement with whānau.
- Visit whānau in their homes at a time suitable and prior to appointments.
- Formulate an engagement style (social contract) directly with whānau to encourage them to take control of their daily lives.

To understand this approach, we acknowledge that disparities for Māori compared to non-Māori are not natural, nor are they an inevitable consequence of society. They result from decisions made by society on potentially life changing issues such as health care funding, welfare, business regulation and tax policy. They also have a negative effect on the population as a whole. It is important to reduce inequalities for several reasons;

- Firstly, the disparities are unjust, unfair and improper or even to a great extent, morally inappropriate.
- Secondly, reducing health inequalities benefits all members of the population as it empowers those who are disadvantaged to participate more actively in society. Excluding or stigmatising people is both inefficient and unsafe.
- Third, it is of great importance to realise that the effects of health inequalities are comparable in importance to realise that the effects of health inequalities are comparable in importance to the health of society as are the risks we undertake in our daily lives.

Māori Health Improvement team representatives have been invited to an 'Equity Hui' being held in Palmerston North Convention Centre on June 13, 2018. Our participation will involve the regions six HDB's (DHB, PHO or NGO) and other stakeholders from the National Bowel Screening Programme, including the Ministry of Health and the National Bowel Screening Māori and Pacific Network. Key objectives of the Hui includes;

1) The provision of an overview of the National Bowel Screening Programme and to view the bowel screening pathway through an equity lens.
2) To discuss possible barriers which may limit the engagement of priority populations through the pathway.
3) To gain an insight and feedback for possible solutions, strategies and health models to address equity, and
4) To establish a Regional Equity Network to support the development of regional and DHB Equity Plans.

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HB CLINICAL COUNCIL

Verbal Update

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Youth Strategy Implementation update inclusive of Zero Fees 13-17**
	For the attention of: **Māori Relationship Board, HB Clinical Council & HB Health Consumer Council and HBDHB Board**
Document Owner	Chris Ash – Executive Director Primary Care
Document Author(s)	Jill Garrett, Strategic Services Manager – Primary Care; and Marie Beattie, Portfolio Manager Integration
Reviewed by	Emma Foster- GM Totara Health/Directions; Julia Ebbett- GM Te Taiwhenua O Heretaunga; Stacey Tito – Directions Youth Social Worker; Ruth Fa'afuata – Rangatahi Youth Services TToH and Executive Management Team
Month/Year	June 2018
Purpose	Information update Progress against outcomes report
Previous Consideration Discussions	Regular update for monitoring
Summary	This paper outlines: • Background to the strategy and commencement overview • Progress to goals • Stakeholder engagement • Highlights and Challenges - Implementing the strategy - Zero fees 13-17yrs update • Recommendations and next steps
Contribution to Goals and Strategic Implications	HBDHB Youth Strategy Goals
Impact on Reducing Inequities/Disparities	Addressing high need youth health through a mechanism of positive youth development
Consumer Engagement	Directions Youth Health Services Youth Consumer Council Zero Fees 13-17 clusters Public health and school based health services (SBHS)

RECOMMENDATION

That MRB, Clinical and Consumer Council:

1. Note the contents of this report

11

HAWKE'S BAY District Health Board Whakawāteatia

Update on implementation of the HBDHB Youth Health Strategy

Author(s):	Marie Beattie
Reviewers:	Jill Garrett – Strategic Services Manager – Primary Care
Designations:	Portfolio Manager - Integration
Date:	May 2018

RECOMMENDATION

That the Executive Management Team, Māori Relationship Board, Clinical Council and Consumer Council

- **For information and consideration**

1.0 **Background information:**

In line with The World Health Organisation's Global Strategy[1], the Hawke's Bay District Health Board (HBDHB) have made a commitment to ensure there is opportunity for the children and youth of their region to thrive. This support to the region's children and youth will realise enormous social, demographic and economic benefits. Working on a strengths based model for positive development the view looks beyond crisis management and problem reduction. It incorporates strategies that increase young people's connection to positive supportive relationships and challenging meaningful experiences[2]

2.0 Progress to Goals (Refer Appendix one below for detailed 2018-19 action plan)

Goal 1: Youth Report Healthy and Safe

HEADSS assessments continue to be completed for all Year 9 students in Decile 1-3 high schools. Youth friendly audits for general practice teams has been completed as part of the Zero fees for 13- 17 year olds. This program is now in operation in 13:14 practices offered. It is an assessment tool used across multi agencies that needs to be supported in its use across a range of health services to effectuate appropriate referrals and support.

Goal 2: Youth Report they Feel Connected

An updated youth services directory is to be created and made available via social media which is an appropriate medium for youth in regard to independent access. It currently includes community and health services and will be expanded based on information gathered from the youth council. More work is underway relating to this goal (see Appendix One for details) Providers report a greater level of connectedness with the strengthening of the management

[1] United Nations Secretary General. Global Strategy for Women's, Children's and Adolescents Health 2016 - 2030
[2] Dr Karen Pittman. The Forum for Youth Investment, Ready by 21

of Directions. Confidence in the multidisciplinary team that operates from this provider is growing. Its strength is in providing service support to the population of Hastings. Areas for development is extending this to the population of Napier.

Goal 3: Productive:
Local councils operate youth projects aimed at preparing youth for a life of productivity and academic success. Rangatahi services support connecting youth to programmes that ensure they have Levels 1-2-3 NCEA in readiness for the workplace and or training. HBDHB contributes to this by operating the incubator programme and participation in the annual careers expo designed to give youth a taste of the varying careers available in health.

Goal 4: Health System Resiliency:
Supporting transgender issues is at the fore in regard to the ‘sense of belonging that youth feel when engaging and connecting with services. Work in this area will continue to be a focus in 2018-19 as we prepare the workforce to be more ably suited to work with rangatahi and specifically LGBTI. The Use of HEADSS across all of sector agencies is a means of supporting positive youth relationships. Work is underway to ensure the health workforce take up the training being provided locally.

Goal 5: Community Inclusiveness
Investing in youth to participate in decisions that affect them is a powerful motivator for change. Establishing a governance group by youth for youth meant that rangatahi have influence on planning that impacts on their peers. The work of the youth consumer council is ongoing and connecting this council with youth governance groups within Hawke’s Bay is part of the mahi of this strategy.

3.0 Stakeholder engagement

3.1 The Youth Strategy and Zero fees for 13-17yrs has built a strong consumer and stakeholder network that are consulted to inform planning and reporting. The list of stakeholder involvement includes; Youth Consumer Council, Local body Youth Councils (representative of our Local Territorial Authorities), Directions Youth Health Centre, HBDHB School Based Health Services and the PHNs within that service, General Practice Teams, Prima Volta Charitable Trust, PHO, YCON, and YMCA/YWCA.

4.0 Highlights (and challenges)

4.1 The Youth Consumer Council has been sustained over a period of 2 yrs since its establishment. Representatives from the council are frequently requested for their input in many forum both in health and across sector. Links between the HBDHB consumer council and local body councils.

4.2 SBHS enhanced (nurse hours) has seen positive results. There was some disquiet with the reduction of GP hours within schools, however this coincided with the introduction of the zero fees for 13-17yrs and funding made available for access to a GP for any presenting student to have access to GP services.

4.3 Increased utilisation of the Directions Youth Health service has been observed and this trend is encouraging. This increase is thought to be attributable to the relocation of the service closer to the city centre. Growing the multidisciplinary team within this service is positive as we move to creating opportunities for rangatahi to access services through normalising health seeking behaviours

4.4 Zero fees for 13- 17 year olds at general practices has now been fully implemented in 13 of the 14 eligible practices. This initiative provides free consultation with members of the general practice team. An additional benefit of the initiative is that it provides early opportunity to engage and foster therapeutic relationships with the young people and members of the practice team. (Appendix Two) Consultation rates have met the projected forecast of 2.15 visits per annum, however there are still youth registered with a general practice who have no contact with this service. Work is underway to determine if they have been able to access services elsewhere (Directions, SBHS etc) or have utilised ED as a primary care provider.

4.5 The zero fees funding was provided to the practice team in order to enhance the utilisation of the full general practice team, not solely GPs. This has been a positive step in models of care change that see multidisciplinary teams included in general practice; e.g. social worker, counsellors, health care assistants, navigator's et.al.

Challenges

4.6 There is currently a review being carried out at Ministry of Health level of all Mental Health Services (nationally). Hawke's Bay is hosting the ministry panel of enquiry in the week 4-8 June. The findings from this review will highlight the areas of strength and development for Hawke's Bay. Preliminary local findings is that mental health is an area that needs strengthening.

4.7 There still exists low consultation rates for 13-17yr olds within general practice; 56% have 0-1 consults per annum when registered with a practice. Investigation into this is underway (see para 4.4 above)

4.8 Sexual Health Services in Hawkes Bay continue to see an equity gap in our rangatahi accessing this service particularly our tane. Further implementation of the Youth Health Strategy and development of a regional Sexual Health Strategy will set a clear direction for this service in the future.

5.0 Recommendations and next steps

5.1 Monitor access of young people 13-17 years to their general practice teams and the Emergency Department and respond to trends and/or equity gaps.

5.2 Provide comparative general practice consult and utilisation data between practices in the program and those outside of the program to fully demonstrate its impact on rangatahi health seeking behaviours.

5.3 Promote the zero fees for 13-17 year olds widely and at touch points where these young people are known to come together or access ie secondary schools, career expos, Kapa Haka competitions and on social media via the youth consumer council Facebook page.

5.4 Strengthen the cluster plans in the zero fees 13-17 to ensure collaboration and coordination of services and referral pathways for rangatahi are in effective in meeting their needs.

5.5 Supporting primary care to include 'behaviourist type roles' as part of model of care development.

5.6 Implement the transgender pathway for young people in Hawke's Bay who are seeking support with gender issues.

Appendix One – HBDHB Youth Health Strategy
2018-19 Action Plan

Goals	Outcome relates to	Objective	Activities	Who …
Goal 1: **Youth report that they are healthy & safe**	Social connectedness	System wide use of HEADDS assessment across primary care services to support an appropriate referral process if required. Proactively address absenteeism / behaviour issues due to health or social issues.	HEADDS -90% coverage rate in SBHS environment. Appropriate follow up completed with consent and actioned this includes connecting to whanau for relevant support. HEADDS assessment training is being offered locally by the SYPHANZ group. It is open to anyone who works with young people. Facilitate up skilling of ED staff in their interactions, assessment and treatment of youth.	PHNs GP clinical teams. Youth Workers DYS ED Staff
	Emotional wellbeing	Maintain the services currently provided by Directions. Ensure workforce development around mental health is ongoing for youth workers. Use utilisation data to inform the mental health inquiry currently in play	Nurses from participating 13-17year old free fees practices have participated in a mental health credentialing process. Youth are accessing this service in the general practice they are enrolled in. SBHS nurses are regularly being up skilled and credentialed in the area of mental health. There are currently 12 nurses completing this process. Wellington Youth Workers Collective have delivered in HB a free workshop on gender diverse youth. School nurses are screening young people's mental health status in the school environment. Brief interventions occur or referrals to the school counsellors or one of the providers of mental health services locally are actioned. Additional new Ministry of Health funding will see the SBHS service provision grow across more secondary schools.	DYS MoE Practice Nurses SBHS Peers CAFS SWIS Te Kupenga O Ahuriri. NEETS

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	Avoidance of risky behaviours	Minimise the possibility of youth engaging in behaviours that put their wellbeing at risk.	YMCA are working with Oranga Tamariki to transition young people back to school who have disengaged. Promote the free health and social services of the SBHS, Directions and 13-17 year olds general practice access. 13-17 year old free GP access has been promoted through social media and increased utilisation of the general practice teams has been observed. Plans are in progress to advertise SBHS and Directions services via the same mechanism.	YCC General Practice SBHS DYS YMCA
Goals	**Outcome relates to**	**Objective**	**Activities**	**Who …**
Goal 2: **Youth report they feel connected**	Community Connectedness	An up to date directory of youth services is available via various mediums and widely distributed so that youth are aware of services available.	An audit has been undertaken of the current youth services directory as a result local councils, MSD MoE, HBDHB and youth are working together to update and maintain this resource. The resource will be available at the touch points where there are youth connections. Additionally, the resource will be available and advertised online. Whanau Tahi is an electronic universal mechanism by which young people can be referred to a variety of services within the sector.	HBRC HDC NDC MSD MoE HBDHB YCC

Goals	Outcome relates to	Objective	Activities	Who …
Goal 2 (cont.)	Positive Relationships	Youth experience positive relationships	Directions youth services currently provide informal peer support as well as a place to "be" for the young people of the region. Young people can engage in a variety of physical activities and sharing of food. Resilience building workshops for youth have been occurring in decile 1-3 secondary schools these have been well received and there has been very positive feedback from participants and the schools. Suicide prevention workshops have been held by Te Tai Timu these have been well attended. YMCA holiday programme targets older participants to mentor younger ones and in doing so creates an opportunity for youth be role models.	DYS PHO Te Tai Timu YMCA
	Leadership Development	Youth are provided with an opportunity to be leaders	Establishment of a formal peer mentor group within Directions is underway. Within this group there will be youth who will assume leadership roles within the group. The YMCA encourages the older group attending their school holiday programmes to assume leadership roles and run parts of the programme.	DYS HBDHB YMCA

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Goals	Outcome relates to	Objective	Activities	Who …
Goal 3: **Productive**	Workforce Readiness	Young people are assisted to develop the skills and attitudes they need to take a positive part in society, now and in the future.	HDC currently run a programme called "Youth Connector" Working with service providers or youth to assist with training, interviewing skills and preparations of CVs in readiness for the workforce. Each repetition of this cycle sees approx. 12 young people through the programme. NEETS (Not in employment education or training) support youth to complete academic national standards then transition to the workforce.	HDC Te Taiwhenua O Heretaunga YCON
	Career Awareness	Youth are aware of career opportunities and have a thorough knowledge of what is required to pursue their chosen career pathway.	Every year the careers expo is held in conjunction with EIT and MoE in Hawkes Bay. Youth from secondary schools and alternative education institutions arrange for youth to attend this.	HB Secondary Schools NZ Army NZ Navy HBDHB EIT Massey University

Goals	Outcome relates to	Objective	Activities	Who …
Goal 4: **Health System Resiliency**	Commitment to Adolescents and Youth Development	There are well established programmes within the community where the focus is early intervention/prevention to divert young people away from criminal activity.	Collaboration and consultation around youth development and programmes have occurred with both the Hastings District and Napier City council this quarter. Efforts to create protective environments in a wider context has seen the HBDHB recently endorse a report outlining the evidence showing that underage exposure to alcohol causes harm. A particular focus is on events held on school grounds where children are present. As a result of this endorsement, schools in HB will be encouraged to develop a school alcohol policy. A public statement and alcohol-free fundraising guide is being developed.	HBDHB NCC HCC MoE
	Partnerships and Collaborations for Youth Health Development	All sectors of the community will co-design youth development with the young people at the forefront.	Refer to Leadership development in Goal 2	
	Data Collection collation and analysis	To use health system data to inform program decisions that have a positive impact on youth. Use utilisation data to inform the mental health inquiry currently in play	Utilisation of the zero fees for 13-17yr olds has shown an increase in access to the general practice teams. Equity for Maori and Pacific remains a challenge. Work to address this includes promoting the service in secondary schools, emergency departments, urgent care facilities and	General Practice HBDHB

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Goals	Outcome relates to	Objective	Activities	Who …
Goal 5: **Community Inclusiveness**	Youth as community change agents	Youth are involved with local iwi to work with young people.	The youth consumer council have submitted a proposal to the Hastings District Council for funding to work with local iwi and youth around exam readiness and life skills that include budgeting, food preparation and culinary skills.	YCC TTOH HDC
	Youth Involved in Governance	Youth have the mandate to lead and support themselves as a group to achieve what youth need/want.	A youth governance group is currently being established to support the Mahi of Directions youth services. Two high profile community members and a counsellor from William Colenso secondary school have volunteered to guide the group to ensure good governance and a commitment to youth during this process.	Directions HBDHB Ben Evans Ken Foote
	Youth involved in Organisational Decision Making	Youth are provided with the forum to have their voice heard around proposed health service delivery.	Representatives from the Youth consumer council have contributed to the CSP at every community consultation evening.	HBDHB Directions

Abbreviations

DYS	Directions Youth Services	NCC	Napier City Council
GP	General Practice	NEETS	Not in Education Employment or Training.
HBDHB	Hawkes Bay District Health Board	PHN	Public Health Nurses
HBRC	Hawkes Bay Regional Council	PHO	Primary Health Organisation
HCC	Hastings City Council	SBHS	School Based Health Service
MoE	Ministry of Education	SWIS	Social Worker in Schools
MoH	Ministry of Health	YCC	Youth Consumer Council
MSD	Ministry of Social Development	YCON	Youth Council of Napier

HAWKE'S BAY District Health Board Whakawāteatia

Update on Implementation of the HBDHB Zero fees 13-17yrs

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Author(s):	Jill Garrett
Designations:	Strategic Services Manager – Primary Care
Date:	June 2018

RECOMMENDATION

That Māori Relationship Board, Clinical Council and Consumer Council

- Note the contents of this report

Definitions:

Consultation rate	Consultation rates show the number of times on average that consumers within this age bracket will access the primary health care team where they are enrolled[3]. The programme is funded on an average consult rate of 2.15 per annum
Utilisation rates	Utilisation rates illustrate what percentage of the enrolled population access services where they are enrolled.

1.0 BACKGROUND INFORMATION

1.1 **The aim of the zero fees for 13 -17 is to provide free access to our high needs youth population and in so doing promote confidence in the use of the health care system to support proactive health seeking behaviours.**

1.2 In 2016 proposals were presented to HBDHB committees for the funding of zero fees for 13-17year olds by the HBDHB. It was agreed that coverage of 67% of our Maori and Pasifika populations could be provided for through the funding that was made available ($563,000). Practice eligibility was determined by registered population within this age band of ≥30% or ≥100. This resulted in fourteen practices being eligible for the program.

1.3 Approval by the board was granted in November 2016, Preparation for programme implementation started in January 2017. Rolling start dates began from 1 July, with a number of practices already offering zero fees for this cohort of enrolled patients. (See table 1.0 below). Tukituki Medical was the 14th practice offered the programme but to date they have declined.

1.4 Prerequisites to being eligible for the programme is completion of the RNZGP Primary Care Youth Friendly Audit. Quarterly reporting is a prerequisite of the programme and consists of;

a. Progress against actions identified from the RNZGP Youth Friendly audit[4]
b. ED presentations and admissions: Skin, Respiratory, AoD, Sexual Health, and Mental Health *(pertaining to practices within the programme)*

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[3] Note the programme provides for free access to 13-17yr olds when they access the practice where they are enrolled.
[4] Examples of cluster plans attached.

c. Consultation and utilisation rates of General Practice demonstrating access by eligible population and to the health care team so as to meet the needs of the rangatahi presenting.

1.5 Practices were invited to be part of a cluster according to geographical location. This was well received by the practices and recognised as a means of sharing resources and ideas. Two practices have chosen to opt out of this structure, one to work independently and the other to not engage in the programme.

1.6 Programme wide comparable reporting commenced in Q3 due to the rolling start date of the clusters / practices. Tukituki medical is the only practice to opt out of the programme, siting reporting requirements as the reason. Table 1.0 below lists the practices in the programme and their respective start dates.

Table 1.0 – Rolling start date – zero fees 13-17yrs

General Practices offering zero fees 13-17yrs	**Start dates**
Hauora Heretaunga [5]	Pre 1 July
Hastings Cluster	
Totara Health, Medical and Injury,	Pre 1 July
Doctors Hastings (Inclusive of Gascoigne and Waipawa)	1 October
Hastings Health Centre	1 November
Wairoa Cluster	
Wairoa Medical, Queen Street Medical, Health Care Centre Ltd	1 July
Napier Cluster	
Maraenui Medical	1 July
The Doctors Napier, Tamatea Medical,	1 December

*Drs Hastings Group

Reporting against evaluation framework
Evaluation of the programme is based on the evaluation framework established at programme outset. (See Appendix One).

2.0 CLUSTER PLANS

2.1 Each cluster was required to complete recognised audit based around being youth friendly. Two options were provided that of the RNZGP network and that of recognised leader within adolescent health for New Zealand Dr Sue Bagshaw. All practices within the programme have completed this and used the findings to generate their own action plan.

2.2 Key items within the plans include, training of staff in supporting rangatahi to utilise services available, linkages with other youth based services for ease of referral and follow up, employment of youth workers within the team, identifying youth champions within the team advertising of the programme to raise awareness, promoting the use of manage my health – patient portal by youth, improved communication developed by rangatahi to promote what services are available and the confidentiality they can have faith in when engaging with the services.

2.3 The cluster plans include three activities that are common to all members for economy of resourcing and one individual activity. As we move towards the commencement of the new financial year and contracting, the cluster will be encouraged to revisit the audit and evaluate against progress made to date.

2.4 Included in those activities will need to be a focus on how to engage rangatahi in health promoting, and normal health seeking behaviours, as we now have the data that tells us that

[5] Hauora Heretaunga is operating separately to the cluster currently as they had wanted to consolidate internal processes and systems for meeting the needs of youth before joining a cluster.

56% of consumers in this cohort only have 0-1 contacts with their health care team within a 12 month period. Research tells us that early engagement in health seeking behaviours lead to better health outcomes in adulthood.

3.0 CONSULTATION AND UTILISATION RATES:

3.1 Rates at which youth access primary care has now been broken down into two dimensions for evaluation purposes. Initially consultation and utilisation rates were terms used interchangeably. They are now distinguished as outlined under definitions above.

3.2 Currently the funding buys out-patient co-payments.[6] The rates are $53.75 p.a. per registered patient (VLCA practice) and $63.43 p.a. (non VLCA practice) for an anticipated consultation rate of 2.15 p.a.

3.3 Consultation rates for the programme (See Appendix Two for full summary)

Consult rate[7]	**Māori**	**Pasifika**	**Other**
2014 – 2016[8]	1.61	1.23	1.80
2017 - 2018[9]	2.21	1.97	2.50

3.4 Consultation rates per cluster

	Equity Gap[10]	**Māori**	**Pasifika**	**Other**
Napier	-0.65	2.18	1.75	2.83
Wairoa	-0.49	2.65	*	3.14
Hastings	-0.26	2.15	2.08	2.41

**Insufficient numbers*

3.5 Whilst the consult rate has met expectations and is predominantly over the threshold of the 2.15 funded rate, an equity gap still exists and the utilisation data provides a different narrative.

3.6 Utilisation has been made available to the clusters for the first time in quarter three. On consultation with the clusters, the focus needs to be on the 0-1 consults p.a. cohort rather than the 4 and 6+ who are known to the practice due to their health needs warranting this level of contact.

3.7 Utilisation rates for the programme (See Appendix Two for full summary)

Utilisation rates - programme	**Number**	**0-1 Consults**	**2-3 Consults**	**4-5 Consults**	**6+ Consults**
Maori	3418	57%	21%	10%	12%
Pasifika	505	65%	19%	9%	9%
Other	4,140	54%	22%	11%	13%

3.8 Utilisation rates per cluster (See Appendix Two for full summary)

Utilisation rates	**Number**	**0-1 Consults**	**2-3 Consults**	**4-5 Consults**	**6+ Consults**
Napier Cluster					
Maori	989	60%	18%	10%	12%

[6] Alternatives to how the funding could be allocated was discussed at length with practices prior to programme start. Options discussed were packages of care being allocated to only those youth in need, identified by the practice.

[7] Consultation rates includes GP and Nurses, recognising the use of the general practice team support and management of this cohort

[8] Pre implementation

[9] 1 May 2017-30 April 2018, reflects the rolling start dates of the practices involved. Napier cluster were the last to come on board in Dec 2017.

[10] Equity gap between Māori and Other

Pasifika	122	66%	24%	5%	6%
Other	1229	54%	21%	10%	15%

Utilisation rates	**Number**	**0-1 Consults**	**2-3 Consults**	**4-5 Consults**	**6+ Consults**
Hastings cluster					
Maori	1,844	57%	22%	9%	12%
Pasifika	379	63%	17%	11%	9%
Other	2,437	53%	23%	12%	12%

Utilisation rates	**Number**	**0-1 Consults**	**2-3 Consults**	**4-5 Consults**	**6+ Consults**
Wairoa Cluster					
Maori	459	54%	20%	12%	15%
Pasifika	4				
Other	109	53%	17%	13%	17%

3.9 Work will commence in quarter 4 to analyse the NHIs for this cohort against ED data and to determine if there is engagement with ED instead of primary care and if so what work can be done to reengage these consumers.

3.10 All practices within the programme recognise there is work to be done to normalise health seeking behaviours with this cohort and promoting proactive engagement for education and advice as the first step. Group appointments where rangatahi bring friends with them to their appointments is openly encouraged as one mechanism for achieving this.

4.0 ED PRESENTATIONS AND ADMISSIONS:

4.1 The evaluation framework identifies that proactive use of primary care may have an impact on ED presentations and admissions.

ED Utilisation for top 4 conditions[11] by programme

ED Utilisation for top 4 conditions[12] by cluster 12 months to 30 April 2017

ED utilisation data 13-17yrs[13]	**AoD**	**Mental Health**	**Respiratory**	**Skin**
Hastings cluster	29	22	91	62
Napier	8	12	13	7
Wairoa[14]	1	1		1

ED Utilisation for top 4 conditions[15] by cluster 12 months to 30 April 2018

ED utilisation data 13-17yrs[16]	**AoD**	**Mental Health**	**Respiratory**	**Skin**
Hastings cluster	51	48	100	44
Napier	9	21	17	12
Wairoa[17]	3		1	2

[11] Sexual Health non identifiable within list of event reason groupings. This will be addressed in Q4 reporting
[12] Sexual Health non identifiable within list of event reason groupings. This will be addressed in Q4 reporting
[13] Cohort of consumers registered with eligible practices
[14] Wairoa ED Hastings presentations only
[15] Sexual Health non identifiable within list of event reason groupings. This will be addressed in Q4 reporting
[16] Cohort of consumers registered with eligible practices
[17] Wairoa ED Hastings presentations only

4.2 Next steps is the matching of ED and Practice utilisation data for those with a practice utilisation rate of 0-1 to determine if ED is being utilised as the primary care provider. The cluster plan would then be used to identify targeted actions to engage those rangatahi in normalising health seeking behaviours using the primary care team as their health care home.

5.0 GENERAL COMMENTARY

5.1 There has been open sharing of data and cluster plans across the programme. Now that all practices have been fully engaged in the programme for one quarter opportunities to meet at programme level will be created to compare data (anecdotal, quantitative and qualitative) to inform next steps.

5.2 Questions have been asked as to the reporting requirement for this funding when U13s (and soon to be U14s) has no expectations attached.

5.2.1 Cluster plans: The programme lead sees it as important to continue this expectation as the cluster plan provides the mechanism to evaluate against a recognised youth friendly audit tool

5.2.2 The consultation, utilisation and ED presentation data provided by the PHO and DHB provides valued data that the clusters are now beginning to utilise purposefully.

5.3 Sexual health service provision is funded via the Coordinated Primary Options (CPO) Programme (sexual health contract) and it is also an expectation that consults relating to sexual health will be covered with the zero fees 13-17 contract. Analysis of any overlap and potential double funding is underway. Contracts for both programmes now make it the prioritisation of funding to be used explicit.

5.4 Appreciation of the zero fees is illustrated by comments made by practice managers involved in the programme as listed below;

“Group consults are common where rangatahi bring a friend or refer a friend does indeed promote normalising of health seeking behaviours.”

“This programme has been a journey of severe joy, being able to provide care free.”

“One young woman was so sick she had no idea and would not have come in if she had had to pay”

5.5 Advertising of the programme is limited. It is advertised within the practices involved, in the school based health services, Directions and pharmacies. The zero fees programme was launched with limited media coverage outside of the providers. Re advertising and alternative advertising needs to be considered as one means of improving utilisation by enrolled populations.

6.0 PHARMACY

6.1 There is high levels of good will with the pharmacies to provide this service

6.2 Currently the pharmacy software does not enable automatic identification of these patients for ease of system recording. The scripts are identified at practice level but the volume of scripts processed without an automatic system is creating issues in reporting and claiming. If this cannot be resolved within the two year pilot alternative actions may need to be put in place to facilitate an automated system.

6.3 Pharmacy funding was provided based on anticipated volumes measured against the 2.15 consultation rates and previous quarterly pharmacy warehouse data. Current data is showing that actual pharmacy utilisation is lower than anticipated. 2108-19 funding levels to individual pharmacies will be guided by the current consultation rates.

7.0 NEXT STEPS FOR CONSIDERATION

7.1 The introduction of the U14 MoH funded initiative shifts the potential costing of the programme with its current practice participation from $451,300 to $355,266 a per annum saving of 96,034. U14s is flagged to commence in Dec 2108 giving a potential saving of $64,022.[18]

7.2 Clusters have indicated they would like the opportunity to explore options for utilising the savings to improve service provision and connectedness. This needs to be balanced with the recognition that up to 56% of enrolled populations are currently not utilising their capitation funding.

7.3 NHI data matching for ED presentations and Practice Utilisation rates needs to inform activities within the 2018-19 cluster plans

7.4 Training of front of house staff is recognised by all clusters as an area that needs focus as illustrated in findings from the youth friendly audits. Work is underway to identify training opportunities locally and at low cost. HEADSS assessments is a priority.

7.5 Strengthening links with youth related services and an extended primary care team such as social workers, youth health workers, AoD support, mental health counsellors will be discussed at the zero fees 13(14) -17 forum being planned.

7.6 Strengthening links with the education sector and Ministry of Social Development to socialise the programme and strategy to foster a multisectorial approach to support the intentions.

7.7 Pharmaceutical (script) claiming will be closely monitored in lieu of the currently experienced low pharmacy utilisation rates.

7.8 Provide comparative data from a regional control group.

ATTACHMENTS:

Appendix One: Evaluation Framework – zero fees 13-17yrs

Appendix Two: Consultation and Utilisation Rates (Primary Care)

[18] Eight months of savings.

Appendix One: Evaluation Framework – zero fees 13-17yrs

Aim

Proactive utilisation of Primary Care by Youth (12-24yrs)

SLM Measure (1)

Reduced ASH rates 13-17 yrs

- Respiratory
- Skin
- Mental Health
- AoD

Contributory Measures (1)

ED Admission Rates (DHB)

- Skin
- Respiratory
- Mental Health

Contributory Measures (1)

ED Presentation Rates / referral rates back to Primary Care

- Skin
- Respiratory
- Mental Health
- AoD
- Sexual Health

Contributory Measures (2)

Primary Care Utilisation Rates

By Provider

- GP-NP-PN-SW-Other
- Youth Services (Directions)

Type

- Skin, Resp. ,Mental Health, AoD, Sexual Health, Other

Examples of Cluster (Practice) Activities – Measures (3/4)

Formation of Cluster (related services) MoU

Completion of;

- RNZGP Audit
- Use /formation of Youth advisors
- Staff training
- Evaluation survey and feedback from youth
- Annual Cluster Plan

Operational linkages / Referral loop with;

- YOUTH specific services (Directions)
- Whanau wellness program
- Stanford
- School based health services
- PHN
- Youth Transition Services
- Sport – Social groups

Model of care development;

- Workforce utilisation
- Access inclusion of virtual
- Shared care provider record
- Wellness models of care provision

DNA rates - Same Day access

Key:

Data collection and reporting to inform Cluster Planning and Reporting

(1)	DHB Role
(2)	PHO Role
(3-4)	Cluster/Practices Role

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Appendix Two: Consultation and Utilisation Rates (Primary Care)

13-17 Year Olds 12 Month To 30 April 2018 Capitation Consultations

Age as at 31 March 2018

Programme Average Consultations - Total

	12 Months to 30 April 2018				
Practice	**Total Patients**	**Ave GP Consults**	**Ave Nurse Consults**	**Ave Total Visits**	**Nurse to GP Ratio**
CHB Cluster	497	1.43	0.36	1.79	20%
Hastings cluster	4,660	1.82	0.46	2.28	20%
Napier cluster	2,340	1.88	0.62	2.50	25%
Wairoa Cluster	572	1.22	1.51	2.73	55%
Grand Total	**8,069**	**1.77**	**0.57**	**2.35**	**24%**

Programme Average Consultations - Maori

	12 Months to 30 April 2018				
Practice	**Total Patients**	**Ave GP Consults**	**Ave Nurse Consults**	**Ave Total Visits**	**Nurse to GP Ratio**
CHB Cluster	126	1.47	0.35	1.82	19%
Hastings cluster	1,844	1.62	0.53	2.15	25%
Napier cluster	989	1.57	0.61	2.18	28%
Wairoa Cluster	459	1.20	1.45	2.65	55%
Grand Total	**3,418**	**1.54**	**0.67**	**2.21**	**30%**

Programme Average Consultations - Pasifika

	12 Months to 30 April 2018				
Practice	**Total Patients**	**Ave GP Consults**	**Ave Nurse Consults**	**Ave Total Visits**	**Nurse to GP Ratio**
CHB Cluster	6				0%
Hastings cluster	379	1.54	0.55	2.08	26%
Napier cluster	122	1.26	0.48	1.75	28%
Wairoa Cluster	4				67%
Grand Total	**511**	**1.45**	**0.53**	**1.97**	**27%**

Programme Average Consultations - Other

	12 Months to 30 April 2018				
Practice	**Total Patients**	**Ave GP Consults**	**Ave Nurse Consults**	**Ave Total Visits**	**Nurse to GP Ratio**
CHB Cluste	365	1.44	0.37	1.81	20%
Hastings cl	2,437	2.02	0.40	2.41	16%
Napier clus	1,229	2.19	0.63	2.83	22%
Wairoa Clu	109	1.36	1.78	3.14	57%
Grand Tota	**4,140**	**2.00**	**0.50**	**2.50**	**20%**

Programme utilisation - Pasifika

	12 Months To 30 April 2018				
Practice	**Total Patients**	**0-1 Consults**	**2-3 Consults**	**4-5 Consults**	**6+ Consults**
CHB Cluster	6				
Hastings cluster	379	63%	17%	11%	9%
Napier cluster	122	66%	24%	5%	6%
Wairoa Cluster	4				
Grand Total	**505**	65%	19%	9%	9%

Programme utilisation - Other

	12 Months To 30 April 2018				
Practice	**Total Patients**	**0-1 Consults**	**2-3 Consults**	**4-5 Consults**	**6+ Consults**
CHB Cluster	365	59%	25%	7%	8%
Hastings cluster	2,437	53%	23%	12%	12%
Napier cluster	1,229	54%	21%	10%	15%
Wairoa Cluster	109	53%	17%	13%	17%
Grand Total	**122**	54%	22%	11%	13%

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PEOPLE PLAN

Late Paper

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HAWKE'S BAY District Health Board Whakawāteatia	**Implementing the Consumer Engagement Strategy**
	For the attention of: **Māori Relationship Board and HBDHB Board**
Document Owner:	Kate Coley, Executive Director People & Quality
Document Author(s)	Ken Foote, Company Secretary & Hayley Turner, Project Manager
Reviewed by:	Executive Management Team
Month:	June 2018
Consideration:	For Endorsement

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RECOMMENDATION

That the Māori Relationship Board and HBDHB Board

1. **Note** the contents of this paper and the Consumer Engagement Strategy
2. **Endorse** the Strategy

Please note that Consumer Council & Clinical Council have endorsed both the original strategy (August/Sept 2017) and the revised strategy, following MRB feedback/workshop in December 2017, at their April 2018 meeting. They strongly recommend and support this being endorsed by Board at the June meeting. .

PURPOSE

The purpose of this paper is to present the final Consumer Engagement Strategy, and to outline the proposed approach which will support effective implementation of the strategy.

A Strategy was originally endorsed by HB Health Consumer Council in September 2017 and has since incorporated feedback received from EMT and MRB. The proposed implementation approach has evolved as the overall People Plan has been developed, and its various components integrated.

OVERVIEW

It is our ultimate aim to create a culture which puts people at the centre of everything that we do, and one that is respectful of, and responsive to the needs, preferences, and values of our community. Consumer engagement is one enabler of a people centred culture.

The attached consumer engagement strategy has been developed as a key piece of work alongside others to:

- Achieve culture change.
- Strengthen and embed consumer participation at all levels in the health sector
- Ensure consumers are active partners in how we design, deliver and improve services
- Drive improvements - experience of care, quality and safety of care, health outcomes and best value
- Build knowledge and educate health sector staff about the value of consumer engagement.

This is not a standalone strategy. To be effective, consumer engagement should be seen as a "way of working" and part of our 'culture'. It should be linked to other organisational plans and build on existing skills and the work we are already doing. The strategy supports the Hawke's Bay Health Sector vision of "*Healthy Hawkes Bay*" and mission of *"Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community".*

We recognise that across the Hawke's Bay health sector there are a number of examples where consumer engagement is already occurring however there is also a lack of guidance, practical resources and tools to support effective engagement. A systematic approach needs to be developed and implemented to support engagement being effortless and part of business as usual. Consistent processes, policies and guidelines for engagement need to be developed.

IMPLEMENTATION APPROACH

Given that this is not a standalone strategy, an integrated approach to implementation has been adopted. A number of issues have been grouped under the general heading of '**Consumer Experience'**. These include:

- Consumer Engagement
- Recognising Consumer Participation
- Patient Experience
- Health Literacy

This grouping aligns exactly with the terms of reference of the recently approved (but yet to be established) Consumer Experience Committee within the new clinical governance structure, and also with the roles and responsibilities of the currently advertised positions of Consumer Experience Manager and Consumer Experience Advisor. With these structures and resources in place, a Consumer Experience Project team is about to be established to develop the required systems, processes, toolkits and champions that will assist and enable them to achieve their desired outcomes, and ultimately influence the desired culture change and improved experience for consumers.

A project brief is currently being developed for the Consumer Experience Project. The prime purpose of the Project is to assist and provide support to the Consumer Experience Committee and dedicated operational staff. Current objectives for the project include:

- Develop and implement a consumer engagement toolkit for the DHB, and make available for the HB health sector
- Strengthen and embed the level of consumer participation in service redesign and improvement initiatives through co-design methodology
- Ensure that consumer feedback is the key driver in improving experience of care, quality and safety of care, health outcomes and best value
- Build knowledge and educate health sector staff about the value of consumer engagement and how to engage with consumers
- Develop databases and processes for recording and matching service requests for consumer engagement with available and appropriate consumers
- Develop guidelines and procedures for implementing the 'Recognising Consumer Participation' policy
- Develop communication channels for keeping health related community groups informed and engaged in health related developments
- Define specific roles and responsibilities for consumer experience issues
- Develop a preferred patient experience monitoring tool and simplify centralised surveys
- Ensure appropriate IS tools are available to support consumer experience activities and measures
- Further develop 'health literacy' framework, assessment surveys and toolkits
- Champion the goal of a HB 'health literate sector', where health is 'easy to understand'.
- Develop measures of success and relevant monitoring tools and reports.

An update of progress and further details will be provided once the project brief is completed and the project team is established.

PERSON & WHANAU CENTRED CARE

Apart from addressing specific issues included within the scope of ‘Consumer Experience’ as set out above, it needs to be acknowledged that this is a component of the wider concept of ‘Person and Whanau centred Care’. As this concept is being further developed, those involved in Consumer Experience (and therefore Consumer Engagement) will be ideally placed to assist and support this, to ensure that all relevant components are fully integrated and that ‘consumers remain at the centre’.

ATTACHMENT Consumer Engagement Strategy.

CONSUMER ENGAGEMENT STRATEGY

EXECUTIVE SUMMARY

Consumer engagement refers to the wide range of approaches in which consumers are involved in the planning, service delivery and evaluation of healthcare. Done well, it contributes to fostering a relationship led culture of person & whānau centred care. It supports active, ongoing partnerships, relationships and communication that benefits consumers, staff and will ultimately transform the system.

This strategy is not a detailed work plan. It provides a clear direction for the future and a framework for making decisions. It provides guidance around types and levels of engagement and the benefits of engaging. The goal being that consumer engagement is embedded in all of the ways we work with consumers and is a key driver for achievement of the 'Triple Aim'.

This is not a standalone strategy. To be effective, consumer engagement should be seen as a "way of working" and part of our 'culture', rather than additional work on top of an already demanding workload. It should be linked to other organisational plans and build on existing skills and the work we are already doing. Effective consumer engagement supports the Hawke's Bay Health Sector vision of "*Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community".*

PURPOSE

The goal of this strategy is to strengthen and embed consumer participation at all levels in the health sector, ensuring consumers are active partners in their own care and how we design, deliver and improve services. It is a driver for improving experience of care, quality and safety of care, health outcomes and best value. The strategy also exists to build knowledge and educate health sector staff about the value of consumer engagement.

Ultimately, our aim is to create a relationship and values led culture which puts our consumers and their whānau at the centre of everything that we do, and one that is respectful of, and responsive to their needs, preference, and values. Consumer engagement is one enabler of a person & whānau centred culture and this strategy sits alongside others to achieve culture change.

WHAT IS CONSUMER ENGAGEMENT?

Consumer engagement refers to the wide range of strategies in which consumers/whānau are involved in their care planning, service delivery and evaluation of healthcare. It can be at an individual, service, governance or community level. Engagement should always be mana enhancing building strong and sustainable relationships.

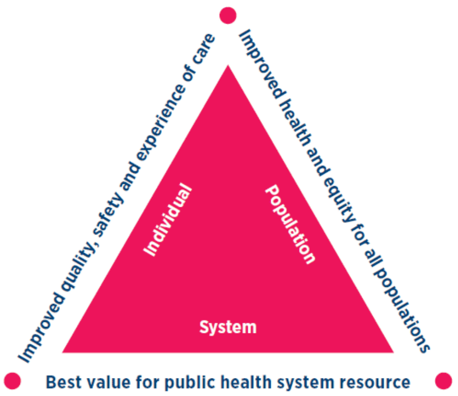
Consumer refers to patients and their families / whānau / caregivers / personal support persons, who have had personal experiences in the health and disability system. The term also includes those who might use services in the future and members of the public generally, given they are the targeted recipients of health promotion and public health messaging and services.

WHY ENGAGE WITH CONSUMERS?

Consumer engagement done well fosters a culture of person and whānau centred care. It supports active, ongoing partnership, relationships and communication that will benefit consumers, staff and ultimately transform the system.

There is evidence to support the benefits of engaging with consumers. These include improvements, such as reduction in inequities, more responsive services, improved clinical quality outcomes, and improved patient experience. In addition, safer care, less waste, reduced length of stay, lower costs, better consumer and health provider satisfaction and staff retention.

Consumer Engagement supports the New Zealand Triple Aim framework (right) for quality improvement at individual, population and system levels. One of its aims is improved health and equity for all populations. Hawke's Bay is a great place to live, but not everyone has the same opportunity to be healthy. Health inequities exist in some parts of our community. Successful consumer engagement will focus on how to be effective within this broader context.



Without proactive consumer engagement, the drive for change is usually either motivated through system failures (e.g. adverse events) or from external advocacy to improve the quality and safety of care. Waiting until there is a problem creates avoidable costs for consumers (physical, psychological and economic) and organisations (review processes, staff morale and more expensive treatments).

HOW DO WE ENGAGE?

Engaging with consumers can and should happen at different levels depending on the situation, and as early as possible. How we engage will be determined by the purpose, timeframes and level of impact of different projects, initiatives or programmes of work. Many will require multiple engagement methods at multiple levels.

Principles of engagement

The principles of partnership, participation and protection underpin the involvement of maori and the wider community. In addition to these core principles there are a number of other guiding principles in relation to effectively embedding consumer engagement at all levels alongside the shared values and behaviours of our sector.

These are:

1. **Being open and honest -** Consumer engagement is more successful when all parties involved are mutually respectful, listen actively and have the confidence to participate in full and frank conversations.

2. **Providing support -** Support for consumer engagement means being welcoming when meeting consumers, valuing their expertise, considering their cultural needs and acknowledging and taking their viewpoints seriously.

3. **Being real -** Consumers and providers know when we are simply going through the motions of consulting with consumers. Consumer engagement needs to be genuine. All parties should know the purpose of why engagement is taking place and real possibilities for change and improvement.

4. **Patient and whānau focus -** All consumer engagement needs to keep the focus on patient and whānau centred care. It is important that providers and staff are supported to maintain their focus on patient/family/whānau as a core aspect of care.

5. **Making health easy to understand** – all engagement needs to done in a way that meets the needs of the consumer, is easy to understand and so that they can contribute as an active partner in the engagement.

6. **Culturally appropriate:** - all engagement needs to meet the needs, values and be culturally appropriate to the consumer.

Levels of engagement

Individual engagement includes consulting, involving and partnering with consumers in shared decision making about their own health. Put another way – *" 'my say' in decisions about my own care and treatment".* It is easy to see and value the role of consumers at an individual level – engaging in and contributing to decisions about their own care, or that of loved ones. This is covered in more detail within the work being undertaken in the making health easy to understand framework, engaging effectively with Māori, and relationship centred practice training.

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Collective engagement includes collaborating, involving and partnering with individuals or groups of consumers at a service, community or governance level. Put another way – *" 'my' or 'our say' in decisions about planning, design and delivery of services".*

As seen in the below diagram, consumers can be engaged collectively in various ways, at multiple levels including:

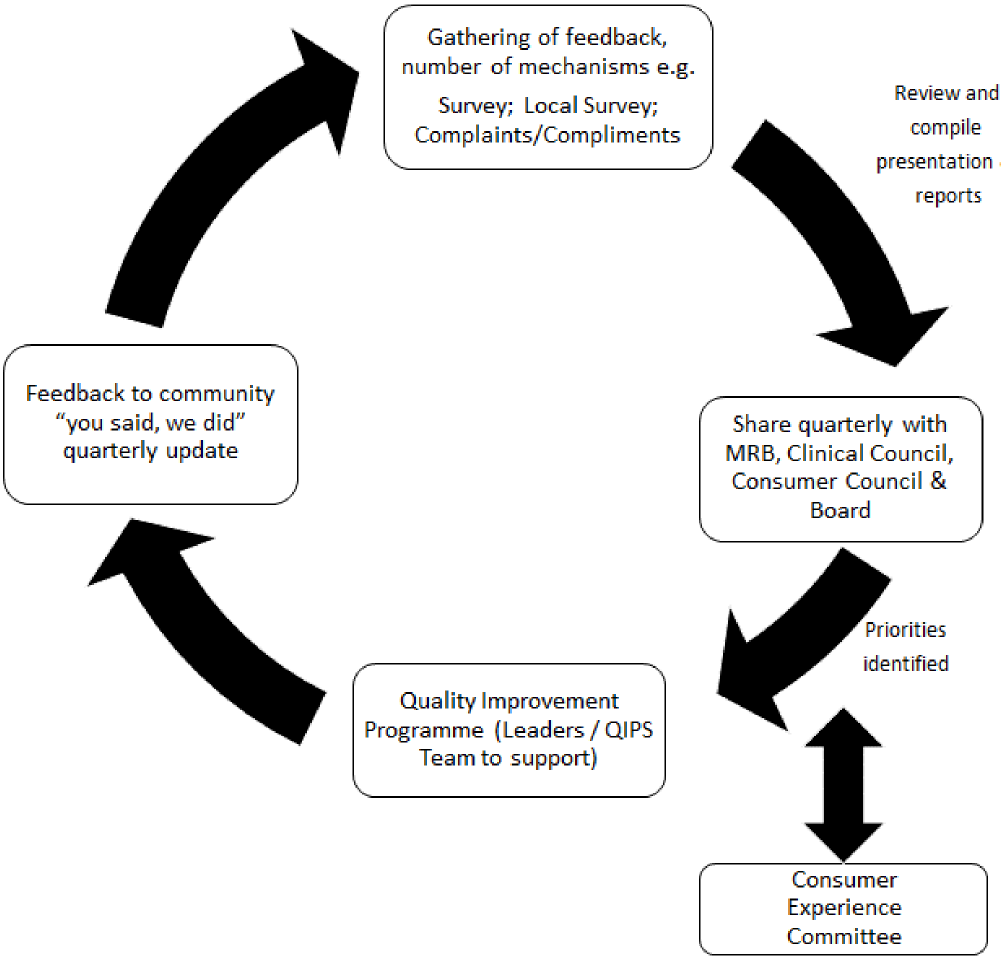
- As partners when redesigning services through co-design groups
- As members of committees, advisory and governance groups
- Through workshops, working groups, steering groups, focus groups and public hui's
- Through consumer and patient experience surveys and feedback mechanisms
- Involvement in consumer interviews, patient stories, patient journey mapping

	Consult Two-way communications Seeking opinions	**Involve** Seek feedback Discuss	**Partner** Identify, plan, implement and evaluate together Shared decision making
Individual	• Information • Diagnosis	• Goals and preferences discussed • Input into treatment plan	• Decisions together • Relationship centred practise
Service	• Surveys • Focus Groups • Social Media	• Consumer Representatives • Advisory groups • Workshops	• Co-design Groups
Community	• Focus Groups • Public Hui • Community Events • Online engagement	• Workshops • Working Groups • Consumer Groups	• Health and Social Care networks (Localities)
Governance	Established sector wide governance • Meetings • Information	• Endorse papers • Workshops	• Joint workshops with Consumer and Clinical Councils

Levels of Consumer Engagement

UTILISING CONSUMER FEEDBACK

One form of engagement with consumers relates to feedback that we receive through various formats, including complaints, patient experience surveys, focus groups and hui's. To ensure that this is effectively used to support system design improvements and changes the following process will be followed:



LINKS TO OTHER STRATEGIES

It is important to acknowledge other strategies and frameworks that link to the implementation of this strategy:

- The Quality Improvement and Safety framework "Working in Partnership for Quality Healthcare in Hawke's Bay" (2013) outlines priorities that support consumer engagement in Hawke's Bay.

- Patients and Whānau at the centre and services developed around the needs of our patients is a core principle of Hawke's Bay Health System – Transform and Sustain 2013 – 2018

- Youth involvement is a core principle of The Youth Health Strategy 2016 – 2019 in building health system resiliency through youth participation in governance, leadership, design and delivery of work.

- The Mai Māori health strategy focuses on engaging better with whānau and responding to the needs of Māori in the way they prefer services and care.

- The Pasifika Health Action Plan 2014 – 2018 supports a collaborative approach with pacific communities.

- Significant consumer input will be required to make a 'health literate sector' a reality.

- The People Strategy will address the development of a culture for the health sector that will need to include respecting and communicating effectively with consumers

- The development of Health and Social Care Localities includes significant requirements to consult with and engage local communities in decision making.

HAWKE'S BAY District Health Board Whakawāteatia	**Policy - Recognising Consumer Participation** For the attention of: **Māori Relationship Board, Clinical & Consumer Councils**
Document Owner/Author:	Ken Foote, Company Secretary
Reviewed by:	Kate Coley, Executive Director People & Quality and Executive Management Team
Month:	June 2018
Consideration:	For discussion and endorsement

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RECOMMENDATION

That the Māori Relationship Board, Clinical & Consumer Council

1. **Note** the contents of this paper and attached draft policy.
2. **Discuss** and provide comment and feedback.
3. **Endorse** in principle the process for implementation of the policy.

Note EMT have endorsed this paper and the attached policy

OVERVIEW

Engaging and partnering with consumers is an important part of ensuring that the Hawke's Bay Health Sector is meeting the needs of our community. Why and how we do this has been pulled together as part of the Consumer Engagement Strategy. One of the key issues to be addressed in this strategy is how we value and recognise consumer participation and engagement.

Currently the only formal policy on this issue is contained within the policy on 'Payment of Fees and Expenses' (HBDHB/OPM/108). Essentially this policy provides for the payment of fees to Consumer Council members only, and reimbursement of justifiable expenses to stakeholders and advisors (including consumer representatives) in exceptional circumstances. The policy does however include a number of principles that address other more intangible ways of recognising and valuing consumer input.

With the more recent heightened awareness and interest in engaging consumers, the appropriateness of this current 'narrow' policy has been raised as an issue by consumers and services alike. In lieu of a broader policy, discretionary ways of recognising consumer contribution are being employed. There is a risk that this could lead to potentially unsustainable precedents being set and unrealistic expectations being created.

CONSULTATION

Consultation with HB Health Consumer Council, and other initial feedback sought from MRB, other consumer groups (including Partnership Advisory Group (PAG), EMT, PMO and Finance confirmed that it was appropriate to establish an organisation wide policy that acknowledges this 'new' environment, and the desired level of engagement.

Through consultation it was agreed that the three Auckland District Health Boards "Recognising Community Participation" Policy (attached as Appendix 2) was a good starting point for how HBDHB might recognise consumer participation and the resulting implications.

Feedback received requested more detailed provisions for recognising consumer participation. Examples of these such as Manaaki, Koha/Gifts, vouchers, support with expenses, refreshments, payments and inclusion in flu vaccinations have been included in the new draft policy.

COST OF IMPLEMENTATION

EMT requested an indication of what the cost of implementation would be based on previous 12 months activity and/or future planned activity. Discussions with finance have resulted in an inability to accurately determine this based on not having a cost centre code that reflects consumer involvement. This deficiency has been addressed in the draft policy.

Discussions with Counties Manukau DHB has revealed that their internal systems and processes do not include being able to accurately reflect the cost of engagement. They do not have a budget for engagement. Teams build it into their project plan or use existing service budget.

In the absence of any evidence or objective assessment criteria, it is subjectively estimated that the total cost of implementation is likely to be around $20k per annum, spread across a number of cost centres. The materiality of this is therefore very low, and the expectation is that all services and projects incurring such costs will absorb them within existing budgets.

LEARNING FROM COUNTIES MANUKAU DHB

Counties Manukau have shared their learnings with HBDHB. These include:

1. Set cost centre codes up in advance of implementation.
2. Associated costs of consumer engagement should be the responsibility of the budget holder of the service or project, as opposed to being centralised. When services take responsibility for the costs of engagement they take better ownership of the relationship with the consumer representative.
3. Costs should be estimated and approved by the budget holder in advance of the project or engaging with consumer representatives. Have a process in place for this.
4. Provide certificates for consumers to acknowledge receipt of travel expenses and vouchers
5. Implement a transparent process that includes an attendance register when accounting for vouchers/taxi chits/reimbursements.
6. Be clear about who administers the process within services.
7. Rates are at the discretion of the budget holder but should be based on the level of the project, not the skill brought (for example, the Chair of Consumer Council is not paid a Chairs rate if involved in a project steering group).

RECOMMENDATIONS

It is recommended that the following process be implemented for this proposed policy:

1. EMT and Consumer Council feedback regarding this draft policy be incorporated.
2. As per policy guidelines, the draft policy should then be distributed more widely for organisational comment.
3. Policy is finalised and approved through governance process.
4. Review and amend existing 'Payment of Fees and Expenses' (HBDHB/OPM/108) Policy in light of this policy.

5. Make consequential changes to the ‘Sensitive Expenditure Policy’ (HBDHB/OPM/015) supported by Maori Health Services. (The definition of Koha to include cash equivalents).
6. Processes to support the policy, including learnings from Counties Manukau DHB to be confirmed in conjunction with the finance team.
7. Policy and processes to be rolled out with training to support.

ATTACHMENT

Draft policy on ‘Recognising Consumer Participation’

HAWKE'S BAY DISTRICT HEALTH BOARD	Manual:	Operational Policy Manual
Recognising Consumer Participation	Doc No:	HBDHB/OPM/120
	Date Issued:	May 2018
	Date Reviewed:	
	Approved:	To be confirmed
	Signature:	
	Page:	1 of 15

PURPOSE

Engaging and partnering with consumers is an important part of ensuring that Hawke's Bay District Health Board (the DHB) is meeting the needs of the community.

The DHB values and wishes to encourage consumers, whānau and community input and participation in HBDHB work. It is important that this contribution is recognised.

This policy explains how consumer participation can be recognised in a way that is fair, simple, consistent and compliant with financial and other imperatives.

PRINCIPLES

The fundamental intent of this policy is to clearly set out HBDHB's position on how we recognise consumer input.

Principles on which the policy is based include:

1. Engaging with consumers adds value by improving decision making, services and outcomes and fosters a culture of person and whanau centred care.
2. The DHB will invite consumers to participate in one off events, focus groups and to join project groups.
3. Consumers who participate by invitation in DHB activities should be offered reimbursement for reasonable expenses incurred in such participation
4. The DHB will ensure that the time and effort of consumers contributing and participating in DHB initiatives will be appropriately acknowledged and recognised. Such recognition may be in tangible and/or intangible form.
5. Expenditure decisions in recognition of consumer participation in DHB activities will be made with integrity and transparency.
6. Costs associated with recognising consumer participation are not centralised. The responsibility lies with the budget holder of the service or project and will be coded to the appropriate cost centre.
7. All consumers participating will be considered equal, irrespective of their employment status, profession, qualifications, experience or background.
8. Genuine appreciation for consumer input will be expressed through consideration of meeting times and venues, timely communication, feedback, follow up and an expression of appreciation.
9. Engaging with consumers is aligned with the vision and values of the Hawke's Bay Health sector; in particular Rāranga te tira – partnership and He Kauanuanu – respect.

SCOPE

This policy will apply to all consumers who are invited to participate in DHB work as a consumer representative.

This policy is applicable to all HBDHB employees who engage consumers in project, planning, improvement and decision making processes.

This policy excludes Consumer Representatives who are paid for their involvement through specific external funding mechanisms.

This policy does not apply to engaging contractors or consultants providing professional services or Consumer Council members attending governance meetings.

ROLES AND RESPONSIBILITIES

The Executive Director People & Quality has overall responsibility for the application of this policy.

Executive Directors, Senior Clinical Leaders, Service Directors, Project Managers and other budget holders, are responsible for engaging and appropriately recognising consumer representatives involved in their respective areas.

The Consumer Experience Manager is responsible for providing management and administrative support related to consumer representation.

The Executive Director Corporate Services has overall responsibility for the development and maintenance of systems and processes, including internal controls and financial monitoring of payments and vouchers.

The HBDHB Company Secretary shall independently monitor all costs associated with the application of this policy.

POLICY

The 8 principles above shall be applied as part of this policy.

In relation to the recognition of consumer participation the DHB will provide:

Manaakitanga (host responsibility)

Manaaki can be defined as “to look after, care for, show respect or kindness to”. Manaakitangi can be loosely translated to “hospitality”. Being hospitable, looking after visitors and caring about how others are treated is very important.

Recognition of people invited to participate in DHB activities requires that they are positively valued and shown respect. It requires sensitivity to people’s cultural and social diversity and an awareness of people with disabilities. It means that people assisting the DHB should be provided with sufficient resources to enable and support effective contribution. It includes the provision of sufficient information (in a format that is easy to understand), support with transport and other needs as required, ensuring the venue and information are fully accessible, providing refreshments, formally acknowledging people for their participation and providing feedback on their input. There should be no barriers to participation.

When offering hospitality, reference should be made to the ‘Sensitive Expenditure Policy’ (HBDHB/OPM/015).

Verbal and/or written acknowledgements, and expressions of appreciation, should be provided in all cases.

Koha/Gifts

A koha or gift may be presented as a token of appreciation for contributions made to DHB activities, but should not be an expectation of the recipient. Koha/gifts may be in the form of petrol or supermarket vouchers or other tokens of appreciation (not cash or cheque). The value of a koha/gift for a person involved in any one project should not exceed $50.00.

Vouchers should not be given regularly to the same person, as they may constitute taxable income.

People already on a salary or a contract, which covers their participation, should not receive a koha/gift.

Refreshments

It is appropriate to provide light refreshments for those who inform or advise the DHB through participation in a public consultation e.g. Hui, fono, discussion group. Reference should be made to the DHB's Healthy Eating Policy (HBDHB/OPM/115)

Reimbursements and Payments

Consumer representatives who participate in DHB activities by invitation should be offered reimbursement for reasonable expenses associated with their participation and may be offered payment for the time and value of their input.

Table 1 below provides a guide to the kind and level of reimbursements and monetary recognition payable. It is based on activities that are attended in person but payments can also be made when people participate in other ways, for example teleconferences or work done by individuals at home.

In all cases, the amount and type of on-going expenses and payments must be approved by the budget holder i.e. Service Director, Executive Director, Project Sponsor (or other role with the relevant delegated authority) in advance of the project, with the upper limit set.

For ongoing activities there must be a letter of agreement sent to the participant and the terms of reference agreed for the project/committee activity with the appropriate sign off. The agreement should include an outline of expectations of the consumer representative's contribution. If, for example a consumer representative is required to chair a meeting, or is expected to seek wider community views on a topic, then consider what additional time would be required to fulfil this function well. The agreement should outline any process for compensation, including a process for compensating expenses for last minute changes to meeting dates or times.

<u>Reimbursements</u>:

Consumer representatives seeking reimbursement of out of pocket expenses should complete a **Consumer Expenses Claim Form**, and provide:

- bank account number;
- receipts or invoices for items less than $50 (incl. GST) or incurred overseas;
- GST tax invoices for items greater than $50 (incl. GST) and incurred in New Zealand.

Consumer representatives receiving vouchers to cover their expenses should also acknowledge receipt of payment by signing a **Voucher Acknowledgement of Receipt Register** and this should be kept on record.

Consumer representatives already on a salary or a contract which covers their participation should be reimbursed for out of pocket expenses using the usual employee expense claim process, or in accordance with their contract.

The DHB will not fully compensate people for taking time off work or for loss of income as a result of providing input into DHB work or projects. The levels of recognition set out below should be regarded as partial compensation.

Payments:

Consumer representatives offered 'remuneration' compensation for the time they have given, should be asked to complete a **HBDHB Joining Form** and an **IR330C Form**, and will be added to payroll and have withholding tax deducted from any payment.

Consumer representatives should not be compensated with vouchers for any time they have given, due to the complications and cost of complying with taxation obligations.

Consumer representatives providing appropriate tax invoices for their time, will be required to complete a **New Supplier Request Form**. Once approved, payments will be made into the verified bank account number provided.

Table 1: Reimbursement and recognition details

Type of activity	Type and extent of financial support or recognition the DHB can provide	Paid by
1. **General invitation to a public hui/ meeting** Participation in a public consultation e.g.: attending a public meeting, hui, fono or discussion group	• No honorarium or koha • Assistance for people who would not otherwise be able to attend, e.g. mobility taxi service • Assistance if requested with interpreters, or other supports that are essential for participation	• Taxi vouchers or bus passes provided prior to the meeting if possible • Carpark pass if meeting is on hospital grounds.
2. **Personalised invitation to one-off event** Participation in focus group, forum, workshop or meeting	• A koha or gift may be appropriate (up to the value of $50.00) • Assistance, if requested, with taxis/transport for people who would otherwise be unable to attend • Reimbursement of reasonable out of pocket expenses up to $125.00 per meeting (see travel expenses) • Expenses may include travel, childcare and special aids for participation	• Koha/gift in the form of petrol or supermarket voucher (it is helpful to provide a choice as not everyone drives) • Taxi vouchers or bus passes provided prior to the meeting if possible • Carpark pass if meeting is on hospital grounds.

Type of activity	Type and extent of financial support or recognition the DHB can provide	Paid by
3. **Invitation to ongoing group membership, partnership or collaboration**	• Reimbursement of reasonable out of pocket expenses (see travel expenses) • Expenses may include travel, childcare and special aids for participation • Inclusion, if requested, in annual influenza vaccination **Consumer Representative working at a Project level** • May be paid a meeting fee of up to $50.00*for each meeting attended. **Consumer Representative working at a governance level (i.e. Consumer Council member)** • Payment as per 'Payment of Fees and expenses' Policy (HBDHB/OPM/108)	• An honorarium is paid in recognition of time made as tax deducted payment • Expenses reimbursed are tax exempt. Paid retrospectively on receipt. • Carpark pass if meeting is on hospital grounds.

*this policy does not preclude paying a lesser amount.

Travel expenses (private vehicle)

Use of a private vehicle will be reimbursed on a distance travelled basis using IRD mileage rates (available on-line by typing "IRD mileage rates" into a search engine). Some common travel distances are provided below.

Return Trip distance
43km (i.e. Napier to Hastings)
14km (i.e. Flaxmere to Hastings)
22km (i.e. Bay View to Napier)
40km (i.e. Te Awanga to Napier)
72km (i.e. Waimarama to Hastings)
99km (i.e. CHB to Hastings)
233km (i.e. Wairoa to Napier)

MEASUREMENT CRITERIA

This Policy will be reviewed annually along with a full summary of costs incurred within the 12 months previous. To facilitate the capture of costs under this policy, expenses should be coded to Community Consultation Costs (currently account code 583500) within the appropriate cost centre.

As an appropriate independent control measure, HBDHB Company Secretary will periodically review all transactions charged against this code

An annual survey will be sent to Service and Project leaders, Consumer Council members and Consumer Representatives regarding feedback on how the policy is working in practise.

DEFINITIONS

"Consumer"

Refers to patients and their families / whānau / caregivers / personal support persons, who have had personal experiences in the health and disability system. The term also includes those who might use services in the future and members of the public generally, given they are the targeted recipients of health promotion and public health messaging and services.

"Consumer Engagement"

Consumer engagement refers to the wide range of strategies in which consumers are involved in the planning, service delivery and evaluation of healthcare. Informing consumers does not, in itself, constitute engagement. Engagement requires dialogue and building relationships.

"Consumer Representative"

A consumer representative is a person with healthcare experiences relevant to the project or management group. A consumer representative provides advice based on their own personal experiences of services or care, and/or on behalf of others.

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"On-going"

For the purposes of this policy, and in the context of activities, ongoing means predictable. If a meeting is scheduled to occur regularly with the same group of people as part of business as usual, or a specified project, that activity is classed as "on-going".

REFERENCES

Health Quality and Safety Commission - Engaging with Consumers: A guide for District Health Boards.

RELATED DOCUMENTS

'Payment of Fees and expenses' (HBDHB/OPM/108)
'Sensitive Expenditure Policy' (HBDHB/OPM/015)
'Healthy Eating Policy' (HBDHB/OPM/115)

FORMS

All relevant forms applicable to this policy may be found on HBDHB intranet – Our Hub.

For illustrative purposes only, copies of such forms current at the time this policy was first approved, are attached:

Appendix 1: Consumer Expenses Claim Form
Appendix 2: Voucher Acknowledgement of Receipt Register
Appendix 3: HBDHB Joining Form
Appendix 4: HBDHB New/Updated Supplier Form
Appendix 5: IR330C – Tax Rate Notification for Contractors

KEYWORDS

Consumer
Consumer Engagement
Consumer Representative
Expenditure
Gift
Koha
Participation
Payment
Project
Recognition
Refreshments
Reimbursement
Travel expenses
Vouchers

For further information please contact the Consumer Experience Manager.

Appendix 1

Consumer Expenses Claim Form

Please complete and forward to the person organising the meeting

Name:	
Email:	
Phone #	
Bank Account	_ _ - _ _ _ _ _ - _ _ _ _ _ _ _ _ - _ _ _

Meeting Attended: __________ **Date:** __________ **Place:** __________

Expense description/justification / and kms travelled in private vehicle		**Amount**
All original supporting receipts/invoices (GST tax invoice for items over $50) must be attached.	Sub total	
	Plus GST	
I hereby certify that the above details are correct and that all expenses claimed were incurred in participating in work of the Hawke's Bay District Health Board.	**Total**	**$**

Signature __________ **Date:** __________

For HBDHB use only

Approved for payment by:

Name: .... Position: ....

Signature: .... Date: ....

Expenses to be charged to

Cost Centre ....

Account Code 583 500

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Appendix 2

Voucher Acknowledgement of Receipt Register

This form is to be used in accordance with the Recognising Consumer Participation Policy. Its purpose is to account for and maintain a record of the issue of vouchers.

Type of Voucher e.g. petrol, super market	Voucher Issuer e.g. MTA, Countdown	Voucher Number	Name of Recipient	Recipients Signature

Staff responsible for the use of vouchers, should ensure this form is completed whenever vouchers are issued, and be able to present the completed form on request.

Appendix 3

WHAKAWATEATIA HAWKE'S BAY District Health Board

JOINING FORM

Please complete all detail in FULL and return to the Recruitment Team

SURNAME: Dr / Mr / Mrs / Miss / Ms	**FIRST NAME (S) (in full):**
PREVIOUS NAME(S):	**DATE OF BIRTH:** / /
ADDRESS:	**PHONE NUMBER(S):**
GENDER: Male / Female	**Have you previously been employed by HBDHB?** Yes / No

NEXT OF KIN:

Name:.. Phone Number(s):...

Address:.. Relationship:...

EQUAL EMPLOYMENT OPPORTUNITY INFORMATION:
The following information will be used for reporting and statistical purposes only. Which ethnic **groups** do you identify with? (please indicate more than one if applicable):

NZ Maori	☐	British or Irish	☐	Other European	☐
NZ European / Pakeha	☐	Asian	☐	Other Ethnic Group (or further detail):	☐
Pacific Islander	☐	Indian	☐	--	

BANK ACCOUNT DETAILS (Please attach deposit slip)

Name of Bank: ....

Account No: ☐☐ ☐☐☐☐ ☐☐☐☐☐☐☐ ☐☐☐

Bank Code | Bank/Branch | Account Number | Suffix

PAYROLL USE ONLY: Cost Centre:...

Employee Number:.. Salary:..

Applicant Number:.. Increment Date:...

Commencement Date:.. Phone Allowance: Yes / No

Position:... Roster Group:...

Signature: .... **Date:** ....

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Appendix 4

HBDHB New/Updated Supplier Form

HAWKE'S BAY District Health Board

Part A – Your information (** Denotes a mandatory field. If you are updating the information we hold on you, only complete the boxes you want us to change*)

Payment details		
* Name/department of the person at the DHB who asked you to complete this form		
Supplier number if an existing supplier		
*Trading name that will appear on your invoices		
*Legal name (if different)		
*Legal status (e.g. registered company, partnership, sole trader, Crown entity etc.)		
*Company No. / NZBN (include certificate)		
*e-mail address (for purchase orders)		
*Physical address (for supplier returns)		
*Postal address - if different from physical address:		
*Type of goods or services you will provide:		
*DHB Employee? ☐ Yes ☐ No	Employee number:	
*Independent contractor? ☐ Yes ☐ No	IRD number:	
*GST registered? ☐ Yes ☐ No If registered you must provide compliant tax invoices,	GST number: see: *http://www.ird.govt.nz/gst/work-out/work-out-records/records-tax/tax-info/*	
Who should we contact at your business		
*Contact name:		
*Phone number:	Mobile number:	*e-mail address:
Purchasing contact person, if different from above		
*Contact name:		
*Phone number:	Mobile number:	*e-mail address:
Payments contact person – for remittance advices		
*Contact name:		
*Phone number:	Mobile number:	*e-mail address:

If you are a contractor receiving scheduler payments, you must also include a completed Tax rate notification for contractors IR330C form (available on the IRD website), or a copy of any Certificate of exemption (COE). Otherwise tax will be deducted at the no-notification rate.

February 2017 Page 1 of 2

HBDHB New/Updated Supplier Form

Part B – Bank Account detail and declaration

2. Bank Account details	
*We accept any of the following as evidence of your Bank Account:	Document attached
A pre-printed deposit slip which includes the full bank account number (bank, branch, account number and suffix) and the account holders name :	☐
A bank statement which includes the full bank account number (bank, branch, account number and suffix) and the account holder's name:	☐
A letter from the bank which includes the full bank account number (bank, branch, account number and suffix) and the account holder's name. This must be signed and stamped by the bank.	☐
An internet printout which includes the full bank account number (bank, branch, account number and suffix) and the account holder's name and the web address along the top or bottom of the page. This does not need to be signed and stamped by the bank unless all of the above is not provided on the printout.	☐
ATM printout must show the bank logo and the full bank account number (bank, branch, account number and suffix) and the account holder's full name.	☐
Hand-written bank account evidence as long as it includes the full bank account number (bank, branch, account number and suffix) and the account holder's name. This must be signed and stamped by the bank.	☐

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3. Supplier Declaration	
*I declare that: • the information given in this application is true and correct • I am authorised to make this request on behalf of the organisation.	
Full name:	Job title:
Signature:	Date:

Payments will be made on the 20th of the month following date of invoice as per HBDHB terms and conditions. *(T&C available on the HBDHB website)*

Return this form to the Contracts Team e-mail:
contracts@hawkesbaydhb.govt.nz

With subject line "New Supplier Request" (Supplier Name)

4. OFFICE USE ONLY		
Contracts approval:	Name & Signature:	Date:
Purchasing approval:	Name & Signature:	Date:
Creditor number :	Name & Signature:	Date:
WHT loaded :	Name &Signature:	Date:

Appendix 5

Inland Revenue
Te Tari Taake

Tax rate notification for contractors

IR330C
March 2017

Use this form if you're a contractor receiving schedular payments.

Don't use this form if you're receiving salary or wages as an employee, you'll need to use the *Tax code declaration (IR330)* form.

Once completed:

Contractor — **Give this form to the person paying you.**

Payer — **Don't send this form to Inland Revenue.** You must keep this completed IR330C with your business records for seven years following the last schedular payment you make to the person or entity.

1. Your details

Full Name

IRD number (8 digit numbers start in the second box. *1 2 3 4 5 6 7 8*)

If you don't have:

- your IRD number you can find it on your myIR Secure Online Services account or on letters or statements from us.
- an IRD number go to **www.ird.govt.nz** (search keywords: IRD number) to find out how to apply for one.

2. Your tax rate

You must complete a separate *Tax rate notification for contractors (IR330C)* for each source of contracting income.

Refer to the flowchart on page 2 and enter your tax rate to one decimal point here. %

Refer to the table on page 3 and enter your schedular payment activity number here.

Your tax code will always be: WT

3. Declaration

Name

Designation or title (if applicable)

For example, director, partner, executive office holder, manager, duly authorised person

Signature

Day Month Year 2 0

Please give this completed form to your payer. If you don't complete sections 1 and 3 your payer must deduct tax from your pay at the no-notification rate of 45%, except for non-resident contractor companies where it's 20%.

Privacy

RESET FORM

Meeting your tax obligations means giving us accurate information so we can assess your liabilities or your entitlements under the Acts we administer. We may charge penalties if you don't.

We may also exchange information about you with:

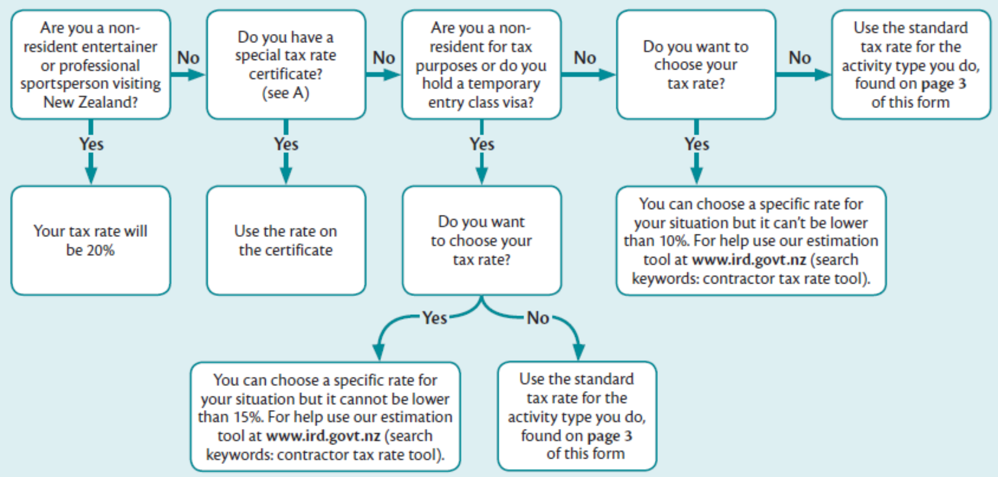
- some government agencies
- another country, if we have an information supply agreement with them
- Statistics New Zealand (for statistical purposes only).

If you ask to see the personal information we hold about you, we'll show you and correct any errors, unless we have a lawful reason not to. Call us on 0800 377 774 for more information. For full details of our privacy policy go to **www.ird.govt.nz** (keyword: privacy).

Schedular payments are payments made to people who are not employees but are contractors. This includes independent contractors, labour-only contractors and self-employed contractors. You're receiving schedular payments if you're not an employee and the type of work you're receiving a payment for is an activity listed on page 3.

If you aren't ordinarily required to have tax deducted from payments you receive you can choose to have tax deducted from them, they'll be treated as schedular payments, if the person paying you agrees. You will need to get their agreement in writing.

Use the flow chart below to work out what tax rate to use



A If you have a special tax rate (STR) certificate enter your special tax rate on page 1 and show your original STR certificate to your payer.

An STR is a tax rate worked out to suit your individual circumstances. You may want an STR if the minimum tax rate that applies to you will result in you paying too much tax. For example, if you have business expenses that will lower the amount of tax you need to pay on your income. You can apply for an STR certificate by downloading a *Special tax code application (IR23BS)* from our website or by calling 0800 257 773. Please have your IRD number handy.

If you're a non-resident contractor the application process is different. For more information go to **www.ird.govt.nz** (search keywords: NRCT special rate).

B If you don't want tax deducted from your schedular payments, you may be able to apply for a Certificate of exemption (COE) online using the *Request for PAYE exemption on schedular payments (IR332)* form on our website.

If you're a resident contractor paid by a labour hire business under a labour hire arrangement you cannot use a COE for these payments. You may be able to apply for a 0% special tax rate instead by completing an IR23BS.

For more information about COEs go to **www.ird.govt.nz** (search keywords: schedular coe).

Non-residents

Applications for non-resident contractor certificates of exemption or enquiries about non-resident contractors should be sent to:

Post:
Team Leader
Non-resident Contractors Team
Large Enterprises Services
PO Box 2198
Wellington 6140
New Zealand

Email: **Nr.contractors@ird.govt.nz**
Phone: 64 4 890 3056
Fax: 64 4 890 4502

Additionally, the following may be entitled to an exemption from tax:

- non-resident entertainers taking part in a cultural programme sponsored by a government or promoted by an overseas non-profit cultural organisation
- non-resident sports people officially representing an overseas national sports body.

Post:
Team Leader
Non-resident Entertainers Unit
Large Enterprises Services
PO Box 76198
Manukau City
Auckland 2214
New Zealand

Email: **Nr.entertainers@ird.govt.nz**
Phone: 64 9 984 4329
Fax: 64 9 984 3081

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Schedular payment tax rates

If you are receiving payment for any of the types of work listed below, enter the activity number in the box at section 2 on page 1.

The description of activities covered may not be exhaustive. For a more detailed description see schedule 4 of the Income Tax Act 2007. You'll generally be required to file an income tax return at the end of the tax year.

If you receive schedular payments you will receive an invoice for your ACC levies directly from ACC.

Activity number	Activity description	Standard tax rate – %	No-notification rate – %
1	ACC personal service rehabilitation payments (attendant care, home help, childcare, attendant care services related to training for independence and attendant care services related to transport for independence) paid under the Injury Prevention and Rehabilitation Compensation Act 2001	10.5	45
2	Agricultural contracts for maintenance, development, or other work on farming or agricultural land (not to be used where CAE code applies)	15	45
3	Agricultural, horticultural or viticultural contracts by any type of contractor (individual, partnership, trust or company) for work or services rendered under contract or arrangement for the supply of labour, or substantially for the supply of labour on land in connection with fruit crops, orchards, vegetables or vineyards	15	45
4	Apprentice jockeys or drivers	15	45
5	Cleaning office, business, institution, or other premises (except residential) or cleaning or laundering plant, vehicle, furniture etc	20	45
6	Commissions to insurance agents and sub-agents and salespeople	20	45
7	Company directors' (fees)	33	45
8	Contracts wholly or substantially for labour only in the building industry	20	45
9	Demonstrating goods or appliances	25	45
10	Entertainers (New Zealand resident only) such as lecturers, presenters, participants in sporting events, and radio, television, stage and film performers	20	45
11	Examiners (fees payable)	33	45
12	Fishing boat work for profit-share (supply of labour only)	20	45
13	Forestry or bush work of all kinds, or flax planting or cutting	15	45
14	Freelance contributions to newspapers, journals (eg, articles, photographs, cartoons) or for radio, television or stage productions	25	45
15	Gardening, grass or hedge cutting, or weed or vermin destruction (for an office, business or institution)	20	45
16	Honoraria	33	45
17	Modelling	20	45
18	Non-resident entertainers and professional sportspeople visiting New Zealand	20	N/A
19	Payment by a labour hire business to any person (eg individual, partnership, trust or company) performing work or services directly for a client of the labour hire business or a client of another person, under a labour hire arrangement	20	45
20	Payments for: – caretaking or acting as a guard – mail contracting – milk delivery – refuse removal, street or road cleaning – transport of school children	15	45
21	Proceeds from sales of: – eels (not retail sales) – greenstone (not retail sales) – sphagnum moss (not retail sales) – whitebait (not retail sales) – wild deer, pigs or goats or parts of these animals	25	45
22	Public office holders (fees)	33	45
23	Shearing or droving (not to be used where CAE code applies)	15	45
24	Television, video or film: on-set and off-set production processes (New Zealand residents only)	20	45
25	Voluntary schedular payments	20	45
	If you are a non-resident contractor receiving a contract payment for a contract activity or service and none of the above activities are applicable, then:		
26	Non-resident contractor (and not a company)	15	45
27	Non-resident contractor (and a company)	15	20

Note: If you need help choosing your tax rate use the estimation tool at **www.ird.govt.nz** (search keywords: contractor tax rate tool)

HAWKE'S BAY
District Health Board
Whakawāteatia

CLINICAL SERVICES PLAN

Verbal Update

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HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Oral Health** For the attention of: **Māori Relationship Board, HB Clinical Council, HB Health Consumer Council and the HBDHB Board**
Document Owner	Sharon Mason, Executive Director Health Services
Document Author	Robin Whyman, Clinical Director for Oral Health Services and Communities, Women and Children Directorate
Reviewed by	Charrissa Keenan, Health Gains Advisor, Māori Health; Wietske Cloo, Deputy Service Director for Communities, Women and Children Directorate; Claire Caddie, Service Director for Communities, Women and Children Directorate and the Executive Management Team
Month / Year	June 2018
Purpose	For monitoring
Previous Consideration Discussions	This report is provided annually.
Summary	Inequity in dental caries levels has multiple causes that are continually developing and changing and there is no universal solution. A wide ranging programme of work of is developing around early childhood oral health with partners across, and external to, the DHB including activity in service change, population health activities and healthy environments
Contribution to Goals and Strategic Implications	• Improving experience of care. • Improving Health and Equity for all populations; • Improving Value from public health system resources.
Impact on Reducing Inequalities / Disparities	Improved equity and reduction of oral disease in Māori , Pacific and young children living in poverty.
Consumer Engagement	Te Roopu Matua – Māori Oral Health Advisory Group established and partners at the table of the project Steering Group for improving equity in oral health for children under 5 years.
Other Consultation / Involvement	Not applicable for this report
Financial / Budget Impact	Not applicable for this report
Timing Issues	Not applicable for this report
Announcements / Communications	Nil

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RECOMMENDATION:

That the Executive Management Team, Māori Relationship Board HB Clinical Council, HB Health Consumer Council, and HBDHB Board

1. **Note** the content of this report
2. **Endorse** the recommendations and identified areas for improvement

HAWKE'S BAY District Health Board Whakawāteatia

Te Ara Whakawaiora: Oral Health

Author:	**Robin Whyman,**
Designation:	**Clinical Director for Oral Health Services and Communities, Women and Children Directorate**
Date:	**18 May 2018**

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OVERVIEW

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

UPCOMING REPORTS

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

Priority	Indicator	Measure	Champion	Reporting Month
Oral Health *National Indicator*	1. % of eligible pre-school enrolments in DHB-funded oral health services. 2. % of children who are caries free at 5 years of age	≥95% ≥67%	Robin Whyman	**MAY 2018**

MĀORI HEALTH PLAN INDICATOR: Oral Health

Oral health, general health and quality of life
Dental decay (dental caries) is one of the most common preventable chronic diseases. It is an important public health problem because of its prevalence, impact on individuals, society, and the public health system.

Severe early childhood caries affects the child's first (primary) teeth and reduces a child's quality of life: causing pain and discomfort, it affects eating and sleeping, prevents healthy growth and weight gain and reduces immunity to disease. Dental caries in early childhood is strongly predictive of an ongoing childhood and adulthood risk of dental caries.

A second opportunity to measure the impact of early investment in prevention of dental caries occurs at Year 8 when the number of adult decayed, missing and filled (DMF) teeth are measured and reported.

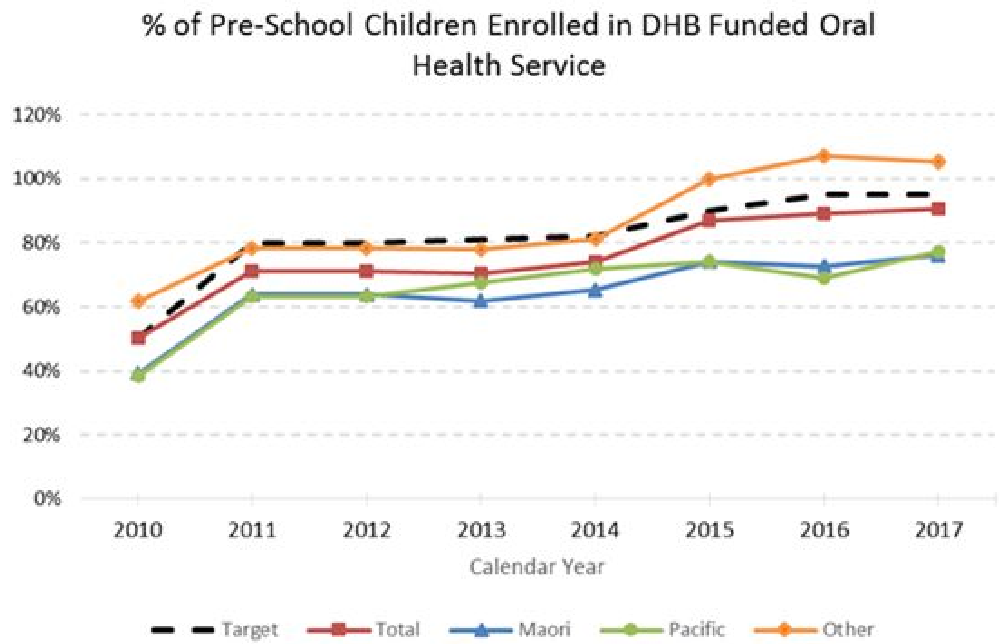
Management of dental caries occupies considerable DHB resources to treat children and adolescents and private resources to manage the effects in adulthood. Untreated acute and chronic infections lead to a higher risk of hospitalisation and loss of school days and work days which has implications for a child's ability to learn and an adult's ability to work.

The determinants of dental caries are known — the risk factors include diet (sugar consumption) and poor oral hygiene. Poverty is also an identified risk factor for dental caries, but the how and why aspects of this relationship are less understood. Effective population health strategies and clinical prevention methods have substantially reduced the amount of dental caries in the child population and reduced the impact of dental caries for the community. However, these improvements are not equitable across all population groups, and barriers to access and substantial inequities in oral health outcomes remain.

Inequality in outcomes in oral health status for Māori
Tamariki Māori and Pacifica, and those children living in socioeconomic disadvantage experience poorer outcomes in oral health status (National Health Committee, 2003). These tamariki also tend to enrol and use oral health services later compared to non-Māori children, highlighting the need to explore in greater detail an appropriate and responsive model of oral health care services for this population group.

WHY IS THIS INDICATOR IMPORTANT?

Percentage of preschool children enrolled in DHB Funded Oral Health Service



	Target	Total	Maori	Pacific	Other
2010	50%	50.4%	39.2%	38.3%	61.9%
2011	80%	71.1%	63.8%	63.3%	78.4%
2012	80%	71.1%	63.8%	63.3%	78.4%
2013	81%	70.4%	61.9%	67.4%	78.0%
2014	82%	73.9%	65.3%	71.7%	81.3%
2015	90%	87.1%	74.1%	74.2%	99.8%
2016	95%	89.2%	72.7%	69.1%	107.0%
2017	95%	90.5%	76.1%	77.1%	105.2%

Early preschool enrolment and engagement with Oral Health Services is considered a key preventive strategy to improve preschool oral health. Earlier engagement raises the profile of good oral health for whanau, enables a relationship to develop between whanau and the Community Oral Health Service teams, increases the preventive care provided by clinical teams and increases the provision of anticipatory advice to parents and guardians prior to the development of early childhood dental caries.

Preschool children enrolled in DHB oral health services have increased rapidly as the DHB has focused on the national priority of earlier preschool enrolment in oral health services. However, the 2016 results raised concerns about the quality of the ethnicity coding.

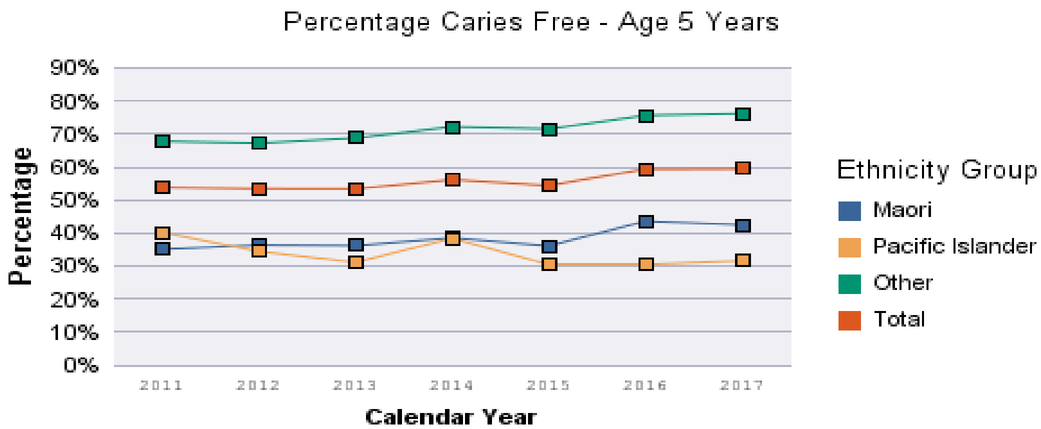
The 2017 results reflect pleasing increases in the proportion of Maori preschool children enrolled, but more importantly the absolute numbers enrolled has increased by a further 234 children. Māori enrolled has increased by 192 children, and Pacific by 56 children. Other children have decreased by 14 children and remain at over 100%.

Considerable work has been put into checking the ethnicity of children enrolled in the Titanium oral health patient management system and comparison with the ethnicity recorded in ECA from the national databases. Data cleansing, along with an absolute increase in numbers enrolled is responsible for the improved result as enrolments primarily occur from the quadruple enrolment process at birth to primary care, immunisation services, Well Child/Tamariki Oral and oral health at birth.

However, a discrepancy exists as we remain reporting 105.2% Other children are enrolled. Our conclusion after discussion with other DHBs and other services reporting preschool data is that this reflects discrepancies in the denominator figures used to report this indicator, which are provided by the Ministry of Health, but based on census projections from the Department of Statistics.

The overall level of preschool enrolment and the continued improvement for tamariki Māori and Pacifica is encouraging and our focus will be to ensure these gains do not level off.. However, the challenge is to engage all of these tamariki/children and their whānau/families with Oral Health Services. Improvements in oral health status will be maximised when tamariki/children are engaged and seen by the Oral Health Services. Our efforts are focused on achieving this goal via the Equity <5 years project. . Ongoing attention to data quality is required. Updated denominator figures may move this indicator after the 2018 census data are available.

Percentage of children who are caries free at 5 years of age



	Target	Total	Maori	Pacific	Other
2010	58%	58.4%	38.1%	34.2%	72.5%
2011	54%	54.0%	35.1%	39.8%	67.5%
2012	54%	54.1%	36.9%	39.2%	65.5%
2013	64%	54.2%	36.7%	31.2%	66.3%
2014	65%	56.5%	38.7%	38.0%	71.2%
2015	65%	54.4%	36.0%	30.5%	70.1%
2016	67%	59.0%	44.0%	31.0%	74.0%
2017	67%	59.5%	42.5%	31.6%	75.1%

The percentage of children caries free (decay free) at 5 years measures the proportion of children that are 5 years of age, and commencing school education without dental decay severe enough to have caused cavitation (holes) to develop in the primary teeth.

Caries free at 5 years is an important indicator as longitudinal studies indicate that children with good early childhood oral health have improved Year 8, adolescent and adult oral health. Children that are free of dental decay in the preschool and early primary school years are also less disrupted with education, eating and sleeping and have better general health.

The 2016 results represented a substantial improvement in outcomes for all groups except Pacific where only a small improvement was noted.

2017 results represent Minimal changes. There was a small decline for Maori and a small gain for Pacific children, who experience the worst oral health among Hawke's Bay groups. Importantly the substantial gain reported in 2016, against the previous trend, has largely been held. The improvement to the proportion of Other children decay free means the inequality in this indicator has not improved in 2017.

The target of 67% caries free has not yet been achieved for Māori or Pacific children, and results for both groups remain particularly concerning.

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

Activity planned to support these indicators has been

1. *Quadruple enrolment in the oral health service from birth, alongside enrolment for primary care, Well Child/Tamariki Oral and immunisation services.*
   Ethnicity coding and data accuracy in the Titanium database was reviewed and updated in early 2018. Ongoing work is checking the accuracy of the database for double enrolments

2. *Improve whānau engagement with early childhood oral health services*
   A Kaiawhina employed in the Community Oral Health Service started in July 2017 and was able to bring 282 children back into the service in the first 6 months. The Hastings Central team have adjusted their booking and appointment systems to be able to accommodate Kaiawhina appointments for families. Changes to ensure a flexible and responsive model of care for tamariki/children under 5 years are being explored to avoid losing these children in the first place.

3 *Changing the relationships with Māori health providers*
Changes to incorporate additional visits for high risk whanau through the Well Child Tamariki Ora providers contracts between Te Taiwhenua o Heretaunga, Kahungunu Executive, Plunket NZ and Māori Health and were implemented in late 2017. The emphasis of this work is to engage tamariki/children and their whānau with the Oral Health Service by age 1 year, and subsequent annual visits.

Changes to the operation of the Titanium database operated by the Community Oral Health Service were put in place for the start of the 2017 calendar year to enable Well Child/ Tamariki Ora providers to select and place appointments for tamariki and whanau directly in the system.

4 *Audit of the clinical pathway and patient experience for preschool children receiving dental care under general anaesthetic*
During 2017 and early 2018 an audit of preschool children who received dental care under general anaesthetic was undertaken including data review and whanau interviews. A series of recommendations are being finalised with the Steering Group for the project improving equity in oral health for children under 5 years.

5 *Improving preventive practice in the Community Oral Health Service*
Work with the clinical teams of dental therapists to improve the utilisation of fluoride varnish, bite wing radiography and fissure sealants to prevent dental decay is ongoing. All of the indicators show improvement and work is currently focussed on reducing variation between clinical teams across the service. 16

6 *Training in Relationship Centred Practice*
Training for the clinical teams in relationship centred practice was undertaken during 2017 by the Director of Allied Health as part of the service's ongoing programme of in-service education.

7 *Community water fluoridation*
Community water fluoridation remains an ongoing and serious concern as it has been absent from the Hastings District Council supply since August 2016 and no clear timeframe for its reinstatement has been announced by Hastings District Council.

A submission to Select Committee supporting the Health (Fluoridation of Drinking Water) Amendment Bill, by the DHB, was made in January 2017 and an oral submission made, on behalf of the DHB in March 2017. A conversation with the Central Hawke's Bay water team was held in October 2017. Further progress on extension of community water fluoridation (beyond Hastings) is now awaiting progress on the Bill by the government.

8 *Population health strategies*
Population health strategies are an important contributor to improving child oral health, and in particular:

HBDHB's *Best Start Healthy Eating and Activity: A Plan (2016-2020),* with 4 interlinking objectives:

1) Increasing healthy eating and activity environments – Working with Sport Clubs and Code via Sport HB to introduce healthy food choices and Water is the Best Drink". Work continues with Schools to promote 'Water is the Best Drink' and supporting water only schools. Work has started with early childhood centres to support healthy weight and oral health. Key HB events are delivering "Water is the Best Drink" messaging. A church with 2000 members in Flaxmere adopted a water only policy in November 2017. All events and activities held at or outside the church facilities are water only. Recent report back has indicated successful implementation with minimal disruption.

2) Develop and deliver prevention programmes - “Healthy Foods- Healthy Teeth and eating for under 5’s” is now finalised and distributed to B4SC nurses and other health professionals – the information on oral health has been enhanced as part of this process.

3) Intervention to support children to have healthy weight – Raising Healthy Kids Health Target is supporting referral to lifestyle change programme which include healthy eating, water only and oral health -the BESMARTER Goal Setting Tool has been adapted to include oral health activity.

4) Provide leadership in healthy eating - HBDHB Board has endorsed the reviewed Healthy Eating Policy and this now aligns with the MoH’s guideline. The DHB is sugar sweetened beverage free and soon will be mostly confectionary free.

The DHB enhanced this in March 2018 when a “Water for Kids” programme and policy was introduced in the Paediatric Ward and SCBU at Hawke’s Bay Hospital.

Breastfeeding
The March 2017 Te Ara Whakawaiora: Breastfeeding report acknowledged that currently challenges exist meeting the 6 week target and that a drop off occurs between 6 weeks and 3 months. Initiatives to improve and sustain early breastfeeding are important to early childhood oral health. Recent literature (Gussy et al 2016) has demonstrated that early introduction of sugary beverages (before 18 months) is significantly associated with early development of dental caries. Initiatives associated with breastfeeding have been reported in the Te Ara Whakawaiora: Breastfeeding report identifying a new 6 week to 6 month programme initiative run by TTOH, Plunket HB and Kahungunu Executive to provide in home breastfeeding support. The emphasis of this contract is to provide appropriate advice and support for Māori and Pacific mothers and their whānau. From discharge to 6 weeks recent sign off has agreed an LMC incentive package to increase postnatal visits during the first two weeks post birth and a consistent messaging community based campaign.

Oral health promotion
The intermittent national campaign and TV advertisement run by the Ministry of Health and Health Promotion Agency “Baby Teeth Matter” and brushing teeth with fluoride toothpaste 2x a day are being supported locally with posters and repeated on the HBDHB Facebook page. Evaluation of the national programme by the Health Promotion Agency reported strong recognition and resonance with the programme particularly for Māori and Pacific whānau.

In addition to these initiatives, other population health activities that reduce the effects of poverty and improve living standards for whānau are linked to improvements in health, including oral health. An example of these initiatives is the Child Healthy Housing programme.

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

Māori and Pacific preschool enrolment and engagement with Oral Health Services and improvements in the proportion of Māori and Pacific children caries free at 5 years represent a complex interplay of societal, environmental and service delivery factors.

1 Under 5 years equity project-
In late 2016 the Communities, Women and Children directorate commenced a project focussing on delivering equity in oral health outcomes for 5 year-olds with a 5 year time frame.

The project is aiming to:

- strengthen consumer engagement and participation with Oral Health and to substantially improve consumer input to Oral Health Services and to oral health strategies to improve child oral health.
- coordinate consistent messaging and health promotion activity focussing on improving equity in early childhood oral health.
- improve whānau engagement with early childhood oral health services commenced in the Hastings Central community clinic hub.
- spread innovation that is successful within the service.
- work in collaboration with other providers for early childhood such as B4SC, Health Hawkes Bay, Well Child Tamariki Ora providers, Child Health Team, Early Childhood Education & Kohanga Reo and Outreach Immunisation teams to reduce the siloed nature of oral health services delivery.
- Lead improvement to ensure culturally appropriate and responsive oral health services
- influence policy change, particularly for water only environments
- review practice and implement change, or advocate for change, where appropriate

The project sponsors are the Service Director Communities Women and Children and Clinical Director for Oral Health, the Project Manager is the Communities Women and Children Deputy Service Director and a Project Steering Group with broad representation from services, Māori Health, PHO and consumer has been established.

2 Workforce change and kaiawhina engagement

Community Oral Health Services have changed the service's workforce mix by redeploying a clinical vacancy within the service to employ a kaiawhina to support the service's engagement with the community and other providers. This initiative commenced at the Hastings Central hub clinic and the preschool attendance rate has improved from 72.8% to 76.7% at the clinic. The Kaiawhina is expanding her work to Mahora and Flaxmere, and assisting the wider service and further work to investigate the role of kaiawhina in the model of service and workforce mix within the Community Oral Health Service.

3 Clinical quality indicators

Community Oral Health Services are continuing to monitor the implementation of a greater preventive focus in the clinical activity of the service. This involves monitoring 3 quality indicators (fluoride varnish, bitewing radiography and fissure sealants). Levels of use of fissure sealant use are satisfactory. Fluoride varnish use requires better targeting and work is ongoing to ensure that children at greatest clinical risk are receiving 6-montly applications of fluoride varnish.

Use of bitewing radiography remains lower than optimal as it represents a significant clinical practice change, but levels have continue to improve throughout 2017. Six-monthly reporting to the service and peer discussion is being used to effect these changes to clinical practice.

RECOMMENDATIONS FROM TARGET CHAMPION

The primary concerns associated with these preschool oral health outcomes relate to

1 Enrolment data quality

Work needs to continue to ensure that Māori and Pacific 5-year-old children are enrolled for oral health services and are as correctly reported as the denominator data allows. That work will continue by checking the Titanium oral health database has the status of children correctly reported. Further change may occur once the 2018 census becomes available with updated denominator data for preschool child numbers.

2 Accelerating equity in caries free status Māori and Pacific children

The project to improve equity in 5-year-old caries free status is ambitious and aims to take a cross sector focus. It will require ongoing support over 3-4 years to achieve the planned outcomes. Multiple initiatives are planned and are outlined in the table below.

3 Community water fluoridation

An ongoing conversation is required with Hastings District Council regarding the reinstatement of community water fluoridation as water plant improvements are made following the Havelock North gastro illness. Reinstatement is a high priority for Maori and Pacific oral health, particularly when the decline in Maori 5-year-old oral health in CHB is considered as reported in this report in 2016.

Work on community water fluoridation is primarily awaiting further progress on the Health (Fluoridation of Drinking Water) Amendment Bill. However, in the meantime meetings with drinking water staff of the Councils are held where appropriate to discuss the proposed changes under the Bill. It is appropriate to wait until the outcomes of the Bill are clear before making wider recommendations for community water fluoridation in Hawke's Bay.

4 Model of care improvements.

Both the audit of the clinical pathway and patient experience for preschool children receiving dental care under general anaesthetic and the demands of an aging workforce are strong drivers for continued attention to the model of care. Issues are being identified both within the Community Oral Health Service and across the DHB and the Hawke's Bay health system. The Community Oral Health Service is embarking on review of the model of care and will develop a paper recommending the mix of clinical, administration and Kaiawhina staffing that best supports the contemporary needs of the population group. It is also important that recommendations from the audit are finalised and confirmed by the Steering Group of the project group focussed on equity in oral health for children under 5 years and that an action plan is then developed to work through the recommendations.

The identified areas for improvement and timeframes are outlined in the following table

Description	**Responsible**	**Timeframe**
Continue quality control of the ethnicity coding and patient status accuracy within the oral health patient management system (Titanium)	Unit Manager Oral Health Clinical Director for Oral Health Children, Women and Communities Deputy Service Director	June 2019
Under 5 years of age caries free equity project Consumer engagement, participation and feedback. Te Roopu Matua is established and their guidance and advice assists in project delivery and prioritisation.	Project Manager and Project Steering Group Unit Manager Oral Health	Phase 2 Jan – Dec 2018 and Total project 2017-2019 Total project 2017-2019 throughout the project

Healthy Foods - Healthy Teeth and eating for under 5s prevention programme Specific tools for ECE, Kohanga Reo and Pacific Island Language nests are being developed with the sector Environmental scanning of water only policies and decisions about next steps, Water for kids in Paediatric ward and SCBU evaluation July 2018 and decisions about widening of the scope Early intervention in general practice in conjunction with Systems Level Measures work. Heath HB to trial the "lift the lip" at 15 month immunisation with 2 high needs practices (2018-2019) Agree recommendations from preschool child general anaesthetic audit and develop action plan	Population Health Oral Health Population Health Advisor Project Manager and SLM group Project Manager	March 2019 March 2019 July 2018 July 2018 December 2018 July 2018
Community Oral Health Service Model of Care review and decisions	Deputy Service Director CWC Directorate Unit Manager Oral Health Clinical Director for Oral Health	September 2018
Well Child Tamariki Ora provider outreach services TTOH , KE and Plunket continue regular collaborative meetings with COHS to improve systems	Māori Health Services Unit Manager Oral Health	Ongoing June 2019
Continue to transition clinical service delivery towards a preventive care focus using clinical quality indicators to monitor service performance	Clinical Director for Oral Health Unit Manager Oral Health	Ongoing June 2019
Community water fluoridation Ongoing discussion with Hastings DC to establish the process and timeframe for reinstatement of community water fluoridation. Monitor legislative change timetable Build relationships with communities of interest	Clinical Director for Oral Health	December 2018 Legislative timeframe uncertain 2017-2019

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Breastfeeding initiatives to improve and sustain early breastfeeding	Breastfeeding Champion	July 2019

CONCLUSION

Eliminating inequity in dental caries levels is difficult to solve, has multiple causes, is continually developing and changing and has no universal solution. It has been described as a "wicked problem" (Thomson 2017). It represents the outcome of complex societal inequities in social conditions and health services.

However, significant steps to control early childhood dental caries would be made with region-wide access to optimally fluoridated water and removal of sugar sweetened beverages from all early childhood environments. Improvement in both of these indicators will require focus on collaborative activities to improve social and economic environments, including community water fluoridation and sugar-free environments,

A very wide ranging programme of work of is developing around early childhood oral health with partners across, and external to, the DHB. There also remains willingness by Oral Health Services to continue to question the best model of care for delivery of preschool oral health while also maintaining positive outcomes for the primary school child population.

Data quality issues, particularly related to enrolment, have improved but continue to challenge the reporting of the enrolment indicator. Some of these issues are out of the direct control of the DHB.

Dr Robin Whyman
Target Champion for Oral Health
Clinical Director Oral Health

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Gussy M et al. Natural history of dental caries in very young Australian children. *International Journal of Paediatric Dentistry*. 2016: 26: 173-183.

Thomson WM. *Oral Health and NZ Children*. Presentation to the University of Otago Public Health Summer School. Wellington. 2017.

RECOMMENDATION:

That the Executive Management Team, Māori Relationship Board HB Clinical Council, HB Health Consumer Council, and HBDHB Board

3. **Note** the content of this report
4. **Endorse** the recommendations and identified areas for improvement

HAWKE'S BAY
District Health Board
Whakawāteatia

HE NGAKAU AOTEA – STRATEGIC PRIORITIES

Discussion