Māori Relationship Board Meeting

Date:	**Wednesday, 14 November 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
General Manager Māori Health
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.

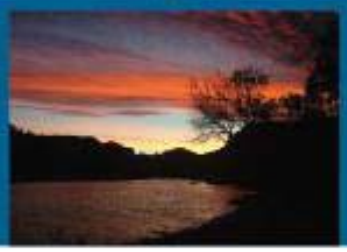
Our values

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 (am)
1.	Karakia	9.00
2.	Whakawhanaungatanga	
3.	Apologies	
4.	Interests Register	
5.	Minutes of Previous Meeting	9:30
6.	Matters Arising – Review of actions	
7.	MRB's Board Report October 2018 (for information)	
8.	Workplan	
9.	Māori Relationship Board Chair's Verbal Update – Heather Skipworth	
10.	General Manager's Monthly Māori Health Report – Patrick LeGeyt • Māori Workforce • Nuka Conference	9:50
11.	Clinical Council Verbal Update – Ana Apatu	10:25
	Section 2: For Discussion	
12.	Scoping Report – Addictions – Chris Ash	10:30
13.	Health Equity Report – Andy Phillips, Patrick LeGeyt, Nick Jones and Jess O'Sullivan	10:50
14.	Clinical Services Plan (including summary of changes and feedback) – Chris Ash	11.45
	Section 3: For Information Only (no presenters) – any feedback to document owner	
15.	Best Start Healthy Eating & Activity Plan update	-
16.	Te Ara Whakawaiora "Smokefree update" (6 monthly)	-
17.	Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) Qtly	-
18.	HBDHB Performance Framework Exceptions Q1 (July-Sept)	-
19.	**Section 4: Recommendation to Exclude the Public** Under Clause 32, New Zealand Public Health & Disability Act 2000	-

PUBLIC EXCLUDED

	Section 5: Routine	
20.	Minutes of the Previous Meetings (public excluded)	11:55
21.	Matters Arising - Review of Actions	
	Karakia Whakamutunga (Closing) – followed by light lunch	noon

NEXT MEETING:

Wednesday, 5 December 2018, Boardroom, HBDHB Corporate Office
Cnr Omahu Road & McLeod Street, Hastings

Māori Relationship Board Interest Register - 10 October 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 Whararíki Trust (a member of Takitimu Ora Whanau Collective)	A relationship which may be contractural from time to time	Will advise of any perceived or real conflict prior to discussion	PCDP Chair	5.12.16
	Active	Whakaraki Trust "HB Tamariki Health Housing fund"	Formed a relationship and MoU with HBDHB Child Health Team Community Women and Children's Directorate. The Trust created a "HB Tamariki Health Housing fund" to ensure warm dry homes for Hawke's Bay whanau.	Will advise at the outset of any discussions on this topic, and will not take part in any decisions / or financial discussions relating to this arrangement.	The Chair	8.08.18
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

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict (if any)	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by:	Date Declared
	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 (ADHT)	Contribution to the health and wellbeing of Māori in Napier, as per the settlement under WAI692.	Declare an interest and withdraw from any discussions with respect to any contract arrangements between ADHT and HBDHB	The Chair	14.06.17
	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
	Active	Contract being negotiated with the Ministry of Health for Research work in relation to WAI 2575. Contract with Ministry finalised for research work in relation to WAI2575.	Unknown at this time.	Declare any potential conflict of interest, prior an discussion on work undertaken for HBDHB and/or health service organisations.	The Chair	13.06.18 13.09.18
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
Beverley TeHuia	Active	Trustee and employee of 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	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.	The Chair	28.05.18
	Active	Claimant of Treaty Health Claim currently with the Tribunal; WAI #2575	Yet to be heard by the Waitangi Tribunal as of May 2018	Unlikely to be a conflict	The Chair	28.05.18

MINUTES OF THE MĀORI RELATIONSHIP BOARD
HELD ON WEDNESDAY 10 OCTOBER 2018, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 9.05AM

PUBLIC

Present:	Heather Skipworth (Chair) Ana Apatu Hine Flood Na Raihania Trish Giddens Lynlee Aitcheson-Johnson
Apologies	Ngahiwi Tomoana, Kerri Nuku, George Mackey, Beverly Te Huia and Fiona Cram
In Attendance:	Kevin Atkinson (HBDHB Chair) Peter Dunkerley (HBDHB Board Member) Patrick Le Geyt (Acting General Manager, Māori Health HBDHB) Chrissie Hape, (CEO of Ngati Kahungunu) Emma Foster (Deputy Executive Director, Primary Care) Lillian Ward (Māori Health Manager Health Hawke's Bay) Tiwana Aranui (Kaumatua) Hawera Hape (Kaumatua) Tiwana Aranui (Kaumātua) Tanira Te Au (Kaumātua Kuia) JB Heperi Smith (Senior Advisor Cultural Competency)
Minutes:	Brenda Crene

KARAKIA

Hawera Hape opened the meeting with a Karakia.

INTRODUCTIONS of those in attendance was undertaken.

APOLOGIES

Apologies were received from MRB members mentioned above.

In addition an apology was received from Wayne Woolrich CEO Health HB and Chris Ash, ED Primary Care

INTEREST REGISTER

A change had been advised by Trish Giddens via email the day of this meeting and the register was updated accordingly.

No members indicated any interest in items included on the day's agenda.

5. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the MRB meeting held on 12 September 2018 were approved as a correct record of the meeting.

Adopted with the spelling of Wananga amended, changes and additional comments noted.

Moved: **Na Raihania**
Seconded: **Trish Giddens**

6. MATTERS ARISING FROM PREVIOUS MINUTES

Item 1 Function and Form of MRB + Youth representative: Item closed

Item 2 Nuka Model Wānanga: Item closed

Item 3 GM Maori Health Report: Stats for Māori and non-Māori on programmes NEtP and NEsP through reporting. This will commence in November and be reported 6 monthly thereafter (May-Nov) Ongoing

Item 4 Recommendation to the HBDHB Board: around Equity and Cultural Competency. The Chair updated members under item 8 below. Item closed

Item 5 Kaupapa Maori terminology in programme development: This was further discussed in the GM Maori's report (item 9 below), with Charrissa Keenan in attendance. Item closed

Item 6 Primary Care: Unenrolled within the community, review what equity looks like in the 'access' area. CEO Health HB to follow up. Ongoing

7. MRB WORK PLAN

The Work Plan was noted for November.

8. MRB CHAIR'S REPORT

A verbal update was provided by the Chair. Concerns to Board FTs bowel screening.

Kaupapa Māori Terminology – and sensitivity around how DHB uses this. It was advised that management wish to understand more therefore MRB need to provide clear guidance as to how and how not to use the term. Charrissa Keenan provided update under item 9, around its use for Maternal Wellbeing project.

There was an active discussion around **Equity and Cultural Competency** which has come through with a recommendation to the Board.

- The Board wish to understand the background and reasoning for the Recommendation put forward by MRB.

  Following general discussion at the MRB meeting, Board Chair Kevin Atkinson rephrased the recommendation to focus more around a process to address the areas raised by MRB around Equity and Cultural Competency.

The HBDHB Board recommended:

a) that a Working Group come together to study and focus on next year's planning; and

b) that a Workshop be set up in the New Year (including MRB members and other representatives as required), the result of which will be clear actions and targets we can aim for.

This was agreed.

The CEO added that the first Equity Report (prepared by Dr Carolyne McElnay) was to raise awareness within the wider community and within the organisation. He noted there appeared to be a level of ignorance at that time, however a few years later there is now much broader acceptance. The third Equity Report (including recommendations/actions) will be released in 2018. Within the HB region, this Equity Report, together with intersector work being undertaken provides greater regional emphasis in many areas, including economic development and social inclusion. This demonstrates that the DHB is not the only player in equity, that all agencies within HB are in this together.

9. GENERAL MANAGER MĀORI HEALTH REPORT

In presenting his report Patrick LeGeyt advised for information that he had not included the Radio NZ article around synthetic drugs in HB. This had subsequently been followed up by TV3. A small group of leaders had been organised to gain some views on where to next.

The nursing gap figures provided within the GMs report did not include nurses working within General Practice. Currently HBDHB are working closely with Rochelle Robertson (of Health HB) who is participating in meetings with the Maori Workforce action plan team. The information gleaned will be shared with Health HB.

The New Oranga Niho initiative will lift the profile around delivery of oral health care to whanau to ultimately improve access within the Māori community especially CHB, Maraenui and Wairoa. Also planning is in hand to host the Defence force as part of their dental training exercise in March 2019.

It was learned that funds originally designated for Oral health delivery (in Napier) by Ahuriri District Health Trust (ADH) had been redirected to the Maraenui Medical Centre facility. Advised the focus on a capital project versus an oral health programme with no ongoing sustainable funding took priority.

- **Maori Workforce Project**

  Patrick advised a Māori Workforce Project (6 monthly update) will be provided within the GM Maori Health Report in November.

- It had been noted that the projected Māori FTE gap in 2021 will be 219 (ie, 2018/19 49; 2019/20 99; 2020/21 156 and 2021-22 = 219). That is a large number and a plan is required to ensure the numbers are lifted year on year.
- The suggestion to approach/poach Māori staff within other DHBs was not seen as acceptable.
- It was advised there has been lot of work done to ensure those identifying as Maori are included on interview / selection panels, however comment was made that this has not been done well.
- Kevin Atkinson felt there should be focus on retaining existing staff and utilising them as part of the drive to encourage others towards work/careers in health.
- First need to work on levels of cultural competency area and stamping out racism/ bullying before that can occur.

Action: Time will be included on MRB's agenda in November for discussion on Maori Workforce.

- **Kaupapa Maori terminology** and sensitivity around how the DHB uses this term had been discussed the month prior. At the HBDHB Board meeting held on 29 September 2018, it was advised that management wished to better understand more and asked MRB were to provide clear guidance as to how and how not to use the term "Kaupapa Māori".

  Kaupapa Māori Maternal Health Programme: Charrissa Keenan joined the meeting and very passionately explained the methodology used to formulate the Maternal Health and Wellbeing Project as true Kaupapa Māori. Some good positive discussion followed and Charrissa provided handouts to assist understanding.

Ā matau uarā, me ō mātou whanonga	Our expectations	What we think success looks like when we meet our expectations	Principles and practice
ĀKINA	• Tikanga Māori and beliefs about hapūtanga are supported and reflected in the service/ programme approach • Access to early antenatal care • Appropriate screening, preventive, treatment interventions, and health information • Indigenous measures monitor Māori health improvement • Delivered by a high quality trained and culturally responsive workforce	Māmā and their whānau receive the care they expect Māmā and their whānau come Māmā and their whānau tell their whānau to come Māmā and their whānau are receiving the full benefits of quality antenatal care Māmā are informed and making decisions	Poor quality of care contributes to poor health outcomes and inequity (Rumbold et al, 2011) Eliminating barriers in early life improves health in later life Equity is necessary to achieve quality Quality of care is more than timing and frequency Māmā have every opportunity to seek and receive maternal health care to ensure the best possible maternal health outcomes
HE KAUANUANU	• Māmā and her whānau feel understood and empowered by the way in which their views, beliefs, and values have been respected	I belong here I descend from deity My experience is valued	Kaupapa Māori is valid and legitimate The approach is Kaupapa Māori but of necessity, is diverse and recognises the diversity of our people so that it is accessible and available to all (Pihama, 2002). Tamariki are tapu, and are connected to and represent Atua (Jenkins et al, 2011)
RARANGA TE TIRA	• Whanaungatanga/ connections / whakapapa	I'm important Mana is intact I belong to whānau and they belong to me	Meaningful relationships will build networks of influence (Mitchell et al, 2016) Whānau are an intrinsic part of hapūtanga
TAUWHIRO	• Aroha ki te tangata • Kanohi kitea • Titiro, whakarongo, ka korero pea • Manaaki ki te tangata • Kia tupato • Kaua e takahia te mana o te tangata	People care about me Our workforce is culturally competent	Self-worth is lifted Unconscious biases are eliminated

In summary:

It was a good opportunity to provide clarity of why and how the project was developed and what we need to do to achieve the end result (the latter is unknown at this stage).

Listening to the real needs of the person is the norm. In this instance we listen to and understand that what māmā is saying is real to her. This is Māori centric. Māori academics who have fed into this work. We have a responsibility to look at whanau and challenge what is going on. Unpicking those inequities, describing, looking at data. We have a responsibility find solutions. We have a close relationship with Maternity and the Population Health team and those that are not working for Māma.

MRB members applauded and were pleased to receive the above template which reflected how our values are being delivered to our most vulnerable. This project will be an exemplar for service delivery.

10. CLINICAL COUNCIL VERBAL UPDATE

MRB observer Ana Apatu provided an update:

- Focus of late has been managing clinical risk.
- ED remains extremely busy.
- Risk within the provider arm is what we need to hear about also.
- Any concerns about care should be registered as a complaint and always relay how it made you feel as this is significant and matters greatly.

SECTION 2: DISCUSSION

11. NATIONAL BOWEL SCREENING PROGRAMME (NBSP), INDICATIVE EQUITY OUTCOMES IN MĀORI AND PASIFKIA

A draft discussion document entitled "NBSP: Hawke's Bay Equity" was provided to members the day prior to the meeting to provide some context and clarify. Emma Foster (Deputy Director of Primary Care) was in attendance for this item. MRB have been very focused for a number of months on lowering the age of bowel screening for Maori to 50 years and over and were disappointed the MoH had not agreed to this. The draft discussion document provided a summary of what was known know about inequities in the NBSP.

- Bowel cancer is the second most common cancer registered for Māori females in New Zealand (NZ) after breast cancer. For Māori males, it is the third most common cancer registered.
- Bowel cancer is currently more common amongst non-Māori, but bowel cancer incidence is increasing for Māori and Māori tend to present with more severe symptoms.
- Survival is lower for Māori than non-Māori, even when stage at diagnosis and comorbidities are adjusted for. *(National Bowel Screening Unit, Ministry of Health, Considerations of the potential equity impacts for Māori of the age range for screening, 2018).*

- What is the cost of extending the bowel screening programme for Māori to 50 years of age and up?
- What do we need to do to achieve equity in the participation rates for Māori as it currently stands?
- What are the contractual obligations that the Ministry of health have placed on us with regard to bowel screening?

Asked what were the main causes of premature death in Maori were? In response Lisa Jones (Business Intelligence Team Leader) advised:

- The main causes were Ischaemic Heart disease and Lung cancer. Recent modelling from the University of Otago have shown tobacco control offers some of the largest opportunities to reduce inequity between Maori and non-Maori mortality rates.

  For this reason incorporating smoking cessation into the bowel screening pathway would be beneficial for Maori.

- By increasing Maori participation rates in the current National Bowel Screening programme age group 60-74 years to 73 % or more, is another way to reduce inequities from the screening programme.

Emma Foster advised that to ensure overall thinking was on the right track, all that was known had been pulled together and recommendations developed on how we can reduce the equity gap.

There was general discussion after which the following recommendations were agreed:

RECOMMENDATION

That the Māori Relationship Board:

1. **Note** that National Bowel Screening Programme continues to be rolled out according to national expectations.
2. **Note** that the recommendation nationally is to wait for further data from the roll out of the NBSP as it is at the moment, as there is current uncertainty of rates of adenomas and changing rates of bowel cancer for Māori.
3. **Recommend** that we have a strong monitoring and performance management system to ensure that Māori participation/screening rates achieve 73%.
4. **Identify** some options that may assist management in effectively targeting our Māori population in the screening programme, enable management to utilise available resources effectively and with the best outcome.
5. **Agree** that management advocate on behalf of MRB to become one of the early adopters for any future pilot relating to extending the age of screening for Māori.
6. **Recommend** once the Health Equity Report is complete, that a programme of work is developed with MRB, to reduce Māori health inequities.

Moved: **Ana Apatu**
Seconder: **Hine Flood**

Carried

SECTION 3: FOR INFORMATION ONLY (NO PRESENTER)

12. TE ARA WHAKAWAIORA – CARDIOVASCULAR (NATIONAL INDICATOR)

The report provided summarised the challenge within the central region in meeting the access to angiography indicator for our total population and for Maori due to CCDHB's limited ability to meet regional demand. It is doubtful that Hawke's Bay will meet these indicators without development of a local interventional cardiology service.

RECOMMENDATIONS FROM TARGET CHAMPION

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

It was advised that a review of service provision is being undertaken.

SECTION 4: RECOMMENDATION TO EXCLUDE THE PUBLIC

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

14. Minutes of Previous Meeting
15. Matters Arising – Review of Actions nil
16. He Ngākau Aotea
17. Nuka Conference

Moved: **Ana Apatu**
Seconder: **Trish Giddens**

There being no further business, the public section of the meeting closed at 11.05am

Signed: _____
Chair

Date: _____

MAORI RELATIONSHIP BOARD MEETING
MATTERS ARISING (Public)

Action #	Date Issue first Entered	Action to be Taken	By Whom	Month	Status
1	8 Aug 18	**Ref: HBDHB Performance Framework Exceptions Report Q4** **Did not Attend:** Colin Huchinson advised he would come back with a response and breakdowns for a solution to curb DNAs (which lies with a number of providers), including looking further into highly automated IT solutions – with the ability for clients to respond. He will confer with the **Customer Focussed Booking Team**. Paper planned in Nov 2018 – on workplan	Colin Hutchison	Sep 18 Nov 18	Verbal Update Agenda item Nov
2	12 Sept 18	**GM Maori Health Report** Ngaira Harker to provide stats for Māori and non-Māori on programmes NEtP and NEsP. To be included in GMs Report (Nov) and updates will be provided.	Ngaira Harker		Included. Item closed.
3	12 Sept 18	**Primary Care – resulting from Urgent Care Update** • MRB are concerned about the large number of unenrolled people within HB and want Management to advise what is being done to rectify this? Refer to MRB minutes for further information.	Chris Ash and Wayne Woolrich		Verbal Update
3	10 Oct 18	**Equity and Cultural Competency Recommendation** to HBDHB Board 12 September. Board response follows - around process: 1 A Working Group will come together to study and focus on next year's planning; and 2 The DHB will set up a Workshop in the New Year (including MRB members and other representatives as required), the result of which will be clear actions and targets we can aim for.	Kevin Snee	TBD Feb 19	
5	10 Oct 18	**Maori Workforce Project** Include extra time on the November MRB agenda to discuss the report which will be included within the GM Maori Health Report.	Patrick LeGeyt		Agenda Item Nov

Action #	Date Issue first Entered	Action to be Taken	By Whom	Month	Status
6	10 Oct 18	**Many aspects of the NUKA system have already incorporated into the Clinical Services Plan.** CEO would like linkages shown.			

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board** 144
	For the attention of: **HBDHB Board**
Document Owner:	Heather Skipworth, Chair
Document Author:	Brenda Crene, Board Administrator
Reviewed by:	Not applicable
Month:	October, 2018
Consideration:	For Information

7

RECOMMENDATION

That the Board

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

Note that the Maori Relationship Board:

- **Discussed** detail relating to National Bowel Screening Programme, Indicative Equity Outcomes in Māori and Pasifika and **endorsed** the recommendation.
- **Received** and discussed the Te Ara Whakawaiora – Cardiovascular HBDHB paper, noting recommendations from the Target Champion.

The Māori Relationship Board met on 10 October 2018. An overview of issues discussed and/or agreed at the meeting is provided below.

NATIONAL BOWEL SCREENING PROGRAMME (NBSP), INDICATIVE EQUITY OUTCOMES IN MĀORI AND PASIFIKA

Emma Foster (Deptuy ED – Primary Care) provided a draft discussion document entitled "NBSP: Hawke's Bay Equity" the day prior to the meeting to provide some context and clarify. MRB have been very focused for a number of months on lowering the age of bowel screening for Maori to 50 years and over and were disappointed the MoH had not agreed to this. The draft discussion document provided a summary of what was known know about inequities in the NBSP.

- Bowel cancer is the second most common cancer registered for Māori females in New Zealand (NZ) after breast cancer. For Māori males, it is the third most common cancer registered.
- Bowel cancer is currently more common amongst non-Māori, but bowel cancer incidence is increasing for Māori and Māori tend to present with more severe symptoms.
- Survival is lower for Māori than non-Māori, even when stage at diagnosis and comorbidities are adjusted for. *(National Bowel Screening Unit, Ministry of Health, Considerations of the potential equity impacts for Māori of the age range for screening, 2018).*

MRB asked what were the main causes of premature death in Maori? In response Lisa Jones (Business Analyst) advised:

- The highest causes were Ischaemic Heart disease and Lung cancer. Recent modelling from the University of Otago have shown tobacco control offers some of the largest opportunities to reduce inequity between Maori and non-Maori mortality rates.

For this reason incorporating smoking cessation into the bowel screening pathway would be beneficial for Māori.

- By increasing Māori participation rates in the current National Bowel Screening programme age group 60-74 years to **73 % or more**, is another way to reduce inequities from the screening programme.

To ensure overall thinking was on the right track, all that was known had been pulled together and recommendations developed on how we can reduce the equity gap. There was some general discussion, after which the following **recommendations were endorsed**:

1. Note that National Bowel Screening Programme continues to be rolled out according to national expectations.
2. Note that the recommendation nationally is to wait for further data from the roll out of the NBSP as it is at the moment, as there is current uncertainty of rates of adenomas and changing rates of bowel cancer for Māori.
3. Recommend that we have a strong monitoring and performance management system to ensure that Māori participation/screening rates achieve 73%.
4. Identify some options that may assist management in effectively targeting our Māori population in the screening programme, enable management to utilise available resources effectively and with the best outcome.
5. Agree that management advocate on behalf of MRB to become one of the early adopters for any future pilot relating to extending the age of screening for Māori.
6. Recommend once the Health Equity Report is complete, that a programme of work is developed with MRB, to reduce Māori health inequities.

TE ARA WHAKAWAIORA – CARDIOVASCULAR (NATIONAL INDICATOR)

The report was taken as read and MRB agreed with the recommendation from the Target Champion that: The Medical Directorate leadership team in conjunction with the cardiology service will continue to monitor and review its strategies to ensure sustained compliance with both cardiovascular indicators. The service will continue to participate in TAS cardiac network activities to align with regional and national strategies. MRB noted that a review of service provision is about to be undertaken.

EQUITY AND CULTURAL COMPETENCY

Following further discussion with MRB around the recommendation put to the HBDHB Board in September, the HBDHB Board Chair (who attended the MRB meeting) rephrased and MRB agreed to the following recommendation, to focus more around process to address the areas raised:

1. that a Working Group come together to study and focus on next year's planning; and
2. that a Workshop be set up in the New Year (including MRB members and other representatives as required), the result of which will be clear actions and targets we can aim for.

MĀORI WORKFORCE PROJECT

A six monthly project update will be provided within the GM Maori Health's report in November and it was requested that extra time be included on the MRB agenda to further discuss this matter.

KAUPAPA MAORI TERMINOLOGY

Sensitivity around how the DHB uses this had been discussed the month prior. HBDHB management wished to better understand and asked MRB were to provide guidance as to how and how not to use the term "Kaupapa Māori".

Kaupapa Māori Maternal Health Programme: Charrissa Keenan joined the meeting and very passionately explained the methodology used to formulate the Maternal Health and Wellbeing Project as true Kaupapa Māori. Some good positive discussion followed and Charrissa provided handouts to assist understanding.

MRB members applauded and were pleased to receive the template, which reflected how our values are being delivered to our most vulnerable. This project will be an exemplar for service delivery.

MRB Workplan as at 6 November 2018 (subject to change)	**Destination Month**	**EMT Member**	**MRB Meeting Date**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**BOARD Meeting date**
Health Equity Report	Nov-18	Andy Phillips	14-Nov-18	14-Nov-18	15-Nov-18	28-Nov-18
Clinical Services Plan (Summary of changes and feedback)	Nov-18	Ken Foote	14-Nov-18	14-Nov-18	15-Nov-18	28-Nov-18
Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-May-Nov18)	Nov-18	Andy Phillips	14-Nov-18	14-Nov-18	15-Nov-18	28-Nov-18
HBDHB Performance Framework Exceptions Q1 Nov 18 Feb 19 /May/Aug 19	Nov-18	EMT Lead TBC	14-Nov-18			28-Nov-18
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY	Nov-18	Chris Ash	14-Nov-18	14-Nov-18	15-Nov-18	28-Nov-18
Te Ara Whakawaiora "Smokefree update" (6 monthly May-Nov) each year	Nov-18	Andy Phillips	14-Nov-18	14-Nov-18	15-Nov-18	28-Nov-18
Mental Health and Addictions (Board action) late paper	Nov-18	Chris Ash	14-Nov-18	14-Nov-18	15-Nov-18	28-Nov-18
Maternal Wellbeing Programme Update	Dec-18	Patrick LeGeyt	5-Dec-18	5-Dec-18	6-Dec-18	19-Dec-18
Mobility action plan implementation - progress update on the phases	Dec-18	Andy Phillips	5-Dec-18	5-Dec-18	6-Dec-18	19-Dec-18
People Plan (6 monthly - Dec, Jun)	Dec-18	Kate Coley	5-Dec-18	5-Dec-18	6-Dec-18	19-Dec-18
Te Ara Whakawaiora - Alcohol and other Drugs (National and Local Indicators)	Dec-18	Andy Phillips	5-Dec-18	5-Dec-18	6-Dec-18	19-Dec-18
Te Ara Whakawaiora - Improving First Specialist Appointment Access (previously did not attend)	Dec-18	Colin Hutchison	5-Dec-18	5-Dec-18	6-Dec-18	19-Dec-18
Customer Focussed Booking Update **- was quarterly in 2017.** Action Aug 2018 (MRB) needs responding to.	Dec-18	Colin Hutchison	5-Dec-18		6-Dec-18	
Te Ara Whakawaiora REVIEW (paper and discussion)	Dec-18	Patrick LeGeyt	5-Dec-18	5-Dec-18	6-Dec-18	19-Dec-18
Alcohol Harm Reduction Strategy (6 monthly update) Nov-May-Nov-May 9 ..... Realign dates	Feb-19	Andy Phillips	13-Feb-19	13-Feb-19	14-Feb-19	27-Feb-19
HBDHB Performance Framework Exceptions Q2 Nov 18 Feb 19 /May/Aug 19 (jit)	Feb-19	EMT Lead TBC	13-Feb-19			27-Feb-19
Te Ara Whakawaiora - Mental Health (MRB Action)	Feb-19	Patrick LeGeyt	13-Feb-19			
Ngatahi Vulnerable Children's Workforce Development - annual progress Feb 19 (annual update)	Feb-19	Colin Hutchison	13-Feb-19	13-Feb-19	14-Feb-19	27-Feb-19
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov-Feb-May	Feb-19	Chris Ash	13-Feb-19	13-Feb-19	14-Feb-19	27-Feb-19
Matariki Regional Development Strategy and Social Inclusion Strategy update (6 mthly) Sept-Mar	Mar-19	Andy Phillips	13-Mar-19	13-Mar-19	14-Mar-19	27-Mar-19
Te Ara Whakawaiora - Breastfeeding (National Indicator)	Mar-19	Chris McKenna	13-Mar-19	13-Mar-19	14-Mar-19	27-Mar-19
After Hours Urgent Care Service Update 6mthly (Sept-Mar-Sept)	Mar-19	Wayne Woolrich	13-Mar-19	13-Mar-19	13-Mar-19	27-Mar-19
Violence Intervention Programme Presentation Committees reviewed in July - EMT Nov Committees March 19	Mar-19	Colin Hutchison	13-Mar-19	13-Mar-19	14-Mar-19	27-Mar-19

MĀORI RELATIONSHIP BOARD
CHAIR'S REPORT

Verbal Update

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

10

RECOMMENDATION

That the Māori Relationship Board

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

PURPOSE

The purpose of the GM MHS report is to update the MRB on implementation progress of the Māori Annual Plan objectives for the month of October 2018

INTRODUCTION

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

- South Central Foundation visit and NZ Nuka Conference 2018
- Nuka System of Care and Draft Clinical Services Plan
- Oranga Niho initiative
- Māori workforce development
    - Māori staff data
    - Science Academy
    - Tūruki scholarships
- Kaupapa Māori Maternal Health Programme
- Equity and Quality Improvement
- Whanake te Kura
- He Korowai Manaaki Hawke's Bay research
- Social work readiness for practise

South Central Foundation visit and NZ Nuka Conference 2018

From 22-26 October 2018 HBDHB and Ngāti Kahungunu Iwi Inc hosted a delegation of governance and senior executives from South Central Foundation, Alaska USA. and held the inaugural NZ Nuka System of Care Conference in Napier from 23-24 October 2018. The conference was shaped around the key Nuka components deemed transferrable to the Hawkes Bay context. It included powerful plenary presentations from Katherine Gottlieb on the Nuka System of Care and Wellness Warriors initiative that addresses domestic violence, child abuse and neglect.

Other breakout sessions on Tuesday 24 October included:

- Engaging community (to own and design the health system and using voice of consumer to drive improvement)

- Integrated Care Delivery (From Theory to Practice: Integrated Care Teams in Action)
- Behavioral Health (Introduction and Advanced Implementations and Applications)
- Quality Improvement (Improvement Culture; Tools and Processes; Using Data for Improvement)

The key sessions on Wednesday 25 October included:

- Wellness Warriors (an Alaskan native response to domestic violence, child abuse and neglect)
- Core Concepts (intensive and continuous training in organisational values and culture)

The conference capacity was attended by around 335 delegates, including about 250 from local HB stakeholders and community. The programme also included a conference dinner, cultural exchange evening and networking opportunities.

On Thursday 26 October 2018 SCF executive leadership held an intensive leadership exchange session with a group of DHB executive managers, Nuka alumni, Māori providers and iwi leaders. Key themes/questions discussed were:

1. How did you "set the stage" for change?
2. How did Nuka system of care become ‘our vision’?
3. How did you establish the ‘organisational culture’?
4. If you were us – trying to implement changes into health care - how would you approach this challenge from a leadership perspective?

Nuka System of Care and Draft Clinical Services Plan

Key themes from the Nuka System of Care included in the HBDHB Clinical Services Plan include:

1. Incorporating the guiding principles of the Nuka System of Care whilst giving primacy to Māori indigenous thinking, values and solutions (p. 11)
    a. Create a local system that is co-designed by our own communities and whānau, and is completely in tune with our Hawke’s Bay culture (p. 21)
    b. Developing our own model that embeds kaupapa Māori practice and builds on the strength of iwi led services (p.21)
2. Active involvement of consumers in the co-design of the health system (p. 21)
3. Multi-disciplinary teams providing integrated health and care services (p. 21)
4. Extending or up-skilling primary care teams to include behaviourists (p. 29)

Oranga Niho initiative

HBDHB is planning to host the New Zealand Defence Force – Defence Health Directorate Oral Health Division in March 2019. The NZDF, as part of their deployment training, work with a crew of up to 20 personnel and 6 dental chairs to provide free dental treatment for two weeks to people aged over 18 years of age.

An introductory hui was held on 29 October 2018 between NZDF, HBDHB Māori Health, Oral Health, Population Health, Strategic Services, Communications, and members of Health Hawke’s Bay, Te Roopu Mātua (Māori Oral Health Advisory Group), and Te Puni Kōkiri. The purpose of the meeting was to discuss our respective expectations, and possible plans for running the initiative.

The NZDF expectation is the kaupapa will be a partnership approach with HBDHB to enhance oral health efforts that are sustainable, have a strong focus on oral health promotion and education, and reach high oral health need population groups. HBDHB will need to assist with the costs of hosting the NZDF including, accommodation, renting an appropriate site etc. The

NZDF is planning to use this kaupapa as a practice training for their next deployment to Samoa in 2019 and are therefore keen to ensure Pacific whanau are included in the kaupapa. While we support a kaupapa that is inclusive of Pacific and low income whanau, the primary focus will be on reaching whānau Māori.

HBDHB and NZDF visited a number of possible sites including: HBDHB Māori Health, Te Taiwhenua o Heretaunga, Totara Health Flaxmere, Flaxmere Community Centre, Te Aranga Marae, and the Cook Island Community Centre Flaxmere. The NZDF has indicated a strong preference for the Cook Island Community Centre. It was the only site visited that met their full requirements for what they need.

Te Roopu Mātua met in October and identified a number of expectations that will be taken into account throughout the planning of this initiative. These expectations include:

- Need to focus on people with emergency, high needs
- Focus on people who can't afford dental care, especially those over 18 years
- Bring in other services/providers to create a package of care for whānau
- HBDHB need to provide transport (buses) to bring whānau in
- Need to ensure priority groups have the opportunity to be there

Next steps

- Formal agreement to partner with each other
- Organisation of a sub-group
- Start planning, including how and who will be targeted
- Next meeting with the NZDF in December 2018

Māori Workforce Development

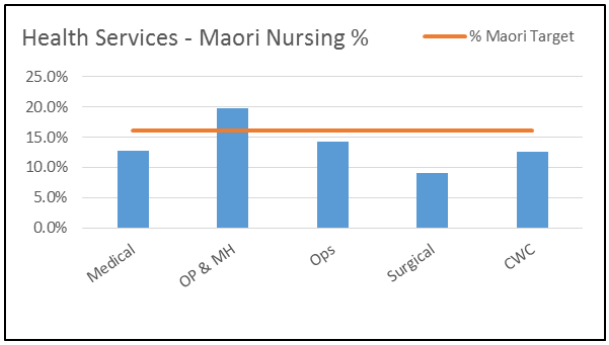
The Māori Workforce Action Plan aligns with the Diversity Strategy lead by People & Quality Directorate. The role is to support and grow the Māori workforce within Hawkes Bay. This report will provide an update on current projects and analysis of this to support tracking of the actions and progress in the new addition to role in Māori workforce action plan.

Monthly updates are provided to track our progress in growing the Māori workforce to meet our population demographic.

Nursing workforce dashboard reviewed to measure:

- No of NETP Maori /PI recruited
- No of Māori/PI nurses achieving post-graduate qualifications
- No of Māori /PI nurses in leadership positions
- Spread of nurses with directorates who identify as Māori /PI

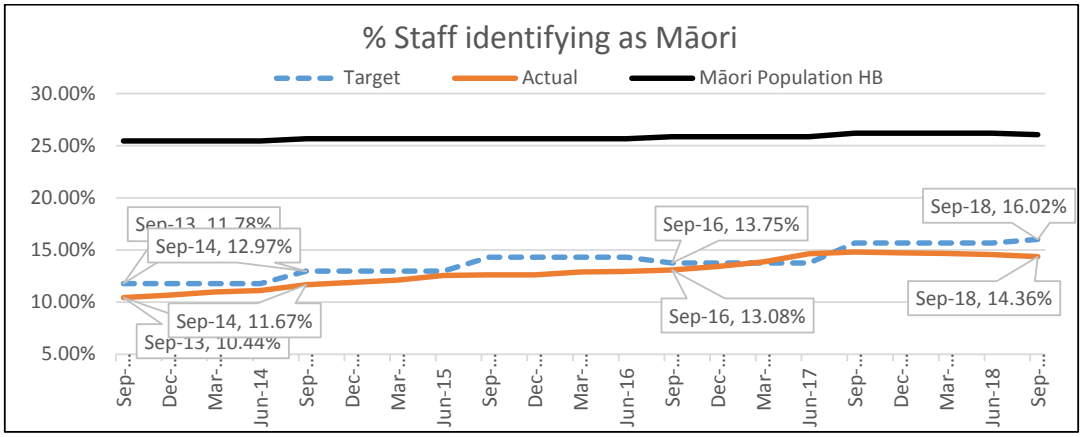
Nursing Workforce



Health Services - Maori Nursing %	Maori	Total	Maori	Maori Target	Gap
Medical Directorate	59	463	12.7%	16.02%	15
Facilities	0	0	0.0%	16.02%	0
Old Person, MH, AH & Options	30	152	19.7%	16.02%	-6
Operations Directorate	46	322	14.3%	16.02%	6
Surgical Directorate	30	330	9.1%	16.02%	23
Communities, Women & Children	47	371	12.7%	16.02%	12
Health Services - Maori Nursing % Total	**212**	**1638**	**12.9%**	**16.02%**	**50**

Maori nursing workforce continues to be remain at 12.9%. A new NETP intake has just been interviewed and potentially Maori nursing numbers will increase from this intake.

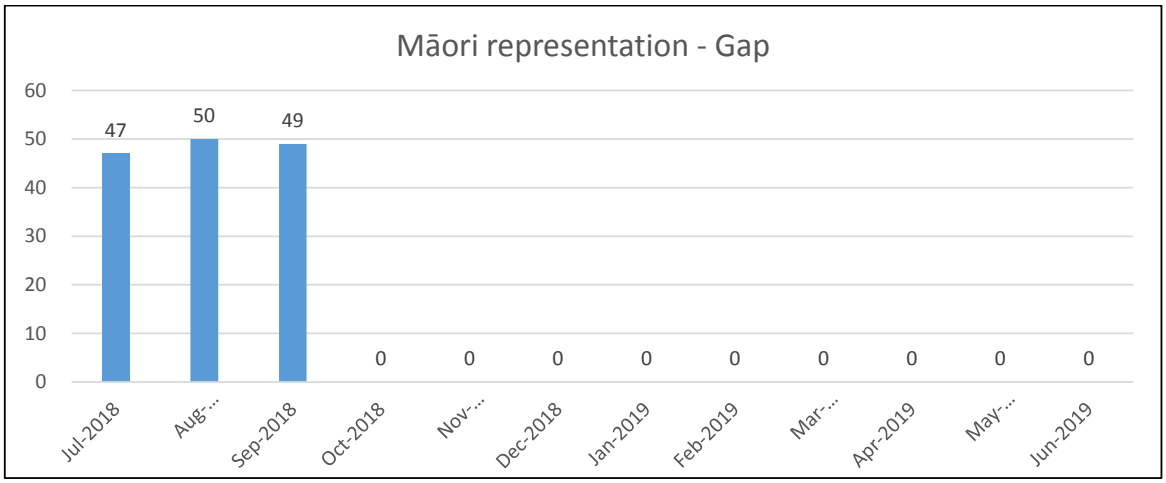
Māori staff growth over 5 years



The last 5 years has seen the Maori population remain stable at 25%. The Maori workforce targets have increased over the last 5 years from 11.78% to a target of 16.02%.

In 2018 we are tracking at 14.36% of the 16.02 %, leaving a gap of 1.66%. Targets over the last 5 years have been fairly close to identified targets accurate with a 1-2% lag in achieving.

Maori staffing gap 2018



Māori Staff - gap against Target for 2018/19		
Total Headcount at September 2018	2,973	
Māori Headcount at September 2018	427	14.36%
Māori Target 2018/19		16.02%
Māori Workforce Gap at September 2018	**49**	

We require a further 49 Māori staff to reach the 2018 target of 16.02%. This number has increased from 47 to 49 over the last 3 months. Important to identify how many Māori have applied for positions and /or how many Māori staff have left positions. Given there has been no drop in this gap important highlighted.

Science Academy Taiwhenua

HBDHB provide funding for Te Taiwhenua o Heretaunga (TToH) and Otago University (OU) to host an annual science wānanga in Heretaunga. Otago University staff and students attend the wānanga and engage the participating Years 7, 8, and 9 Maori science students. This year the science wānanga was delivered in Te Hauke. The kaupapa for this initiative is to:

- Align mātauranga Maori and Western science in a relevant and aspirational way for Heretaunga rangatahi.
- Pro-actively increase and enhance science as a career/study option for rangatahi Maori thus increasing the output of Māori in health related employment. Put some pictures in and review initiative 2019 :

TTOH are to provide HBDHB with an evaluation and analysis of the science academy. They will also identify and track tauira who have completed the programme over the last 4 years and track continued progress and initiatives to keep them connected with health workforce opportunities.

Support Health Career Development: Turuki Scholarships Round 2 Open

Turuki Scholarships are available for Māori health workforce development in Hawkes Bay. Scholarship applications close on 31 October 2018 with the current model for scholarships is to be refocused on supporting areas of growth within the Māori workforce action plan and forecasted shortages.

Kaupapa Māori Maternal Health Programme Update

Māori Health have analysed the initial findings from interviews with māmā for the Kaupapa Māori Maternal Wellbeing Programme. This information will be used to inform the development of the programme. The findings will also ensure quality improvements to existing services are responsive to, and consider māmā experiences, needs, and preferences.

A total of 50 māmā were interviewed.

- The youngest māmā interviewed was 15 years old while the oldest was 42 years. The average age of māmā interviewed was 24.6 years, with the majority of interviewees (46%) aged between 20 – 24 years of age. 16% of māmā interviewed were under 20 years of age.
- 47% of māmā interviewed were first time māmā, 22% were second time māmā, and 31% had three or more tamariki. All together, 49 māmā had a total of 101 tamariki in their care.

- The main types of income māmā received included: own wages, partners wages, WINZ payments, IRD Family Tax Credit, and whānau. WINZ payments were a main source of income for 44% of māmā.
- Māmā identified three main types of living arrangements: renting, living with whānau, and own home. 49% of māmā were renting their home, 40% were living with whānau, and 11% owned their home. Wairoa māmā had the highest percentage of māmā living with whānau (45%), compared to māmā in other areas (33%, 36%, 31%).

Māmā were asked if there was a Kaupapa Māori Maternal Health programme available for hapū māmā and their whānau, would they use it. Why or Why not?

The majority of māmā supported the idea of a Kaupapa Māori Maternal Health Programme. 84% of māmā said were interested in a programme for hapū māmā with many expressing they would '*definitely take that on'*[1]. 12% or 6n māmā said they wouldn't use the programme; two māmā felt ambivalent about using the programme.

If there was a Kaupapa Māori Maternal Health Programme, would you use it?	
Yes I would use it	84% (41n)
No I wouldn't use it	12% (6n)
Maybe	4% (2n)
Total*	100% (49n)

*Note, one interview cut short no response available.

Of the six māmā that said they wouldn't use the programme it was because:

'*I think I can do it on my own without any help*' (CHB01, aged 15 years)

'[*I'm] not a person that reaches out. [I} don't like being dependent on others, I would rather do it...my way*' (CHB05, aged 22)

'*I don't think I'd go there because I'm a know it all and I think I'm fine*' (W10, aged 23)

Other māmā felt that Plunket and midwives are adequately meeting their needs. Although these māmā didn't think they needed the programme, they felt that such a programme would benefit other māmā who they thought needed it.

Many māmā felt that being a Kaupapa Māori programme was an important consideration in her decision to use the programme or not. As expressed by māmā:

'*Yes, it's important to be a Māori programme. I don't have a proper reason, it's just because it's our culture, like, why not?*' (W05, aged 20).

'*I'm not sure how to word it without sounding racist. [that's] Māori – that's why I'd go to it*' (HB12, aged 23).

'*Yes! Because it is Māori and that is where I feel comfortable and there isn't much like it*' (HO1, aged 21).

'*I have always gone toward the Pakeha way and not used the Māori outfits and it would be cool to be with my own people*' (H14, aged 42).

'*With the Māori kaupapa behind it is even better*' (H08, aged 22).

'*I'm Māori, my partners Māori. It's something we'd both understand...cause we have different ways* than other ethnic groups' (W03, aged 24).

[1] N08, W03, W04, H01, H02, HB06, H12.

'*The Māori element is important because I'm very strong about the reo, its important to teach our babies that, anything Māoritanga, these days it's not done, especially the reo'* (W04, aged 23).

Māmā were asked about what would be important to them if there was Kaupapa Māori programme. Māmā outlined a number of areas that have been categorised into five areas: he wāhi, he tangata, he mahi, he āhua, he kaupapa Māori.

Māmā felt that because the programme would be Kaupapa Māori there should be a distinictive point of difference from existing services. Māmā felt '*anything Māoritanga*' should be part of the programme including: Māori birth practices, learning about where we come from, our culture. For example, māmā wanted to make things for their baby that were practical and useful, but reflected tikanga:

'*Make weaving a part of it that you could take it away…like a kete as a shopping bag, that's useful*' (W01, age 18)

'*Just to like learn more about our culture, I don't know much about it*' (W11, age 22)

'*To help our wairua*' (H06, age 29).

Māmā did not have strong preferences about where the programme should be delivered but felt that it should feel like, 'welcoming home' (H01, age 21). Māmā described a place where they could relax '*and be you for a minute and take your baby*'. They shared that they wanted a place where there was a play area for their tamariki, that had access to fitness equipment, and a space where therapeutic mahi could be provided. Transport to the programme was also identified as an important factor because some māmā don't have a car.

There were strong preferences for the programme to have a '*brownface not a whiteface*' because it's '*important that people doing it are Māori*' (CHB08, age 35). There was also a strong preference for the programme to have midwifery involvement, and Māori midwives and staff (Napier māmā x3), as well as kaitakawaenga support at birth for whanau.

It was important to māmā that the programme should be available for as long as māmā need it, and not apply a '*cut-off*'. Māny māmā expressed that they want a programme that is 'inclusive of solo-mums, outside the usual whānau'. It should be a place where māmā and whānau are empowered. A place for partners to talk to someone, a place where you can share and someone will just listen. A kaupapa that '*makes it easier to be a mum – I'd love that*' (W01, age 19).

Māmā described a number of activities that they would expect to see in the programme including:

- Pregnancy information+++
- Breastfeeding support+++
- Being able to talk to someone++
- Connecting māma to all services i.e. LMCs, WINZ+++
- Getting help with your pēpi, tamariki++
- To be connected to the community
- Relationships with other māmā++
- whānau advocates++
- Do activities together+++
- Learning for dads+
- anything Māori+++
- mahi rāranga+++
- karakia, reo, rongoa++
- Māori initiatives
- money management++
- nutrition++

+indicates strong theme

The interviews revealed a number of areas where māmā have not received timely, appropriate, or responsive access to maternal health care e.g breastfeeding support, antenatal scans for Wairoa māmā, C-Section care etc. were some of the areas identified. The Steering Group met on 18 October 2018 to discuss these barriers and how they might be addressed. The project team will take appropriate steps to feedback to, and work with, respective services to improve their responsiveness to māmā Māori. A Kaupapa Māori Maternal Health Programme has a strong potential to address many of these barriers to access to maternal health care and whānau support.

HBDHB are very keen to receive MRB direction into the next steps to develop the Kaupapa Māori Maternal Health Programme, this would give effect to the MRB Terms of Reference to 1) ensure plans are jointly developed, 2) make recommendations for the development of plans, and 3) prioritise the use of funding and access to services [refer MRB TOR Sept 2014].

The project team are exploring possible options for how best to establish and implement the programme.

Whanake te Kura – Pregnancy and Parenting Education Programme

In March this year, Whanake te Kura was launched. Delivered by Te Taiwhenua o Heretaunga, Whanake te Kura is a Pregnancy and Parenting Education programme funded by HBDHB. The new programme was an intentional change from the way traditional antenatal classes were delivered to a programme that is more responsive to the pregnancy education needs of Māori, Pacific, young mothers, and pregnant women on welfare.

Since April, a total of twenty 2-day wānanga have been held in Napier, Hastings, and Central Hawkes Bay. A total of 117 referrals/registrations have been received. 55% of these māmā have attended the programme, 23% are booked into future wānanga, and the remaining 22% had their babies prematurely (10n), stillbirth (1n), decline/no show (15n). Of the māmā that attended the wānanga, 51% were māmā Māori, 9% Pacific, and 39% Other. 38% were aged 20 years and under. 35 whānau attended the programme with māmā, of which 47% were pāpā Māori. Wānanga in Wairoa are also being held. Information about Wairoa will be reported next month.

Whanake te Kura has built strong relationships with other providers such as the HBDHB Safe Sleep programme, Immunisation team, breastfeeding specialist who are frequent presenters at the Wānanga. Feedback from māmā has been extremely positive with many māmā reporting increased knowledge, and confidence about pregnancy, giving birth, and being a parent.

'I'm going to change the environment my baby be in. Change how I'm going to have baby sleeping and be smokefree around baby for the sake of my baby's future'

'*I've learnt things that I didn't and couldn't imagine'*

'*thanks for expanding my knowlecge in fatherhood, will forever be needed*'

A main challenge implementing Whanake te Kura has been the slow referrals from Lead Maternity Carers. The Provider has worked hard to build these relationships, and as a result there has been some improvement. Presently, the main source of referrals is LMCs, self-referral, TTOH facebook/website, and youth worker.

Cot Bank

In September 2018, HBDHB launched the Cot Bank initiative. The Cot Bank is HBDHB's response to prevent SUDI deaths by supporting whānau to a provide safe sleep environment for their pēpi who have outgrown the wahakura/pēpi pod.

HBDHB Māori Health and Child Health teams have partnered with Placemakers, EIT, and Habitat for Humanity who are donating their time and resources toward this kaupapa. EIT has offered to refurbish donated cots at no cost, Placemakers have offered supplies needed to fix cots, and Habitat for Humanity has offered to store the cots.

To date, the Cot Bank has reached 24,933 people via its FaceBook page. The community response has been very positive with nearly 700 likes, and about 500 shares and onshares.

He Korowai Manaaki Hawke's Bay research

Victoria University of Wellington's Centre for Women's Health Research has partnered with Ngāti Pahauwera on He Korowai Manaaki – a wraparound maternal health approach. The kaupapa of He Korowai Manaaki is early, evidenced based care and support, from maternity to childhood, to achieve improved health outcomes and wellbeing for māmā, pēpi and whānau.

He Korowai Manaaki Hawke's Bay is a random controlled trial that involves:

- A small number of Hawke's Bay primary care practices
- Usual maternity care with a midwife but extra appointments with primary care
- Providing more ways of supporting māmā and her whānau during and after pregnancy i.e. more appointments, transport, connection to other services, early registration with a midwife, access to contraception etc...

Eliminating inequities in access to maternal health care and improving maternal and child health outcomes are important to HBDHB. Māmā Māori in Hawke's Bay have poorer maternal and child health outcomes than other māmā. Information about how HBDHB might respond and improve this for whānau Māori is important to us, and therefore we plan to disseminate information about this kaupapa to the maternity and primary care sectors to ensure māmā Māori who may be eligible to participate in this study are given the opportunity to do so.

Social work readiness for practise

Māori Health Gains Advisor met recently with the Department of Human Services and Social Work (Canterbury University) at EIT. They are a team of social work researchers who have been working on a research project titled 'Enhancing the Readiness to Practice of Newly Qualified Social Workers'. This is a three-year project funded by the Ako Aotearoa National Project Fund, and this is the final year of the project. The project comprised of three research questions;

1. 2016 – What is the content of the current New Zealand social work curriculum and how does it relate to the core competencies of the Social Worker's Registration Board (SWRB).
2. 2017 – How well prepared are NQSW's (social workers in their first year of practice) to enter professional social work, and how is their learning being supported and enhanced in the workplace.
3. 2018 – What are the professional capabilities, including cultural capabilities we should expect of NQSW's and of social workers working at a more experienced and advanced levels of practice?

Top 12 Course Topics

Key Course Topic	Number of Courses	Number (and %) of TEI's with key term in title
Field work	29	14 (100%)
Research	29	12 (86%)
Social work theory	25	13 (93%)
Social policy	23	12 (86%)
Social work skills	20	8 (57%)
Professional development	16	12 (86%)
Community work	14	11 (79%)
Te Ao Māori	12	9 (64%)
Fields of practice	11	10 (71%)
Human development	11	11 (79%)
Treaty of Waitangi	11	9 (64%)
Sociology	10	7 (50%)

How well prepared are NQSW's to enter professional social work practice and how is their learning being supported and enhanced in the workplace?

The Managers/Supervisors survey required respondents to have managed or supervised a NQSW within the last two years. There were a total of 139 responses to the survey. 10 failed to meet the selection criteria and a further 25 dropped out of the survey resulting in a final sample of 158.

The NQSW survey required respondents to have completed an approved Social Work Qualification from a NZ tertiary education institute within the last two years, be in current paid employment and been employed in a social service agency for a minimum of six months. There were a total of 195 responses to this survey, however, 71 failed to meet the selection criteria and a further 5 dropped out of the survey which resulted in a final sample of 119 NQWS's.

Data to be printed and presented at MRB meeting

Māori Workforce Action Plan 2018 - 2023

Objective: To build a competent, capable skilled & experienced Māori health & disability workforce over the next 5 years that reflect the values of He Kauanuanu, Akina, Rāranga Te Tira, Tauwhiro.

1. Build the capability and capacity of Māori Workforce

LEAD	Ngaira Harker	RESOURCE	People and Quality – Paul Davies / Maori Workforce Advisory Group / Allied Health Director/ Nga Ringa Manaaki

ACTION 1.	PROJECT	DUE DATE	STATUS	PROGRESS
1. Talent mapping and career planning for all Māori staff.	Complete Talent Mapping and Career Planning process for to support leadership pathway by June 2019,	**June 2019**	**Ongoing**	- Initial meeting with HR to align career planning with current developments in line with people and quality diversity strategy to incorporate mapping and career planning strategy.
2. Obtain guidance and advice from professional bodies to support career and leadership development guidelines.	Review career and leadership Maori within health professional bodies to align with HBDHB leadership development.	**June 2019**	**Ongoing**	- Initial engagement with Allied Health and Nursing Leadership groups to develop and scope leadership in line with professional competencies. - Māori workforce advisory group advised on leadership development and **ongoing plan to** further develop and advise on direction.
3. Sustain and utilise effective models increasing Māori workforce i.e. the uptake of NETP Māori.	Increase the number of Maori Health professionals to meet population demographic and forecasted target 16.02%	**Jan 2020**	**Ongoing**	**NURSING NETP** - Review of Cultural support and retention strategy completed NETP - implementing new cultural / clinical support beginning 2019 - 2018 : Target 16.02% Current Oct - 12.9 % **Gap 50** - Note **9** new Maori graduates to be employed Jan 19. - Business case completed to grow Maori nursing workforce. (See appendix 1) **ALLIED HEALTH** - Currently reviewing cultural support and retention strategy – in line with NETP model which has been successful long term in growing Maori nursing workforce**.** - 2018 : Target 16.02% Current Oct - 14.6% Gap 49 - To review new recruits 2019 (not complete)

Progress update as at November 2018 - Nurse Director (Māori) Ngaira Harker

2. Increase Māori representation in our workforce to reflect population			
LEAD	Ngaira Harker	**RESOURCE**	**Kia Ora Hauora / Incubator Coordinator/ Taiwhenua / EIT/ Otago University / Maori Workforce Advisory / Turuki Database Lead/**

ACTIONS	PROJECTS	DUE DATE	STATUS	PROGRESS
1. Partner with agencies and education sector to promote Hauora career growth	- Delegate of promotion of heath careers to appropriate workforce groups locally and nationally (Kia Ora Hauora / EIT / Schools, Wananga).Re - Redirect early Hauora Career Development to National workforce group Kia Ora Hauora/ Education groups EIT and Primary and Secondary educational partners. - Review relationship with National MOH group Kia Ora Hauora to take lead in support of Hauora Careers promotion early career development. - Review the Nuka RAISE MODEL to further support growth in Hauora development for Māori Rangatahi - Review relationship with EIT and Schools career development teams/principals to further take collaborative approach MOVE	**June 2019**	**Ongoing**	- Initial meeting scheduled Kia Ora Hauora to review relationship Dec 2018 to review relationship with Kura Kaupapa across rohe to enhance knowledge of Kia Ora Hauora and Hauora Careers and to inform of reprioritization promotion health careers - Collaborate with NUKA leads to further investigate gather information RAISE ongoing. - Meeting schedule completed to contact Schools and Kura kaupapa career advisory to support information sharing 2019 - Evaluation of 2018 science wānanga funded by DHB Lead by Taiwhenua and Otago University evaluation commenced. - Reviewed and updated current funding contracts and deliverables with EIT with outcomes changed to include achievement in programmes and transition to higher learning and promotion for Maori workforce.
2. Critically analyse our current activity and results in the 'supply chain' i.e. science academy, science wānanga and health careers promotion.	- Complete analysis of workforce shortage areas within National and local data (ongoing) - Realign activity to support workforce needs and gaps. - Align funding and scholarships to prioritise needs within Health groups where shortage ongoing) - Tracking of all initiatives in pipeline development within one database from science wānanga through to sec, tertiary and leadership development.	**Dec 2019**	Ongoing	- Currently reviewing allocation of scholarships in line with need and priorities to support realignment commencing 2019. - Currently no priority allocation to need and this now to be established for 2019 scholarship allocation. - Commenced a focus target to improve profile of Dental Assistants and Dental technician pathways promotion and potential scholarship focus as identified
3. Align scholarships (HWNZ) to the forecasted workforce demands e.g. leadership.	- Improve tracking and alignment of scholarship to include forecasted shortages - Refocus and invest in workforce and leadership development as priority in supply chain. - Currently aligning Turuki Database to evaluate Turuki scholarship recipients who re working for the DHB and/or within Kahungunu rohe.	**Dec 2019**	**Ongoing**	- Met with Turuki database evaluator to refine tracking alignment. - Initial meeting with incubator to align with Turuki Database and support stronger combined information in establishing workforce growth at the beginning pipeline level. - Aligning incubator / Tūruki data with career planning, leadership development and funding priorities.

3. Improve the cultural capability of the workforce (DONE)					
LEAD	JB Heperi / Ngaira Harker	RESOURCE	Cultural Advisor/ Maori Workforce Advisory Group / People and Quality (HR) Advisor /		
ACTIONS	**PROJECTS**		**DUE DATE**	**STATUS**	**PROGRESS**
1. Engage with stake holders to identify cultural capability indicator needs within workforce. **2. Refresh recruitment and employment processes to reflect DHB core values.**	- Develop Advisory Group Maori Work force - All staff 100% complete engagement with Maori training - HIE incorporate cultural indicators into all performance appraisals for staff		**June 2019**	**Ongoing**	- Maori Workforce Advisory Group confirmed (1st meeting held) - Terms of Reference to support and provide updates from stakeholders confirmed. - Still to review and identify indicators and data to support and scope measurement of cultural indicators DHB wide.
	- Develop HR processes within appropriate Maori model of engagement / recruitment pathway - Completion of recruitment process that embeds tikanga within all recruitment and employment processes evidenced by; - Completion of Interview process inclusive of tikanga - Completion of Value Based interview processes and training commencing Feb 2019 - Hiring managers complete cultural recruitment training programme.		**Feb 2019**	**Ongoing**	- Mapped process to support key levers in supporting employment processes - Confirmed and drafted incorporation of tikanga within recruitment and employment processes. 1st draft completed recruitment processes. - Interview training to commence in 2019 Feb/April - Completed list of Māori Staff available for interviews. - Ongoing fortnightly meetings with People and Quality to support completion and development of deliverables for recruitment and employment processes.
3. Refresh and combine the cultural competency programme to incorporate and evaluate best practise and quality service improvement for Māori. **4. Appropriate actions and campaigns to address culturally unsafe practice environments impacting on retention and safety for Māori.**	Work with services to : Review evaluations and current cultural responsiveness. Establish a curriculum package for engaging with Māori and Pacifica Work with HR to celebrate best practice and develop safe cultural environment to support diversity		**Nov 2020**	**Ongoing**	- JB Heperi commenced new position and updated delivery '***Engagement with Maori*** '. - Evaluations – collated by HR very positive and excellent feedback from participants - To collate a 6 monthly evaluation table to support tracking evaluation feedback with quantitative data.
			Nov 2019		- Collated and referenced findings from Akina mai and Korero Mai to collate themes and present to Maori workforce Advisory.

10.1

4. Increase Māori leadership visibility at all levels within the HBDHB workforce					
LEAD	Ngaira Harker	**RESOURCE**	**HIE leadership team/ Directors of Nursing / HIE leadership team/ Allied Health Leadership Group/ EIT / Maori workforce Advisory Group.**		
ACTION 1.		**PROJECT**	**DUE DATE**	**STATUS**	**PROGRESS**
1. Championing the provision of high quality health care that delivers equity of health outcomes for Māori.		Identify and establish a workforce that is informed and applies equity of health outcomes for Māori. Reduced gap in health outcomes in all key indicators for Māori. An Increased satisfaction engagement evaluations for Maori employees and Maori whanau within DHB. Leadership prioritized in growth workforce Maori Shortages Maori Workforce – provided to all hiring managers and directors.	**June 2020**	**Ongoing**	- HIE leadership team established currently re-developing roles within Maori Health and Population to support clinical services plan – restructure HIE currently due to be completed Nov 30th - Draft 5 year nursing strategy with focus on equity in development to support leadership strategic focus clinical services plan 2019 – 2023 in progress. - Draft recruitment and training package to strengthen recruitment for equity indicators and engagement with Māori. Training to commence Feb 2019 - Recruitment Process to roll out April 2019, - Clinical services plan reviewed and feedback provided in establishing increased equity evaluation expertise within kaupapa Maori frameworks and increased intelligence to support best practice and leadership guidance - Stakeholder engagement to identify profile of leadership styles and models yet to commence.
2. Cascade Māori workforce recruitment KPI into Performance appraisals for all employing managers		Cultural competency KPI incorporated into Performance Appraisal within 6 months. - 100% completion engagement with Maori. - Deliver and evaluate Nga tahi engagement with Māori delivery. - Scoping of current Maori leadership across organisation - Identify KPIs	**June 2019**	**Complete**	- Engagement with Maori (reviewed and updated delivery) - Nga tahi engagement with Maori delivery set for April 2019 (external evaluation) - Initial training for all managers and then rolled out to staff within Nga tahi group collective (April 2019) - Cultural competency indicators yet to be identified in Performance Appraisal processes DHB wide. - KPI's for Maori workforce yet to be incorporated into management
3. Identify and scope leadership programmes which are relevant and cost effective in meeting growth and development Māori health workforce. **Establish Māori leadership programme.**		Identification and delivery of leadership programme commencing 2019. - Promote and ensure Māori and Pacific leaders are employed.			**Scoping leadership yet to commence.** - Collate data to identify (Māori) the number of Māori in leadership positions yet to commence (Maori and Pacific Data available / identifying leadership within data yet to be completed) Nursing - Managers to identify Māori and Pacific leadership potential within their sector. - Equity /leadership training for approval to support nursing leadership professional development 2019.

HB CLINICAL COUNCIL

11

Verbal Update

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

Timing Issues	None
Announcements/ Communications	None

RECOMMENDATION:

It is recommended that Clinical and Consumer Council

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

It is recommended that the Maori Relationship Board

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

HAWKE'S BAY
District Health Board
Whakawāteatia

Scoping Report - Addictions

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

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

EXECUTIVE SUMMARY

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

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

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

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

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

MAP OVERVIEW

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

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

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

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

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

What is Methamphetamine?

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

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

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

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

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

Who is using methamphetamine?

National Surveys

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

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

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

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

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

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

Police information

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

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

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

Who is working in this space?

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

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

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

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

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

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

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

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

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

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

What is the Community saying about their support needs ?

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

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

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

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

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

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

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

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

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

What is working in harm reduction?

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

Cross-sector approaches

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

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

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

[9] Meeting notes distributed by CAYD June 2017
[10] NZ Strategic Approaches https://www.drugfoundation.org.nz/ https://www.health.govt.nz/publication/national-drug-policy-2015-2020 http://www.police.govt.nz/about-us/publication/illicit-drugs-strategy-2010

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

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

Prevention

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

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

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

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

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

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

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

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

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

Education and Community Support

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

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

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

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

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

Treatment

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

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

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

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

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

SUMMARY

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

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

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

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

RECOMMENDATIONS

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

Governance Report Overview

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

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

RECOMMENDATION:

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

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

13.1

Draft Health Equity Report 2018

Contents

Introduction

What is this report about?

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

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

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

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

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

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

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

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

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

What did we find?

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

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

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

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

The role of health services in eliminating inequity

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

The role of social and economic factors in eliminating inequity

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

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

A focus on mental health

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

Summary

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

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

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

Next steps

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

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

Interpretation Guide:

1.The New Zealand Health Survey:

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

2. Ethnicity:

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

3. Amenable Mortality:

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

Summary of key findings

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

Equity for Life

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

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

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

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

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

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

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

Social and economic factors are associated with unequal health outcomes

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

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

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

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

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

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

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

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

Partnering for community gains

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

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

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

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

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

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

Good health begins with the way we live

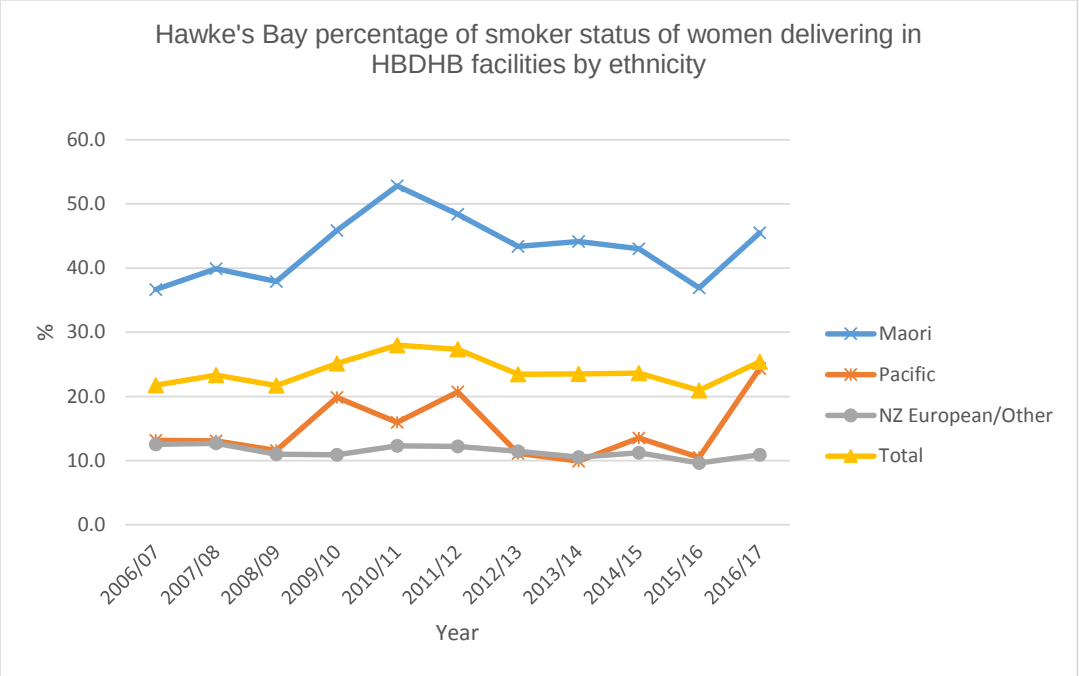
The environment we live in influences our day-to-day behaviours, including nutrition and obesity, smoking, alcohol and other drug use. Health behaviours have a large impact on our health and wellbeing.

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

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

Little change in reducing maternal smoking since 2007

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



Source: HBDHB Data Warehouse

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

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

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

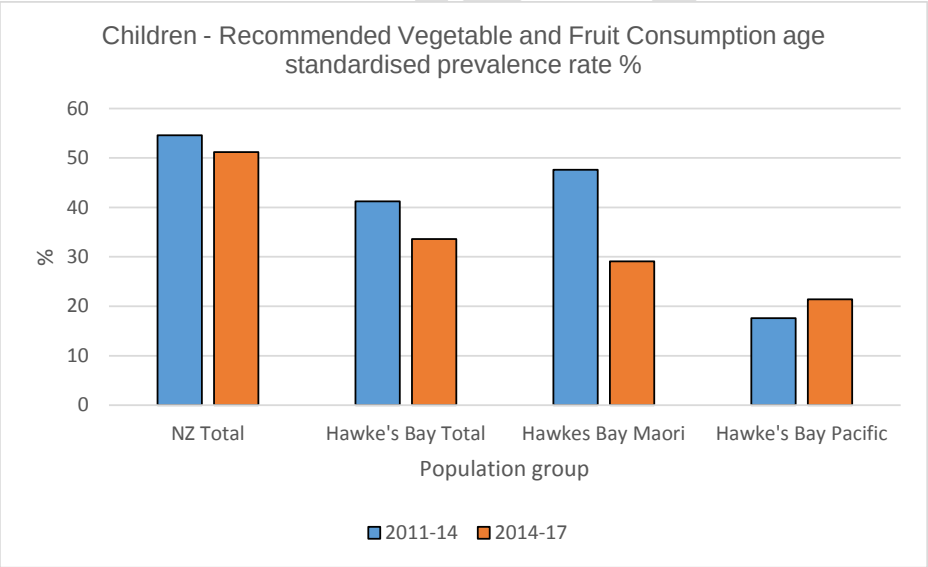
- 15-24 year olds drink the most hazardously although 25-44 year olds are not far behind
- Māori women are more likely to drink during pregnancy than non-Māori
- fewer Māori drink alcohol than non-Māori (Pacific and Asian also lower) but Māori experience more harm overall than non-Māori.

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

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

Fewer adults and children are eating enough fruit and vegetables

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



Source: New Zealand Health Survey

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

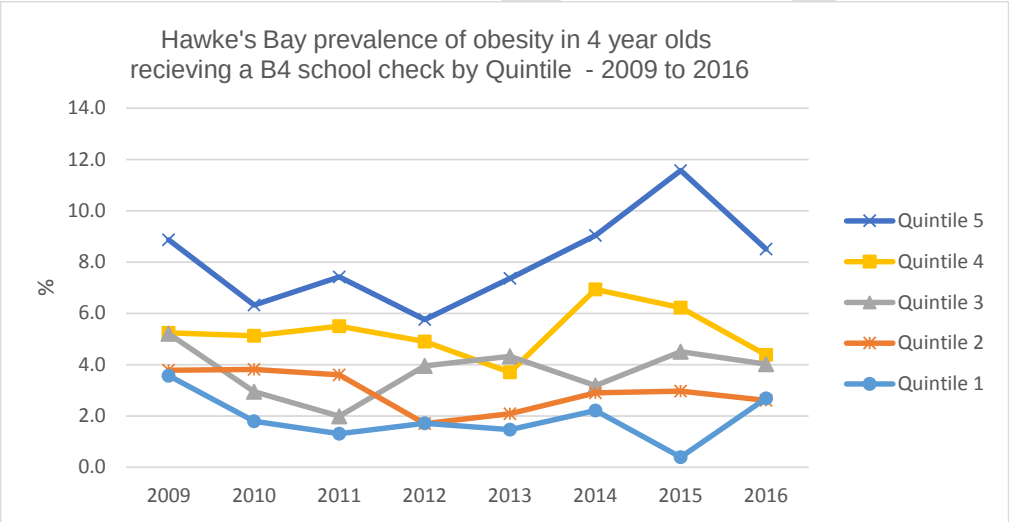
Indicator	Most deprived	Least deprived

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

Source: INFORMAS (University of Auckland)

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

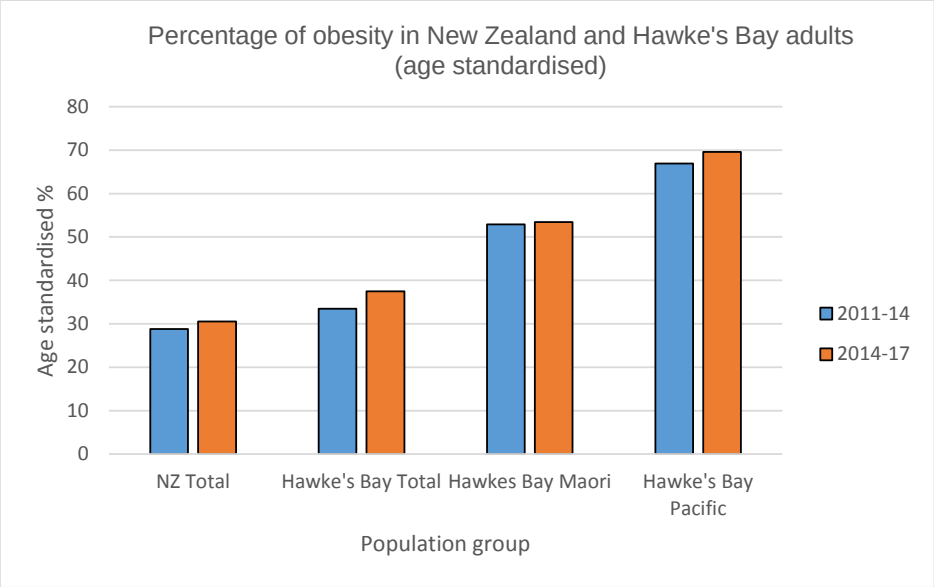
There has been an increase in the percentage of children living in our most deprived communities (Quintiles 4 and 5) who are assessed as having healthy weight at their B4 School Check. However, inequities still remain. Children living in Quintile 5 (highest deprivation) are less likely to be a healthy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



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

Fewer Adults across all ethnic groups are living with healthy weight

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

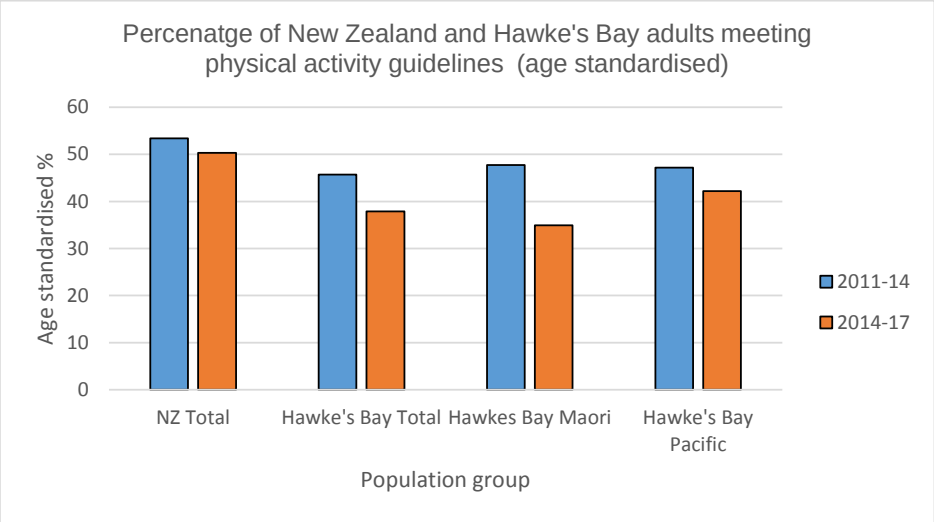


Source: New Zealand Health Survey

Physical activity levels for Māori and Pacific have fallen

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

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



Source: New Zealand Health Survey

Health across the life course – Introduction

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

Health across the life course – Childhood

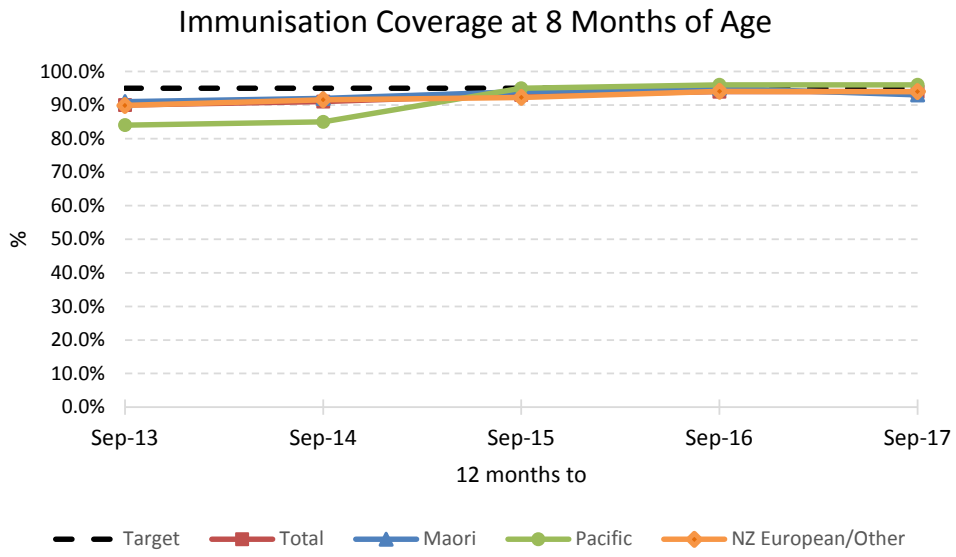
"Many challenges in adult society have their roots in the early years of life, including major public health problems such as obesity, heart disease and mental health problems" (WHO, 2008).

Immunisation shows equity is possible

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

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

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

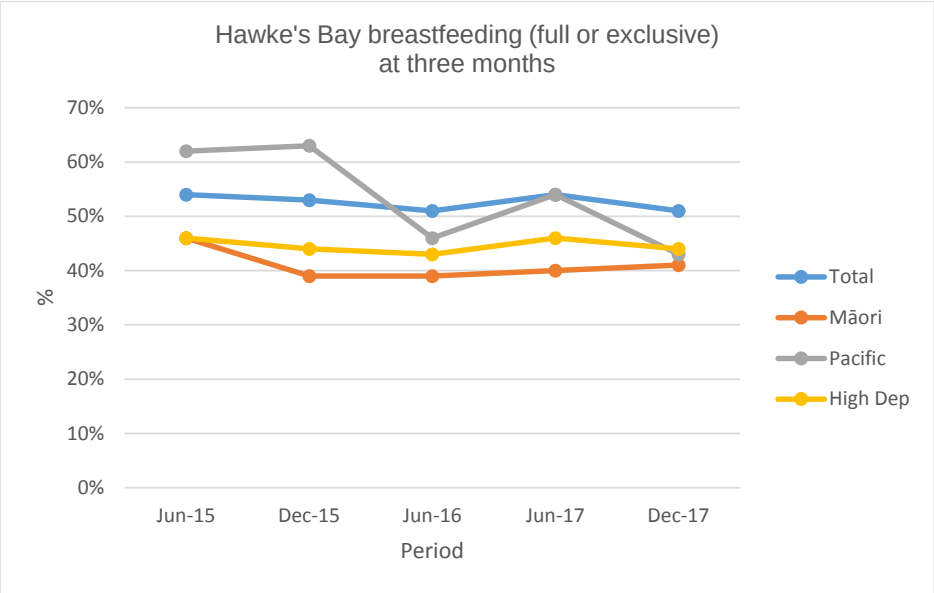


Source: National Immunisation Register

Breastfeeding rates for Māori and Pacific are lower than in 2015

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

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

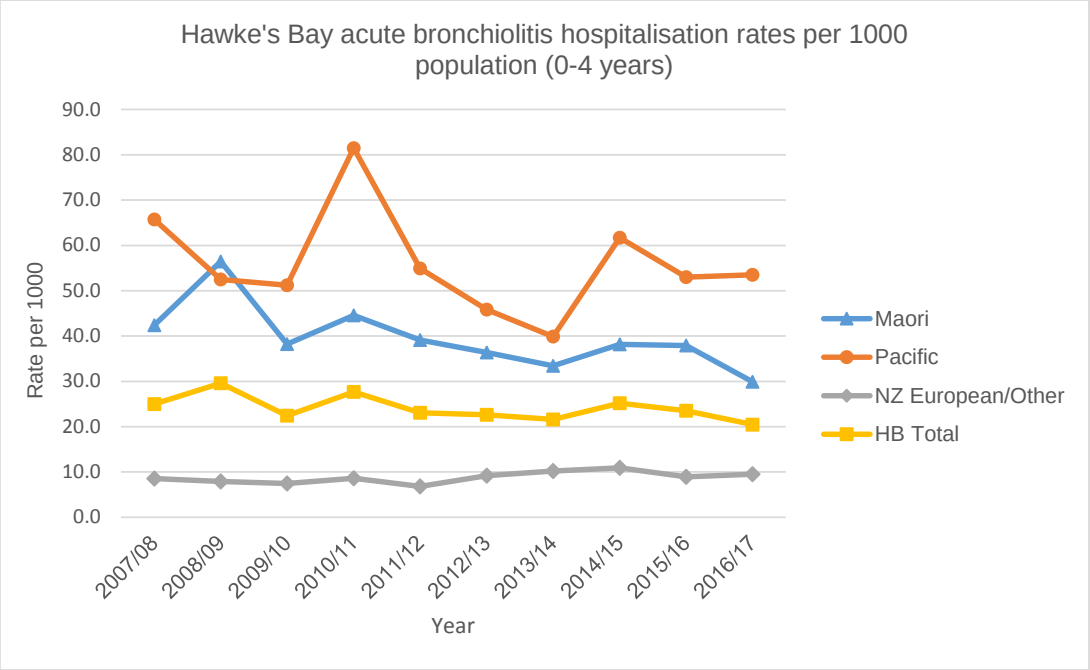


Source: Wellchild Tamariki Ora dataset

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

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

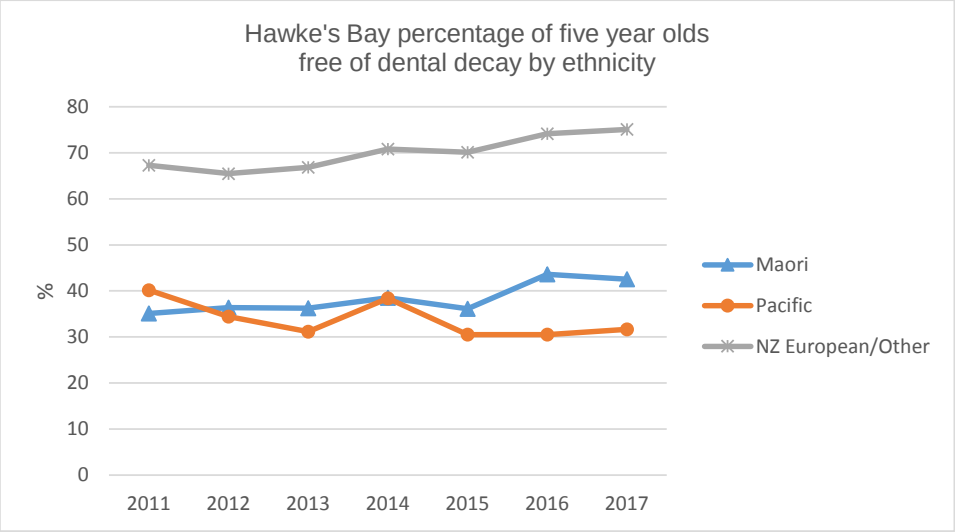
Over the same period, housing demand has increased and demand for social housing has tripled over the last three years. Families are forced to share housing and to accept unhealthy living conditions.



Source: National Minimum Dataset

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

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



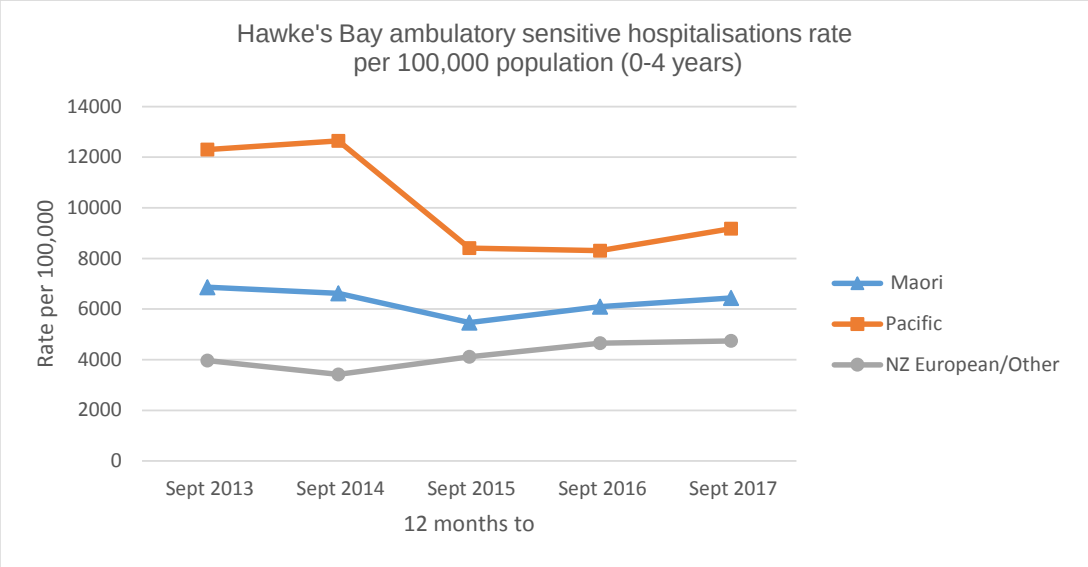
Source: HBDHB Oral Health Information System

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

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

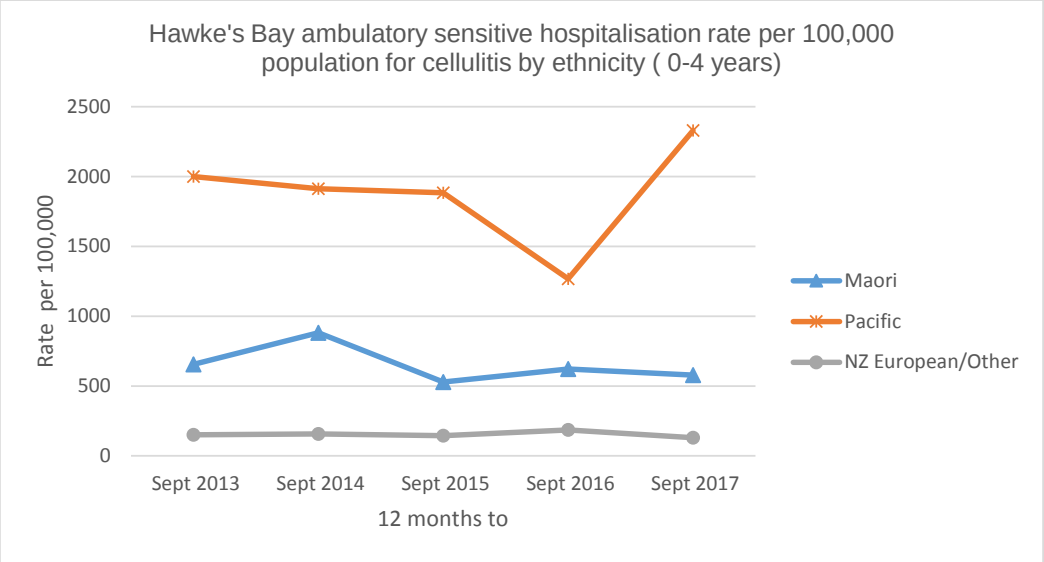
Overall, Hawke's Bay ASH rates for 0-4 year olds remain lower than New Zealand.

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



Source: National Minimum Dataset

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



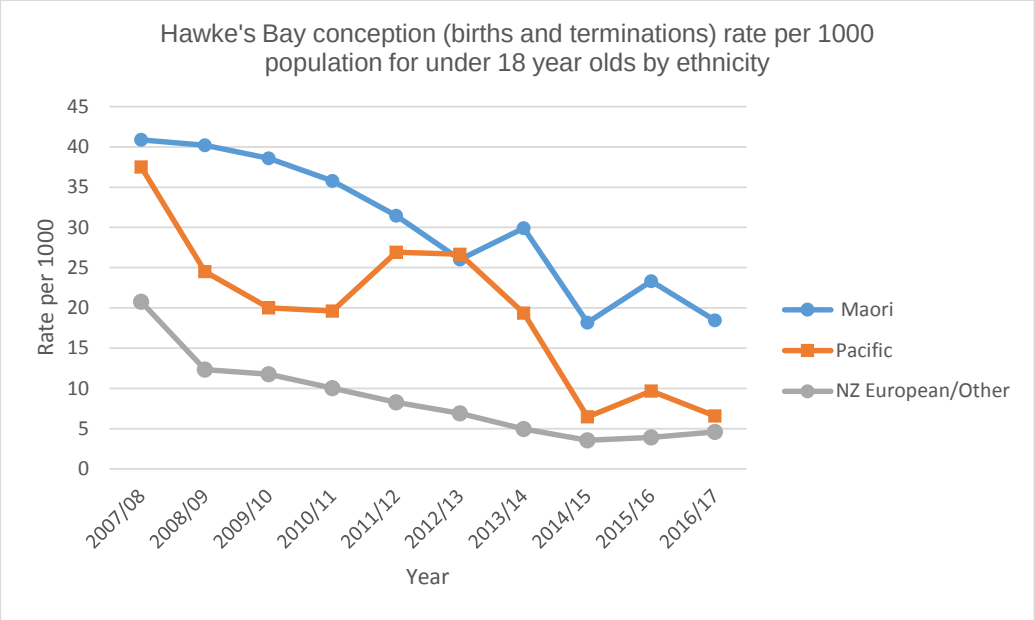
Source: National Minimum Dataset

Health Across the Life Course – Youth

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

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

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

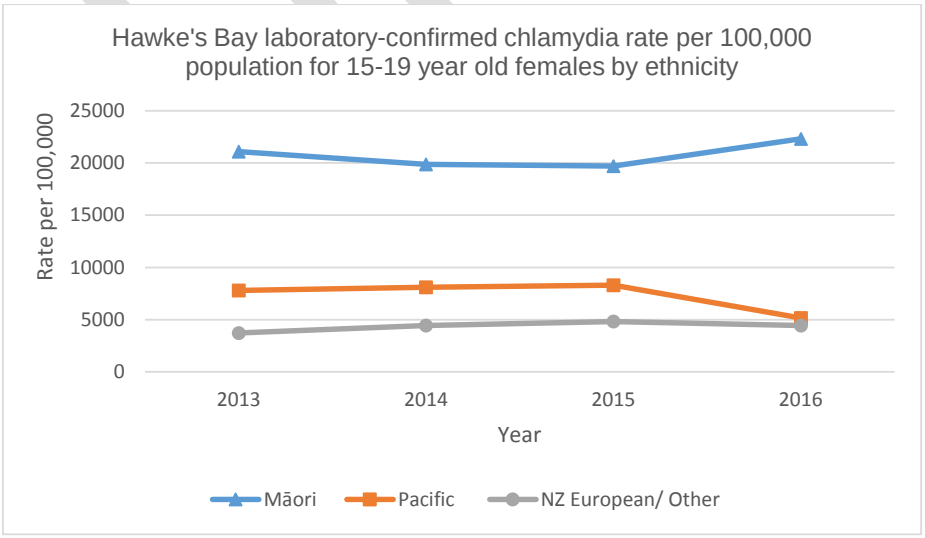


Source: National Minimum Dataset

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

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

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



Source: Institute of Environmental Science and Research (ESR)

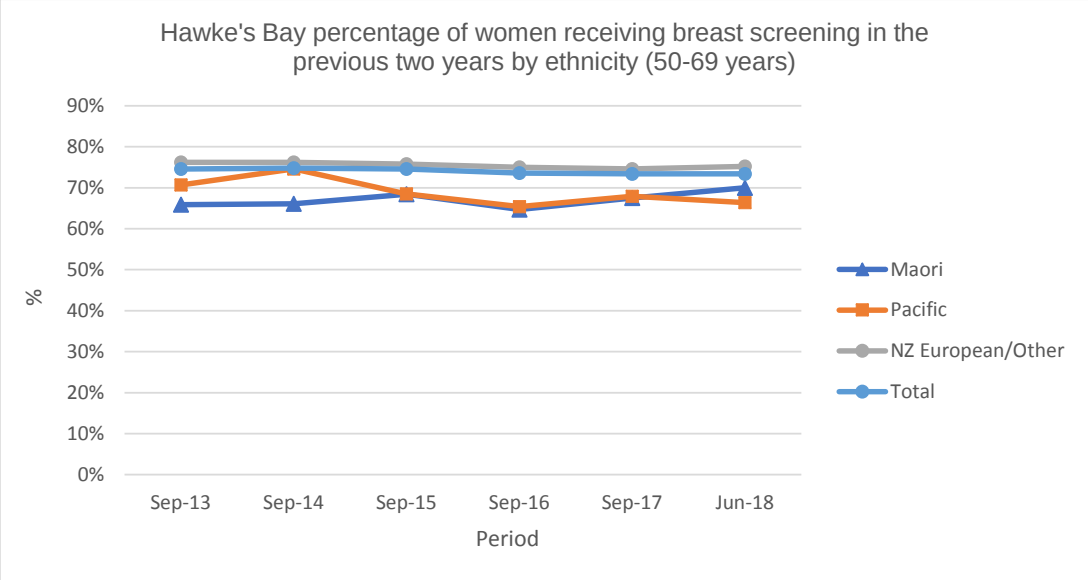
Health Across the Life Course – Adults

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

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

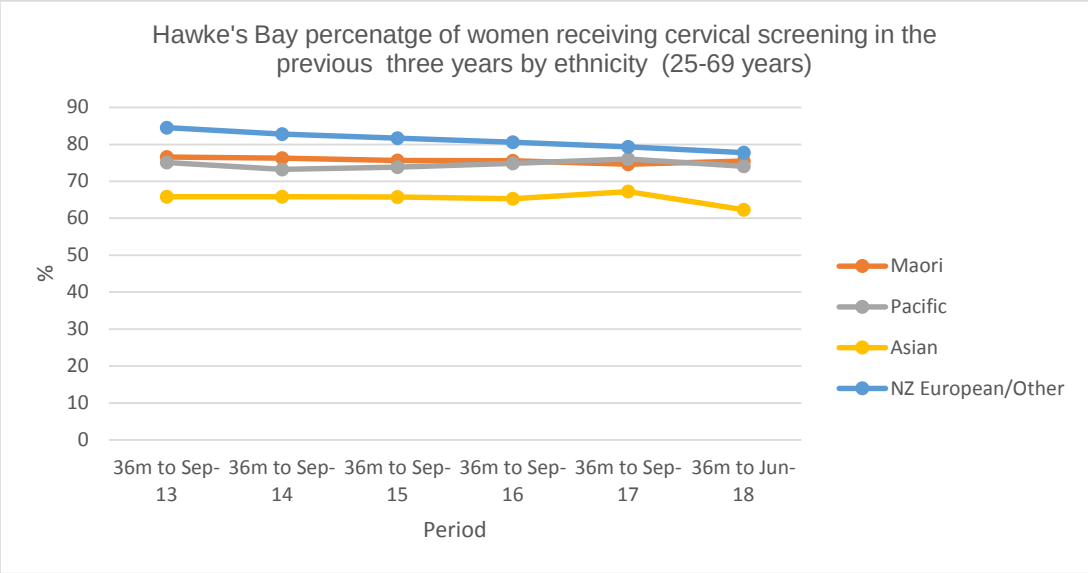
In June 2018, Hawke's Bay reached the Ministry of Health target for breast screening for wahine Māori of 70 percent. This is the first time this target has been achieved.

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



Source: BreastScreen Aotearoa

Māori cervical screening rates are holding despite an overall decline



Source: National Cervical Screening Programme

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

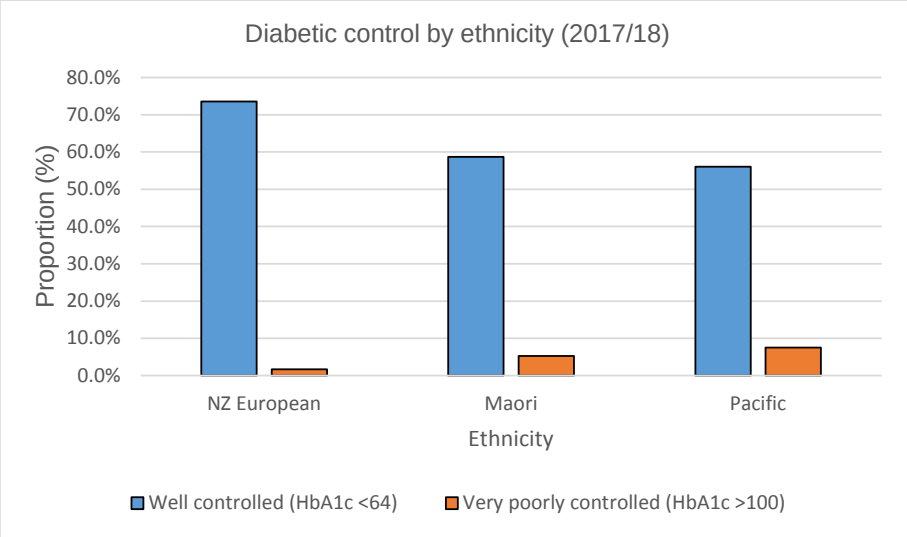
Of concern is that Asian screening rates are persistently lower than other ethnic groups and have declined further in the most recent period to June 2018.

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

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

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

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

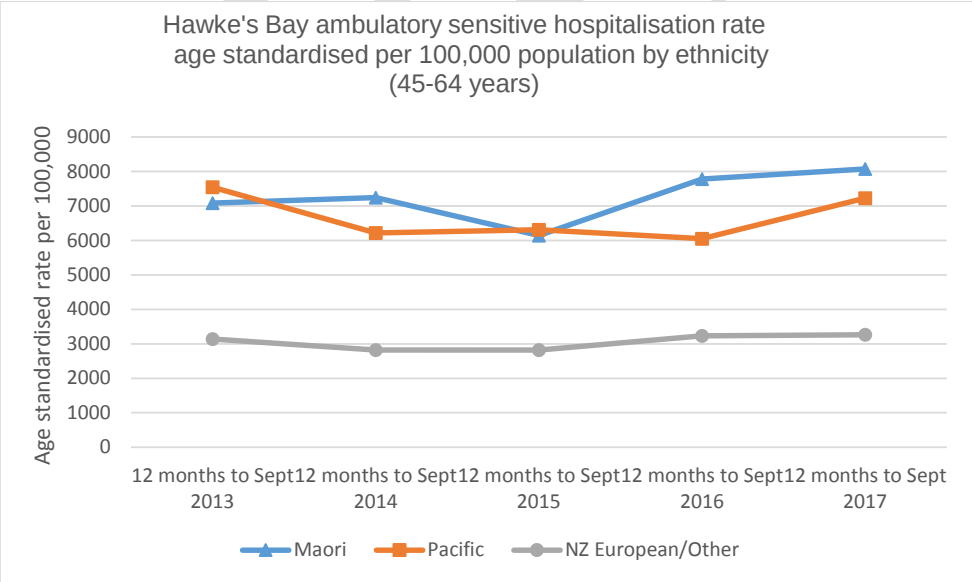


Source: Health Hawke's Bay

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

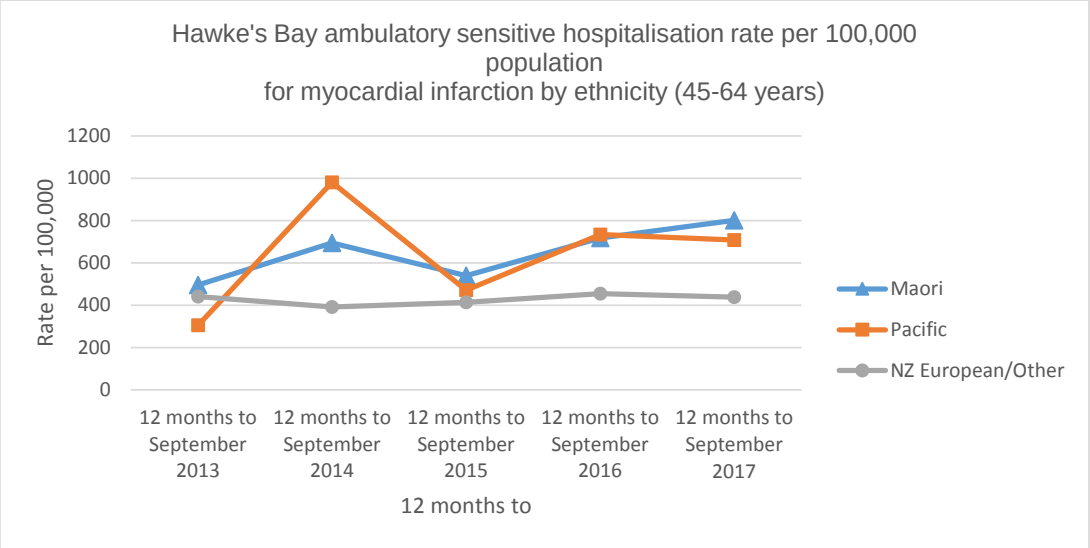
Ambulatory Sensitive Hospitalisations (ASH) are hospital stays for conditions that are potentially treatable or could have been treated earlier in the community. ASH rates provide a useful gauge for primary care access and quality.

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

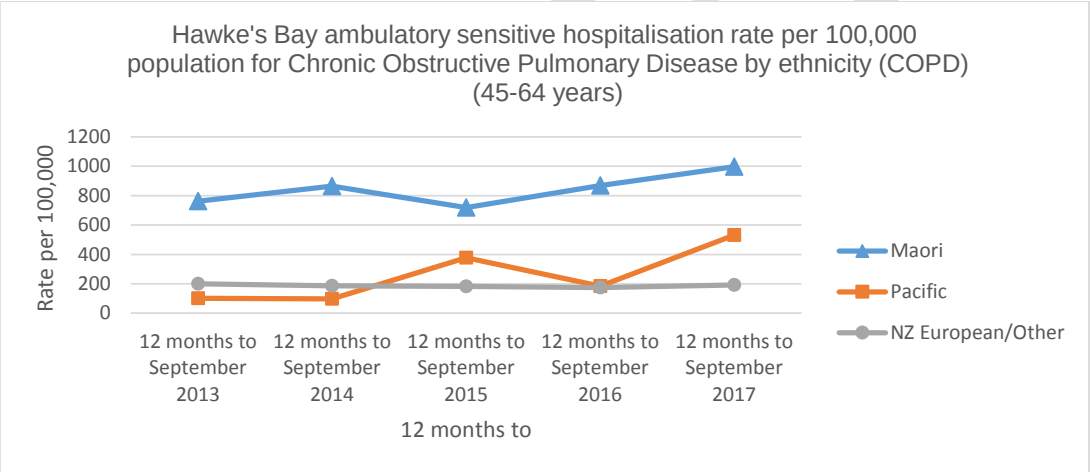


Source: National Minimum Dataset

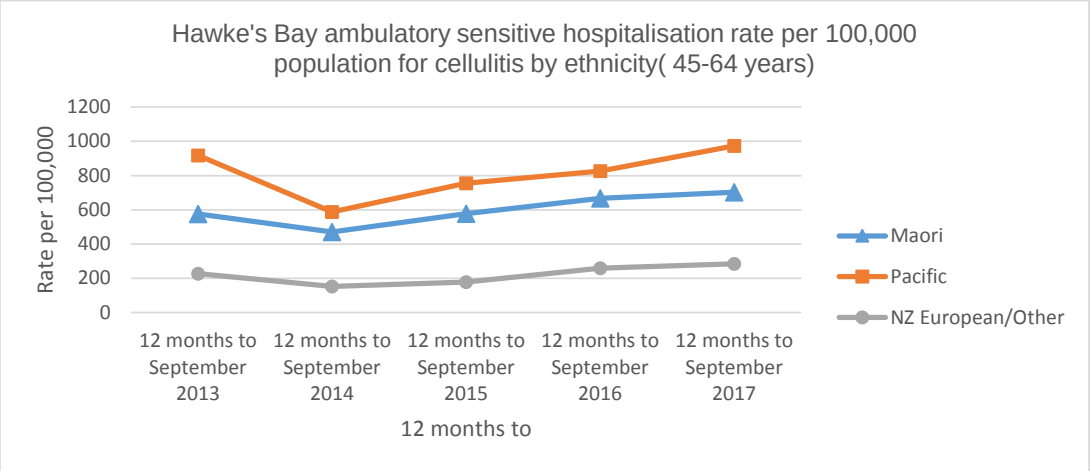
The increase in the overall ASH rate for 45-64 year olds is driven by growth in ASH rates for heart attacks, skin infections and chronic bronchitis and emphysema (COPD).



Source: National Minimum Dataset



Source: National Minimum Dataset



Source: National Minimum Dataset

Health across the life course – The end of life

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

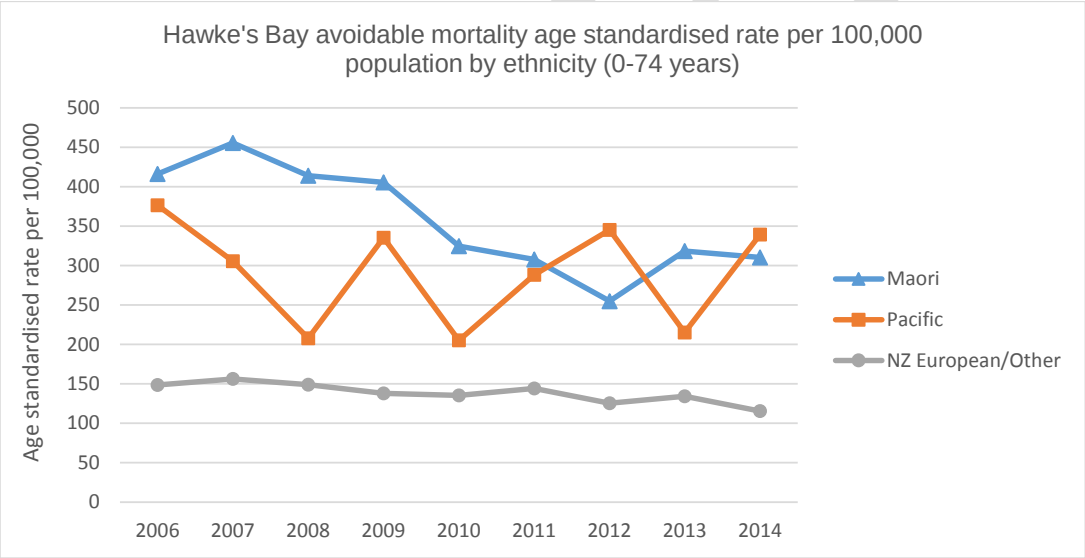
Premature deaths

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

Avoidable deaths

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

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

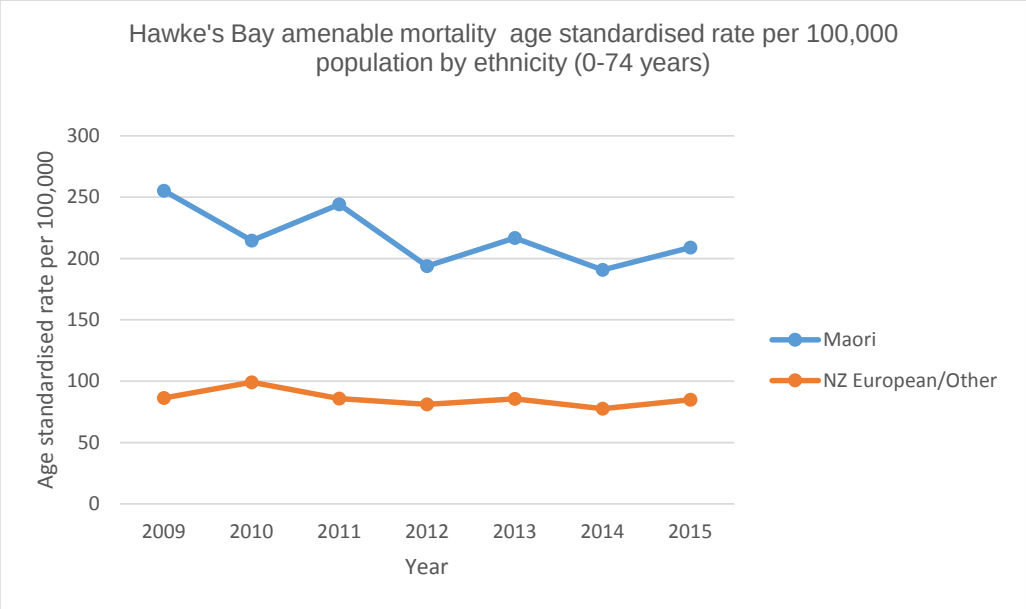


Source: National Mortality Collection 2018.

Amenable deaths

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

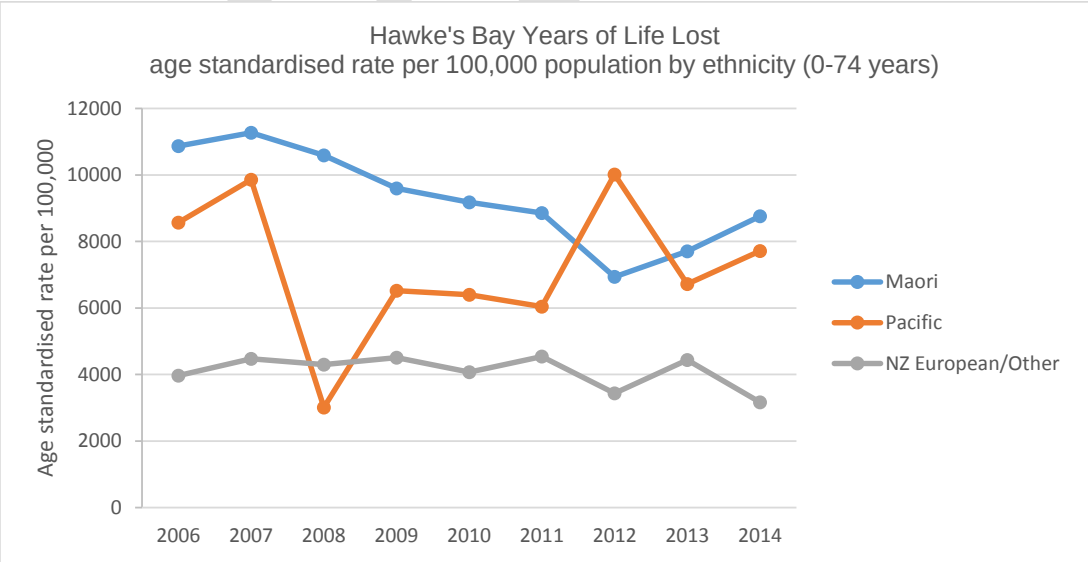
Between 2009 and 2012, amenable deaths for Māori were in decline but in the last three years of available data (2012-2015) that positive trend has stalled.



Source: National Mortality Collection 2018

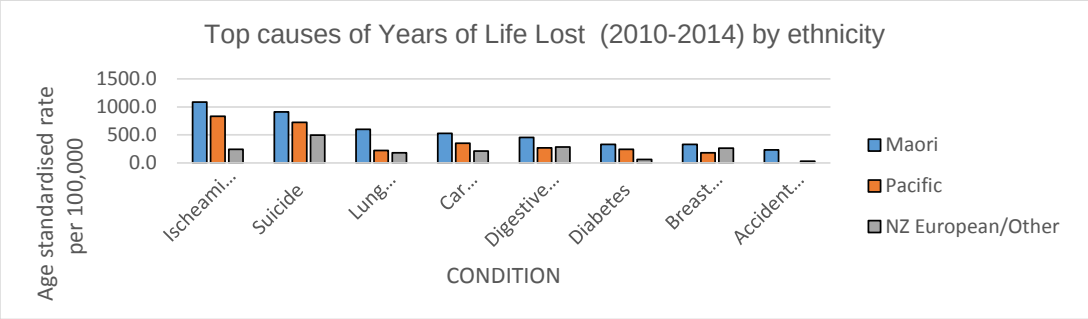
Years of Life Lost

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



Source: National Mortality Collection 2018

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



Source: National Mortality Collection 2018

A spotlight on Pacific health

Doing well: Immunisations

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

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

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

Towards healthy, strong lives

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

Pacific health in Hawke's Bay

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

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

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

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

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

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

What are the building blocks for improving Pacific health?

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

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

Working with families - Pacific style

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

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

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

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

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

A spotlight on mental health

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

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

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

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

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

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

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

Alcohol and other drugs:

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

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

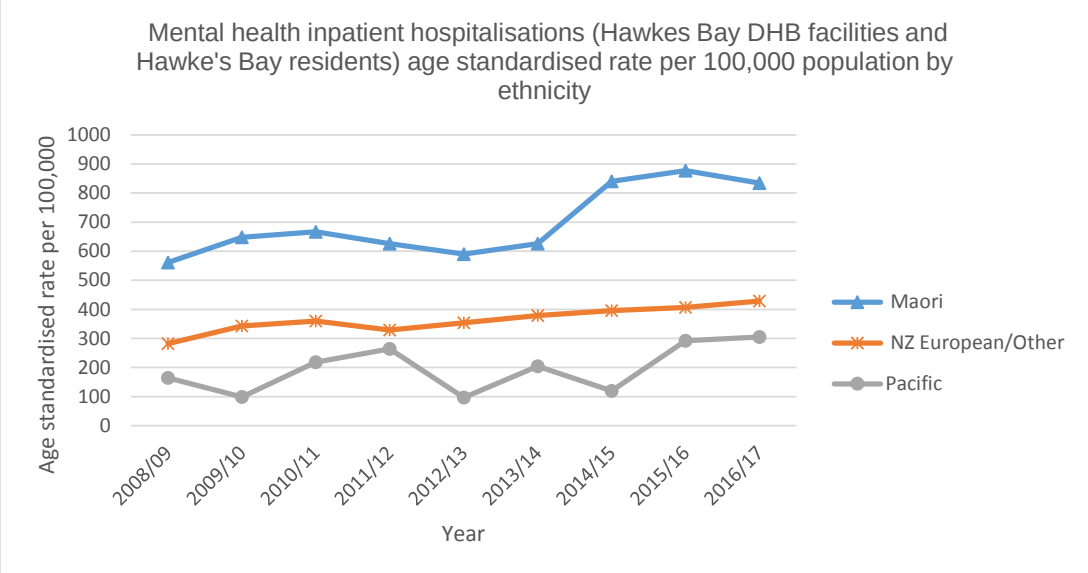
[3] Based on national findings as the Hawke's Bay survey size was too small to reach statistical significance.
4 New Zealand Health Survey
[5] Does not include synthetic cannabis

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

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

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

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



Source: HBDHB Data Warehouse

Intentional self harm

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

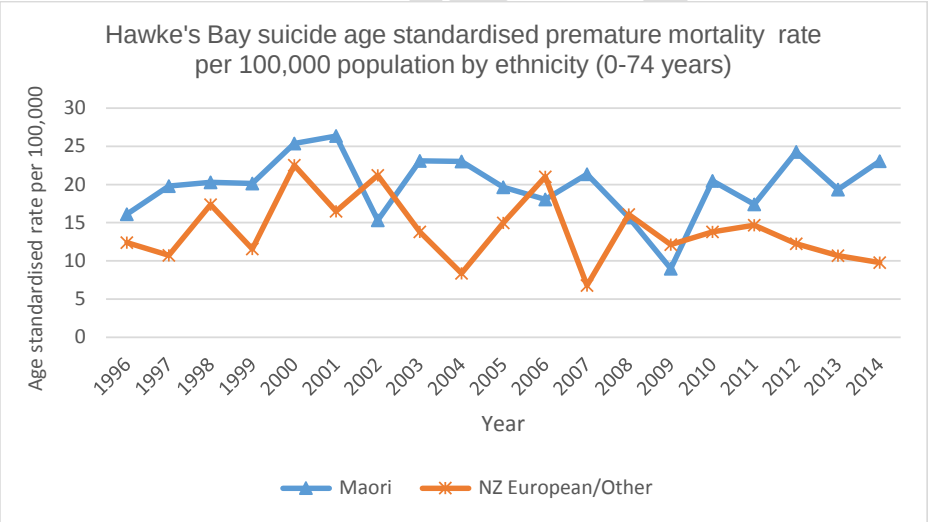
- Hawke's Bay self-harm hospitalisation rates have increased by 30 percent between 2013/14 and 2016/17. While the overall numbers are not large (180 admissions in 2013/14 increasing to 241 admissions in 2016/17) it is a concerning marker of suffering for both individuals and whānau. This is

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

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

Suicide

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



Source:

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

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

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

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

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

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

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

A spotlight on family violence

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

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

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

The national picture in family violence[7]:

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

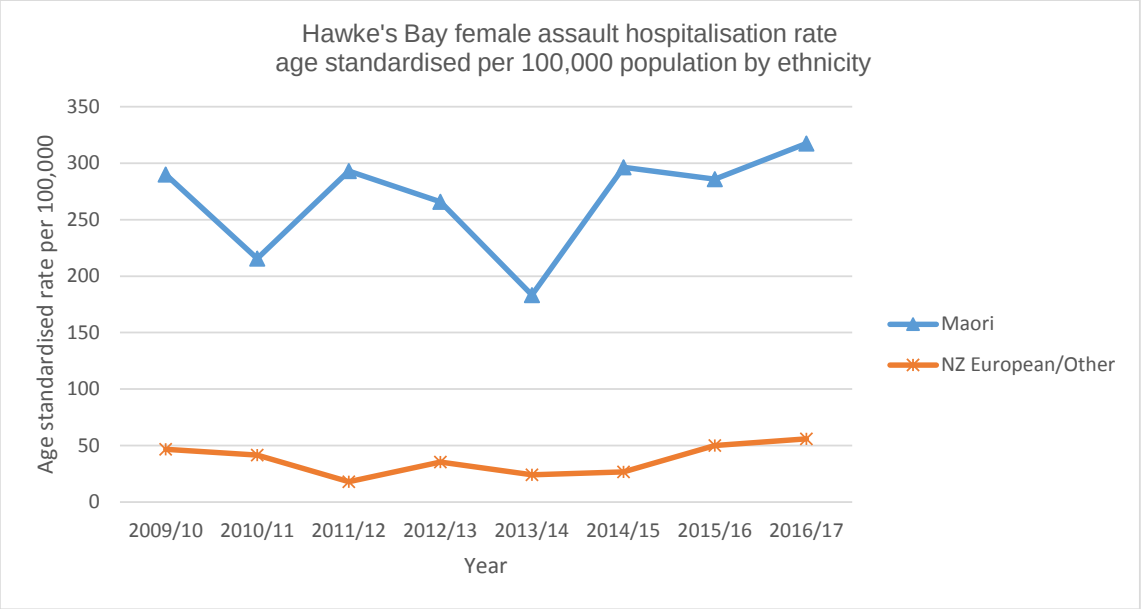
Female hospitalisations for assault in Hawke's Bay

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

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

[7] Family Violence Clearinghouse

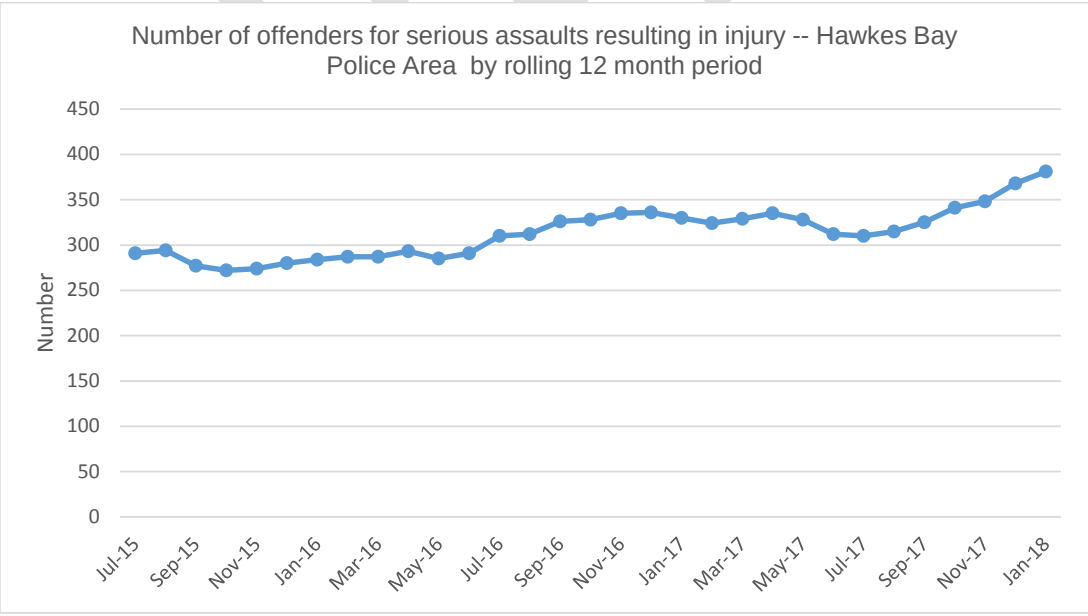
[8] Includes females of all ages but predominantly adult females



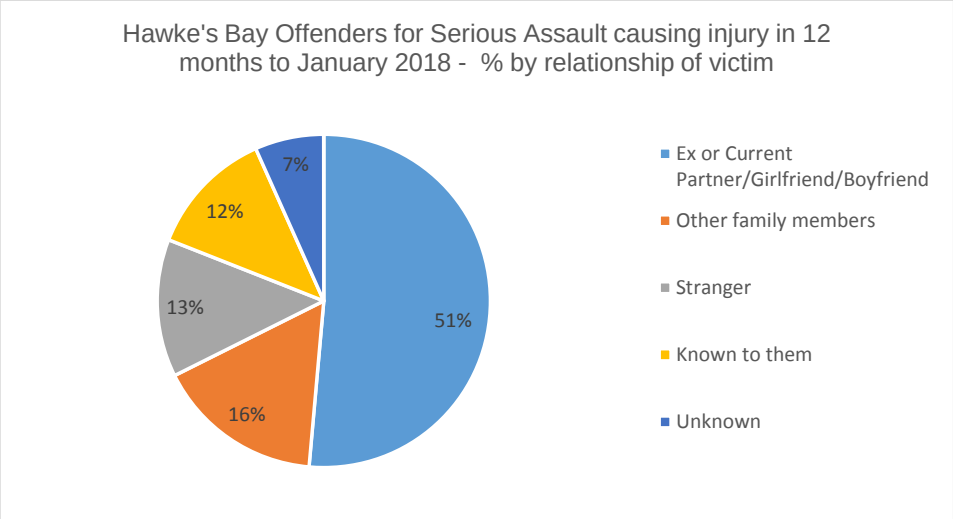
Source: National Minimum Dataset

Serious assault causing injury

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



Source: New Zealand Police



Source: New Zealand Police

A spotlight on housing and health

Poor housing causes poor health.

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

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

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

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

Hawke's Bay's challenges:

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

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

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

Home is where the health is

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

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

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

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

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

Ready to Rent

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

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

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

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

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

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

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

A spotlight on screening

Reaching Out

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

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

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

Cervical Screening Outreach Service Insight

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

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

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

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

The outcomes

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

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

Benefits beyond screening

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

Culture counts – the significance of age in Māori society

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

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

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

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

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

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

Mauri ora!

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

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

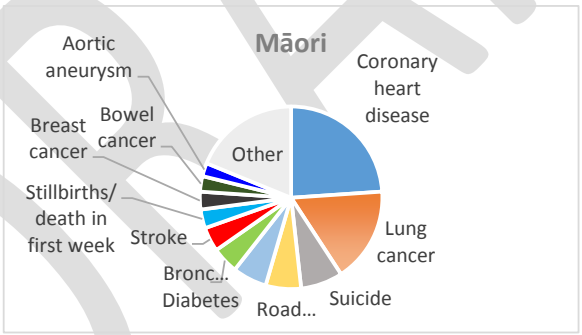
Avoidable deaths are deaths before the age of 75 years that could have been avoided either by disease prevention or effective treatment *and health care.*

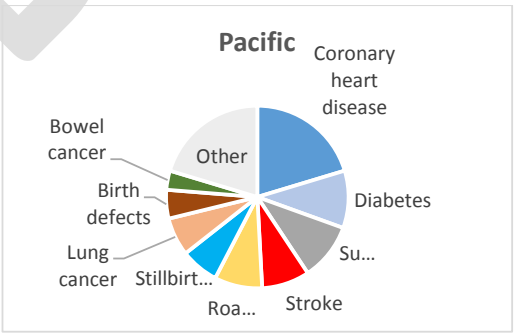
After a long period of improvement, avoidable death rates for Māori have stopped falling. For Pacific people, there has been no discernible change in avoidable deaths since 2006/2007. Meanwhile, the long term picture for NZ European/Other is one of steady improvement, resulting in a widening of the equity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

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

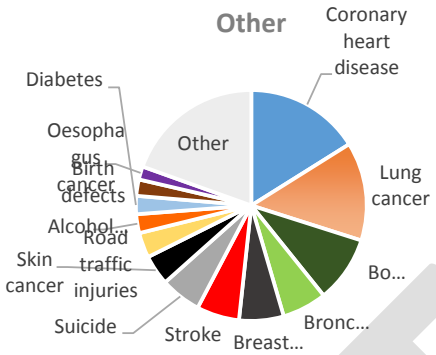
Top causes of avoidable deaths

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





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



13.1

How could these early deaths be avoided?

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

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

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

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

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

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

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

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

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

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

The priority health issues

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

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

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

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

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

The underlying causes

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

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

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

Learning from our successes

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

Learning from world best practice

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

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

Wider opportunities to achieve equity

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

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

Next Steps

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

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

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

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

3. Invest in whānau ora approaches to community needs

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

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

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

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

Due to

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

Which could have been avoided through

Healthy behaviours *Effective and timely health services*

Which are influenced by

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

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

RECOMMENDATION:

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

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

PURPOSE OF THIS PAPER

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

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

Attached are the following:

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

Questions:

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

CONTEXT

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

Feedback Received:

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

Feedback Responses:

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

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

Accepted changes to be incorporated into the final CSP:

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

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

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

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

Next steps:

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

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

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

15

HAWKE'S BAY
District Health Board
Whakawāteatia

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

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

OVERVIEW

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

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

REPORTING ON PROGRESS

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

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

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

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

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

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

3) Intervention to support children to have healthy weight

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

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

4) Provide leadership in healthy eating

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

WIDER CONTEXT FOR CHILD HEALTHY WEIGHT

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

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

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

NEXT STEPS

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

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

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

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

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

RECOMMENDATIONS

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

RECOMMENDATION:

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

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

Appendix One

Objective 1: Increase healthy eating and activity environments

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

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

What the data shows

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

Activity to deliver objective one				
	What	**How**	**Progress**	**When**
Current activity	• Work with settings to increase healthy eating including education, schools, workplaces, events, Pasifika churches, marae • Support national messaging including sugar reduction i.e. Water Only • Advocate for changes in marketing and council planning	• Healthy eating policies which reduce sugar intake in 5 ECE centres, key community events increase healthy food choices, 4 Pasifika churches have a healthy eating approaches and guidelines for marae reviewed with Ngāti Kahungunu Iwi Incorporated • Communication plan implemented for national and regional messages • Supporting the implementation of programmes and plans i.e. i Way, Active Transport, Sport HB and Ngāti Kahungunu Iwi Incorporated plans	• School water only policies reviewed by PHNs, all primary schools have policies and two secondary schools. Support is being developed for ECEs with MoH licensing staff. Four churches engaged, two are working toward reducing sugar. Hasting District Council is going sugar sweeten beverage free at their facilities. • Water only messaging promoted in schools, under 5 Healthy Food messages • DHB rep on Active Transport group, supporting Ngāti Kahungunu Iwi Inc. events to provide health messages and supplying water.	July 2017
New actions	• Support education settings to implement healthy eating and food literacy- early childhood, primary schools secondary schools,	• 50% increase in schools with “water only” policy annually • Decile 9/10 communities have a whānau co-designed programme delivered in primary schools, - trialled 2016, 5 new schools annually	• Schools are being engaged via Public Health Nurses and to support this a new resource is being established in the Child Health Team. • Best Start Advisory Group has been meeting monthly to support coordination and the development of	Reported annually to 2020

Activity to deliver objective one				
	• Establishing a base measure for monitoring • Engage cross-sector groups to gain support and influence to increase healthy eating environments • Investigate food security for children and their whānau identifying issues	• All schools surveyed for status in healthy eating/water only policies • Establish a group to influence changes in the environment across Hawke's Bay • Partner with Auckland University to establish a baseline for the Hawke's Bay food environment and monitor annually	resources/programmes/project. Includes: Health HB, Child Health, Oral Health, Maori Health, Population Health, Pasifika Health, Paediatrics, Primary Care Directorate. Current work is looking at delivering an 8 year measurement for weight • Pre-piloting an 8 year old measure to monitor impact acorss the lifespan. Food Environment data collection complete and report shared with stakeholders. • Working with Boyd Swinvurn from Auckland University to look at a HB research project. • Presented Healthy Weight Strategy to Hastings and Napier Council.	

Objective 2: Develop and deliver prevention programmes

Indicator 2a: Rates of breastfeeding at 6 weeks increase

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

What the data shows

- Child fully or exclusively breastfeeding at 6 weeks rates as 72% for total population, 66% Māori and 82% Pasifka (December 2015 Ministry of Health), these show slight increases
- 67.8% of Hawke's Bay four year olds are healthy weight, 62.7% Māori and 55.7% Pasifika (2016 Before School Check data, Health Hawke's Bay), this is 2016 data. Most recent data is obesity data with 13% of Māori, 26% Pasifika and 5.8% other four year old children in the 98th percentile for weight (June –Dec 2017 B4SC)

Actions and Stakeholders				
	What	**How**	**Progress**	**When**
Current activity	• Implementing Maternal Nutrition Programme activities- breastfeeding support, healthy first foods • Supporting settings to implement healthy eating/sugar reduction programmes/policies • Supporting health promoting schools	• Breastfeeding support resources provided via Hauora • All Well Child/Tamariki Ora providers trained in Healthy First Foods • All schools, ECE, Well Child/Tamariki Ora Providers with health eating policies are provided with information resources and advice • Health Promoting Schools health promoters are up-skilled to implement healthy eating approaches	• Complete • Complete • Information and resources shared • Meeting HPS coordinators, attended workshop with other providers. • Training is completed for Tamariki Ora and Plunket staff, LMCs and B4SC nurses. Training plan being delivered for ECEs. • Maternal Nutrition and Physical Activity programme being delivered in Wairoa – great response and across HB	July 2017
Next actions	• Extend the Maternal Nutrition programme developing programmes in ECE and resources to support B4 School Check providers	• Deliver training to LMCs, Well Child providers and B4 School Check nurses to increase skills to promote healthy eating- Healthy Conversation, Healthy First Foods, B4 School Check resources	• Active Families contracts in place and delivered by Iron Māori and Sport HB. Tamariki Ora and Plunket staff trained and delivering Healthy First Foods programmes. Trial programme being delivered via	Reported annually until 2020

Actions and Stakeholders				
	• Supporting healthy pregnancies, via education and activity opportunities • Support the development of whānau programme (building on existing successful programme) • Develop food literacy resources including sugar reduction messages -deliver via programme and settings • Support healthy eating programmes and approaches in schools	• Contract and support local provider/s to deliver the maternal healthy eating activity programme • Contract and support local provider/s to deliver whānau based programmes i.e. Active Families • Deliver key messages for whānau with 2–3 year olds • Develop food literacy resources for B4 School Check provider, promote Healthy First Food and heart foundation school resources • Support the co-designed programme for deprivation 9/10 communities	Maternity Services to provided increased support for breastfeeding. • Resource developed with early childhood providers and resources to support healthy weight messages for whānau and children – expert group completed this. • Healthy conversation tool implemented and evaluated – this includes BE SMARTER whānau plan, B4 Schools Check nurses • Working group developing the survey for all primary schools and tool to support design and delivery of healthy weight schools. • Schools programme facilitated via Child Health Team, with additional resource to support this work.	

Objective 3: Intervention to support children to have healthy weight

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

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

What the data shows

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

Activities and Stakeholders				
	What	**How**	**Progress**	**When**
Current activity	• Screening including gestational diabetes, Well Child/Tamariki Ora and B4 School Checks • Whānau activity based programmes for under 5s • Paediatric dietetic referrals	• Monitor the screening and responding referrals • Fund Active Families under five and monitor implementation. Investigate extending to further providers • Monitor referrals and outcomes	• Monitoring provided via HBDHB Board and MoH. Raising Health Kids target has been met. • Active Families under 5 is funded and DHB has received additional funding from MoH • Majority of referrals are to Active Families which has 80% of children increasing healthy eating and activity.	July 2017 Māori Health Targets - 6 monthly to the Board
New actions	• Support screening in maternal programme, Well Child/Tamariki Ora and B4 School Checks	• Support training for health professionals completing screening - maternal, Well Child/Tamariki Ora and B4 School Checks.	• Completed WellChild/Plunket Health First Foods training, B4 School Check Conversation Tool training	Annually until 2020

Activities and Stakeholders				
	• Provide whānau based programmes to support lifestyle changes which support healthy weight i.e. Active Families • Support referrals to programmes via a range of pathways • Develop a clinical pathway from well child/primary care to secondary services • Support child health workforce, to deliver healthy conversations	• Contract community providers to take referrals for whānau with an overweight child (3-12 years) • Clinical pathway developed with key stakeholders- whānau, parents, children and health professionals • Healthy Conversation training delivered	• Active Families – delivered by Iron Māori and Sport HB. New contracts in place from Oct 2017. • Clinical pathway for B4 School Check complete. Working with diabetes pathway • Training in healthy conversation completed in 2016. Delivered the Healthy Food conversation tool 2017. Complete. • 8 year old measure includes a referral pathway to support whānau with children identified as obese. This includes clinical and family support.	

Objective 4: Provide leadership in healthy eating

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

Indicator 4b: Engage support from key partners

What the data shows

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

Activities and Stakeholders				
	What	**How**	**Progress**	**When**
Current activity	• Share information, evidence and best practice and healthy weight data with key community partners • Show leadership by establish the HBDHB Healthy Eating Policy and implementing the Healthy @ Work work plan	• Regular updates provided via Maternal, Well Child/Tamariki Ora and B4 School Check forums. Regular meetings with community providers • Review and monitor the HBDHB Healthy Eating Policy and support the implementation of the Health @ Work work plan	• Strategy and Best Start Plan shared with - Sport HB, Mananui, Napier and Hastings Councils, HB Community Fitness Centre Trust, DHB staff and placed on DHB website. Communication Plan developed to increase awareness • Policy complete	July 2017
New actions	• Lead an equity focus by applying an equity lens to review this plan and delivered activity • Lead messaging and delivery to reduce sugar intake • Align HBDHB Healthy Eating Policy with national food and beverage guidelines	• Equity assessment written and finding used to refine this plan to improve response to equity • Cross-sector activity includes a sugar reduction focus • Framework/process implemented for cross-sector approach and inter-agency activity reported	• All contracts have targets for Māori and Pasifika, resources are tested with Māori and Pasifika whānau and equity lens was applied to funding. • Water only and healthy food has been delivered in event planning, Pasifika churches, workplaces and education. • Shared Healthy Eating Strategy with Intersectorial Forum – Intersector Group	Ongoing until 2020

Activities and Stakeholders				
	• Develop a process for a cross-sector approach to support healthy eating environments • Influence key service delivery stakeholders to maintain best practise and consistent messaging • Continue engagement with community particularly key influencers for Māori and Pasifika i.e. marae and church leaders	• Hauora, general practice, LMCs, contracted community providers provide national messages consistently to whānau, community and their workplace • Key activities Waitangi Day celebrations - policy/guidance document development Ngāti Kahungunu Iwi Incorporated and engagement with Pasifika church leaders	establish and setting out leadership activities • Messaging is “water is the best drink” and promoting the MoH Nutrition Guidelines • We have worked with the Te Matatini steering group and promoted water and healthy food choices (with a reduction in high fat, sugar and salt foods). The Healthy Events – Food guide material has been reviewed by Ngāti Kahungunu Iwi (events and comms staff), available on DHB website. • Completed submissions and providing feedback on national work including Child Poverty and Child and Youth Wellbeing Strategy. • Partner agencies have delivered policies – HDC has “no fizzy” at the venues, Sport HB is working clubs and code to implement “water is the best drink” and healthy food options.	

Governance Report Overview

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

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

RECOMMENDATION:

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

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

HAWKE'S BAY
District Health Board
Whakawāteatia

Te Ara Whakawaiora - Smokefree

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

OVERVIEW

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

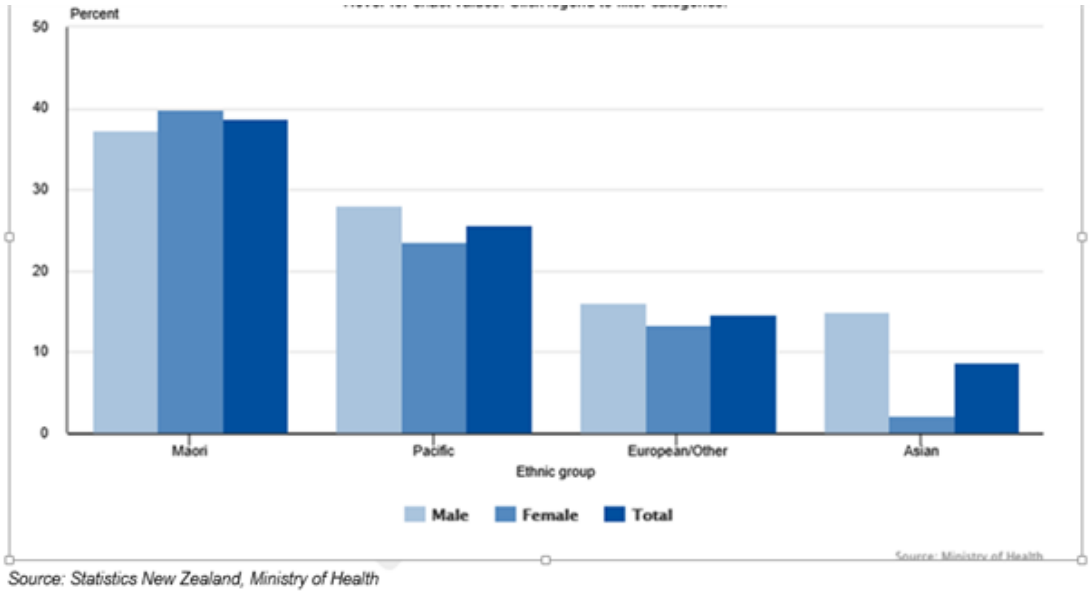
MĀORI HEALTH PLAN INDICATOR: Smokefree

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

WHY ARE THESE INDICATORS IMPORTANT?

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

Figure 1: Proportion of population who currently smoke tobacco



Source: Statistics New Zealand, Ministry of Health

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Whole of DHB

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

Māori

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

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

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

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

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

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

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

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

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

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

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

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

Wahine Hapu ISPP referrals from 1 January to 31 July 2018

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

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

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

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

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

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

Hospital Smokefree Target

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

Primary Health Organisation Smokefree Target

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

Maternity Smokefree Target

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

NEXT STEPS

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

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

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

RECOMMENDATION:

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

Note the content of the report.

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

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

RECOMMENDATION:

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

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

HAWKE'S BAY District Health Board
Whakawāteatia

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

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

ASH 0-4yrs

1. Keeping Children Out of Hospital

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

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

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

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

Activities:

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

Summary Comments:

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

ASH 45-64 yrs

2. Using Health Services Effectively

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

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

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

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

Summary Comments:

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

Activities:

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

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

Status of Recommendations (45-65 yrs)

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

RECOMMENDATION:

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

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

Governance Report Overview

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Performance Framework Exceptions Report Quarter 1 2018/19**
	For the attention of: **Māori Relationship Board, Pasifika Health Leadership Group and HBDHB Board**
Document Owner	Chris Ash, Executive Director of Primary Care Directorate
Document Author(s)	Peter Mackenzie, Business Intelligence Analyst
Reviewed by	Executive Management Team
Month/Year	November, 2018
Purpose	Monitoring
Previous Consideration Discussions	N/A
Summary	Areas of Success: HPV Vaccination Areas of Progress: DNA Rates, LMC Booking by Week 12 Areas of Focus: Shorter Stays in ED, Breastfeeding at 3 months
Contribution to Goals and Strategic Implications	Ensuring the DHB meets/improves performance for our Ministry of Health key performance indicators and local measures outlined in the DHB Annual plan.
Impact on Reducing Inequities/Disparities	This report highlights areas of inequity, comments are provided in relation to programs of work that are underway/planned in order to positively affect equity gaps.
Consumer Engagement	N/A
Other Consultation /Involvement	Comments are supplied from various staff members throughout the DHB including service directors or their delegate, program Leaders and the PHO
Financial/Budget Impact	NA
Timing Issues	NA
Announcements/ Communications	NA

RECOMMENDATION:

It is recommended that the Māori Relationship Board, Pasifika Health Leadership Group and HBDHB Board:

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

HBDHB PERFORMANCE FRAMEWORK
Quarter 4 2017/18

Author:	Peter Mackenzie
Designation:	Business Intelligence Analyst
Date:	August 2018

OVERVIEW
The purpose of this paper is to provide the Board with exception reporting on the Hawke's Bay District Health Board's performance on the Statement of Intent (SOI) and the District Annual Plan (DAP).

As this report ends 30th September 2018, the results in some instances may vary to those presented in other reports.

BACKGROUND
The National Health Board (NHB) facilitates DHB performance planning and monitoring within the Ministry of Health. DHB non-financial monitoring arrangements operate within wider DHB accountability arrangements including legislative requirements, obligations formalised via Crown Funding Agreements and other contractual requirements, along with formal planning documents agreed with the Minister of Health/Minister of Finance.

ANNUAL PLAN (AP) 2018/2019
The AP is a statutory requirement that includes the key actions and outputs the DHB will deliver in order to meet Government priorities and Health targets. Through the AP, the DHB has formally agreed to deliver on the performance expectations associated with the measures in the NHB-mandated monitoring framework.

STATEMENT OF PERFORMANCE EXPECTATIONS (SPE) 2018/19
The SPE is produced annually within the context of the four-year Statement of Intent (SOI) 2016-19. The SPE informs the House of Representatives of the performance expectations agreed between a Minister and a Crown Entity. Formal agreement is gained annually through the AP process and actual performance is assessed and reported through the audited HBDHB Annual Report.

HAWKE'S BAY DISTRICT HEALTH BOARD (HBDHB) PERFORMANCE FRAMEWORK
The four dimensions of the non-financial monitoring framework, which was developed by the Ministry as a mandatory framework, will reflect DHB's functions as owners, funders and providers of health and disability services.

The 4 dimensions of DHB performance are:

- *Achieving Government's priorities and targets (Policy priorities)*
- *Meeting service coverage requirements and supporting sector inter-connectedness (System Integration)*
- *Providing quality services efficiently (Ownership/Provider Arm)*
- *Purchasing the right mix and level of services within acceptable financial performance (Outputs/service performance)*

MINISTRY OF HEALTH ASSESSMENT CRITERION

Progress towards each target or measure will be assessed using the following criterion:

Rating	Abbrev	Criterion
Outstanding performer/sector leader	O	1. Applied in the fourth quarter only – this rating indicates that the DHB achieved a level of performance considerably better than the agreed DHB and/or sector expectations.
Achieved	A	1. Deliverable demonstrates targets/expectations have been met in full. 2. In the case of deliverables with multiple requirements, all requirements are met. 3. Data, or a report confirming expectations have been met, has been provided through a mechanism outside the Quarterly Reporting process, and the assessor can confirm.
Partially achieved	P	1. Target/expectation not fully met, but the resolution plan satisfies the assessor that the DHB is on to compliance. 2. A deliverable has been received, but some clarification is required. 3. In the case of deliverables with multi-requirements, where all requirements have not been met at least 50% of the requirements have been achieved.
Not achieved	N	1. The deliverable is not met. 2. There is no resolution plan if deliverable indicates non-compliance. 3. A resolution plan is included, but it is significantly deficient. 4. A report is provided, but it does not answer the criteria of the performance indicator. 5. There are significant gaps in delivery. 6. It cannot be confirmed that data or a report has been provided through channels other than the quarterly process.

KEY FOR DETAILED REPORT

Baseline	Latest available data for planning purpose
Target 2018/19	Target 2018/19
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target
Trend direction ▲	Performance is improving against the previous reporting period or baseline
Trend direction ▼	Performance is declining
Trend direction -	Performance is unchanged

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PERFORMANCE HIGHLIGHTS – TOTAL POPULATION

Achievements

- Health Target – The DHB has remained favourable for the Raising Healthy Kids measure with a Total Rate of 99%, Māori at 100% and Pacific at 100% against a target of 95%.

- HPV Vaccination – The DHB is favourable for eligible girls fully immunised with the HPV vaccine with a Total Rate of 75.7%, Māori at 84.9% and Pacific at 88.3% against a target of 75%.

Areas of Progress

- DNA – Overall the DHB have remained favourable at 6.3% against a target of less than 7.5%. This quarter both Māori at 12.2% and Pacific at 12.2% are unfavourable to the target however they have both improved over the previous quarter (page 26)

- Women book with an LMC by week 12 of pregnancy – The DHB overall result has improved from 57.9% in the previous quarter to 69.9% in the current quarter. There were also improvements for Māori from 50% to 57.9%.

Areas of Focus

We continue to focus our efforts in order to make gains with particular emphasis in the following areas:

- Health Target – Shorter Stays in ED has declined from 91% in the previous quarter to 86% and remains unfavourable to the target of 95% (page 7)

- Breastfeeding at 3 months – The DHB is unfavourable against the target of 70% with Total at 51.7% Māori at 35.6% and Pacific at 34.5%. Both Māori and Pacific have declined from the previous quarter (page 16).

PERFORMANCE HIGHLIGHTS – EQUITY

Achievements

- Immunisation HPV Vaccine – The Māori rate is currently 85% and the Pacific rate is 88%, both are above to the Total rate of 76%.

- Mental Health Wait Times: Māori results for the Mental Health provider arm are 80% within 3 weeks and 94.6% within 8 weeks compared with Other ethnicities at 76% within 3 weeks and 91.8% within 8 weeks (page 27).

Areas of Progress

- Immunisation 4 year olds – Māori have improved this quarter from 89% to 92% compared with the total rate of 92% and the rate for Other ethnicities of 91%, all ethnicities are unfavourable to the target of 95% (page 14).

Areas of Focus

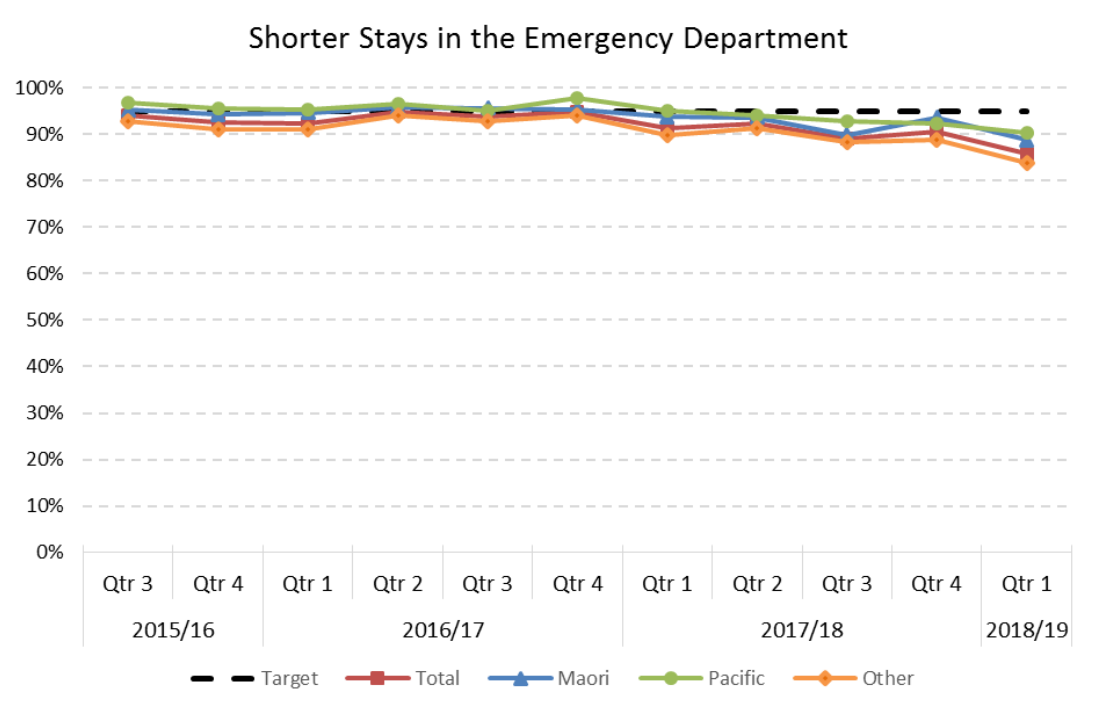
- DNA – The result for Māori 12.2% and Pacific 12.2% are higher than the Other ethnicity at 4.1% (page 26)

- Rate of Section 29 orders per 100,000 population – Māori Rates have improved slightly over the past 12 months from 398 to 385 (per 100,000) against the target of less than 375 however the Māori rates are 3 times higher than the non-Māori Rate 115 per 100,000 (page 29)

HEALTH TARGETS

Health Target: Shorter stays in emergency departments
95% of all people attending the Emergency Department will be admitted, transferred or discharged within six hours

Ethnicity	Baseline [1]	Previous result [2]	Actual to Date [3]	Target 2018/19	Trend Direction
Total	93.9%	90.5% (U)	85.9% (U)	≥95%	▼
Māori	95.3%	93.6% (U)	88.7% (U)	≥95%	▼
Pacific	96.2%	92.4% (U)	90.3% (U)	≥95%	▼
Other	93.0%	88.7% (U)	83.9% (U)	≥95%	▼



Data Source: HBDHB

Comments:
Results for all population groups have been worsening since mid-2017. Poor quarter 1 results are related mainly to inpatient acuity and length of stay along with influenza illness and higher than predicted staff sickness. ED was overcrowded with long delays for patients to be seen, then delays for them to have specialty reviews, including medical, surgical, mental health referrals. There has also been limited resources available to backfill RMO (resident medical officer) sick leave and ICU (intensive care unit) operating at or over capacity, leading to patients remaining in ED until ICU beds are available. Mitigation strategies include putting in place the introduction and reporting of Internal Professional Standards (IPS) and a review of data to identify pressure points either under or outside of ED control. There is ongoing focus by the ED SMO group, Duty Nurse Managers, Senior Nurses and Leadership team on ED length of stay and assessment and referral of patients. HBDHB has extended the hours of the "ORBIT" interdisciplinary team to provide 7 day week patient support and assessment 12 hours each day. Going forward there is the allocation of quality improvement team members to support the department to work through identified work stream to improve patient flow and management. HDBHD will be developing a response requirement for ED and specialty teams, identified by IPS. Over the next month work is being completed on the AAU Model of Carenow that pyhysicians have been recruited. We will complete a rapid cycle of change focusing on moving medical patients through more quickly.

1 October to December 2017
2 April to June 2018
3 July to September 2018

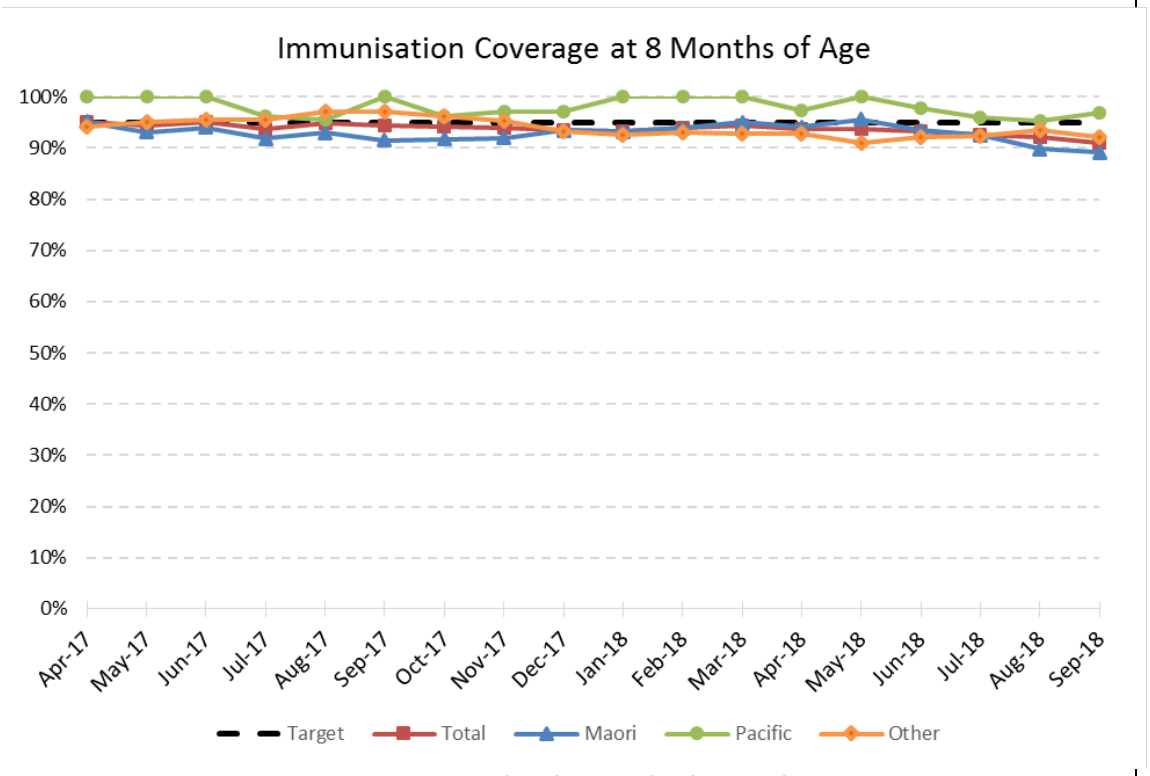
Health Target: Faster Cancer Treatment – 62 Day patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer					
Key Performance Measures	Baseline [4]	Previous result [5]	Actual to Date [6]	Target 2018/19	Trend direction
Total					
Māori					
Pacific					
Other					
*Data has not been supplied by the ministry yet. Data and chart will be added in time for the board report					
Comments:					

4 6 months to December 2016

5 6 months to March 2018

6 6 months to June 2018

Health Target: Increased immunisation at 8 Months % of 8 month olds fully immunised					
Ethnicity	Baseline [7]	Previous result [8]	Actual to Date [9]	Target 2018/19	Trend direction
Total	95%	92.2% (U)	91% (U)	≥95%	▼
Māori	93%	89.8% (U)	89.1% (U)	≥95%	▼
Pacific	97%	95.3% (F)	96.8% (F)	≥95%	▲
Other	86%	93.5% (U)	92% (U)	≥95%	▼



Data Source: National Immunisation Register

Comments:

There is a disappointing result with the 8 month overall coverage of 91%. There is a 1.5% increase in the numbers of Pacifica babies up to date at this age but a 1.5 % decrease in Other of this age, Māori had the smallest decrease at 0.7 %. In this age group 47 babies were at various stages of their immunisation schedule, 24 of whom had received no immunisations. General Practice has experienced a very busy quarter where appointments have not been readily available. We are working with General Practice and the PHO to see how we can support them to ensure on time immunisations. The drop in our clinic outreach service provider sees a number of children attend and there is opportunity to increase these numbers. We will be working with stakeholders to promote this service as an option for those families who are unable to enrol or secure appointments at general practice. Additionally, the death of 2 infants in Samoa post immunisation events has raised concern among our families who have become hesitant towards their child's immunisations. Often multiple conversations in a variety of forums have been required to allay fears and concerns. Our outreach immunisation team continue to monitor and seek to find those babies who are living in transient families across Hawkes Bay.

7 October to December 2017. Source: National Immunisation Register, MOH

8 April to June 2018. Source: National Immunisation Register, MOH

9 July to September 2018. Source: National Immunisation Register, MOH

Health Target: Better help for smokers to quit – Primary Care
% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months

Key Performance Measures	Baseline [10]	Previous result [11]	Actual to Date [12]	Target 2018/19	Trend direction
Total					
Māori					
Pacific					
Other					

*Data has not been supplied by the ministry yet. Data and chart will be added in time for the board report

Comments:

10 15 months to December 2016. Source: DHB Shared Services

11 15 months to March 2018. Source: DHB Shared Services

12 15 months to June 2018. Source: DHB Shared Services

Health Target: Better help for smokers to quit – Maternity % of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking					
Key Performance Measures	Baseline [13]	Previous result [14]	Actual to Date [15]	Target 2018/19	Trend direction
Total					
Māori					

*Data has not been supplied by the ministry yet. Data and chart will be added in time for the board report

Comments:
Wahine Hapu - Increasing Smoke free Pregnancy Programme was reviewed in July 2018. Changes have been made as a result and this has translated into increased referrals to Te Haa Matea. DHB Smoke free Team attends peer support meetings with Te Haa Matea Stop Smoking Practitioners to discuss case studies and find shared solutions and streamline processes as required. Recommendations from the Maternal Incentives Programme have been implemented. The DHB is trialling using CO monitors for all pregnant women and their whanau. This will capture the impact of smoking and inefficient heating devices (unflued gas heaters, smoky fires). The aim is to start the conversation about Smoke free homes for healthy pēpi (and whanau). Referral to healthy homes can then be processed to address heating. If it works this will roll out to all midwives with high Māori caseloads.

13 October to December 2016. Source: DHB Shared Services

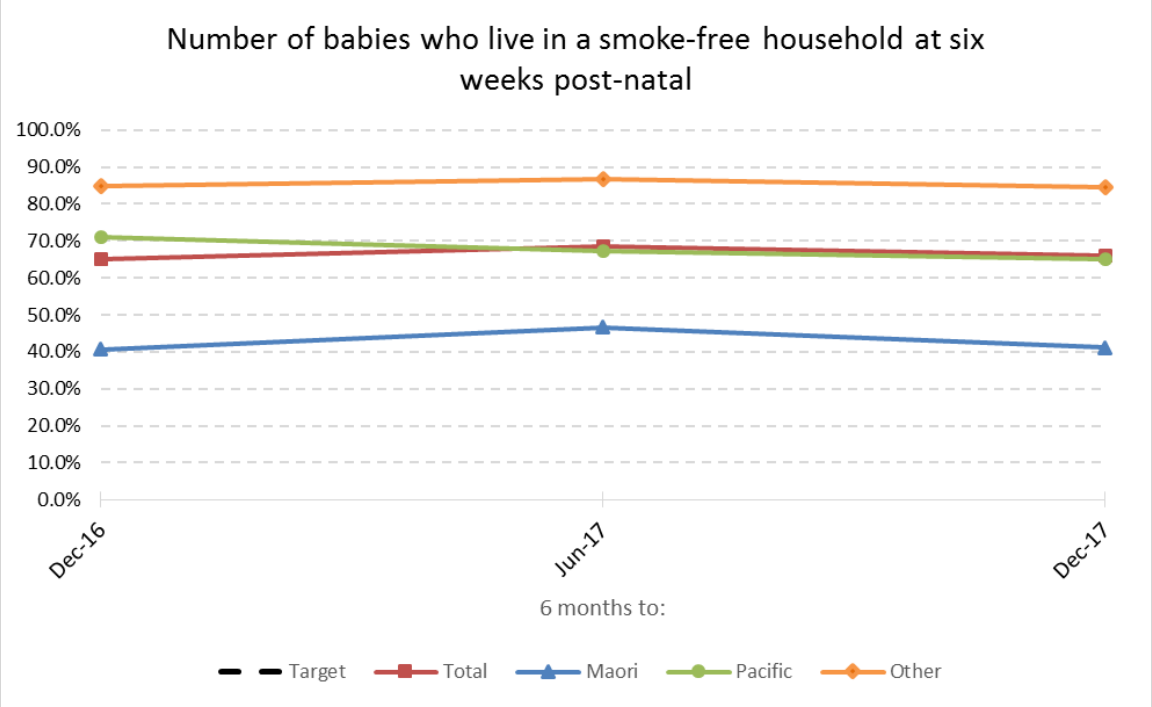
14 January to March 2018. Source: DHB Shared Services

15 April to June 2018. Source: DHB Shared Services

OUTPUT CLASS 1: PREVENTION SERVICES

Better Help for Smokers to Quit – Smoke-free Households
Number of babies who live in a smoke-free household at six weeks post-natal

Key Performance Measures	Baseline [16]	Previous result [17]	Actual to Date [18]	Target 2018/19	Trend direction
Total	66.1%	68.4%	66.1%		▼
Māori	0.0%	46.6%	41.2%		▼
Pacific	0.0%	67.3%	65%		▼
Other	0.0%	86.8%	84.4%		▼

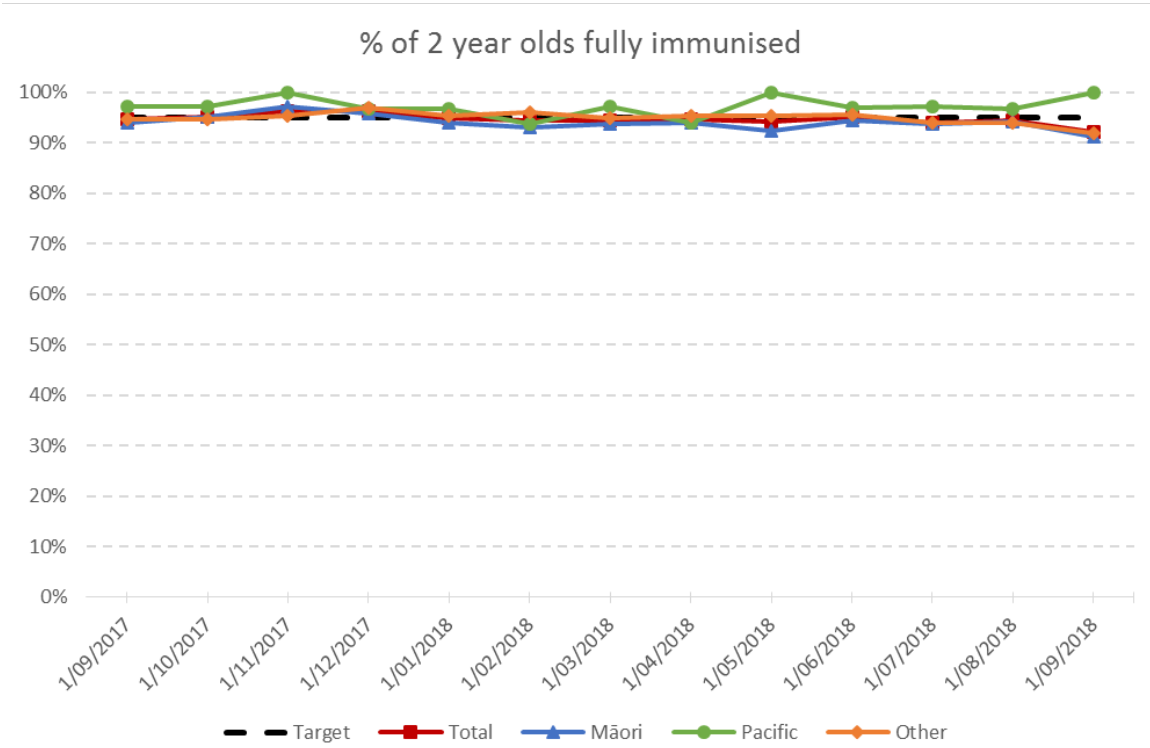


Source: B4SC

Comments:
For the financial year 2017/18 no target was set as this measure was developmental. The 2018/19 Annual plan contains a target and this will be reflected in the Q2 report.

16 6 months to December 2016. Source: B4SC
17 6 months to June 2017. Source: B4SC
18 6 months to December 2017. Source: B4SC

Increase Immunisation – 2 Years % of 2 year olds fully immunised					
Key Performance Measures	Baseline [19]	Previous result [20]	Actual to Date[21]	Target 2018/19	Trend direction
Total	94.0%	95.7% (F)	92.1% (U)	≥95%	▼
Māori	95.0%	94.8% (F)	91.2% (U)	≥95%	▼
Pacific	96.0%	97% (F)	100% (F)	≥95%	▲
Other	86.0%	95.6% (F)	92% (U)	≥95%	▼



Data Source: National Immunisation Register

Comments:
The drop in coverage for 2 year olds is disappointing. However, there has been ongoing challenges with the death of 2 infants at the 15 month old immunisation event in Samoa. Families' are requiring additional support to allay concerns regarding immunisations, in response we have provided additional resources and key messages to across the sector to mitigate the anxiety. Māori rates are continuing to decline and we are unsure of the reasons for this. However, we continue to explore innovative methods to engage with Māori and their whanau to ensure equitable access.

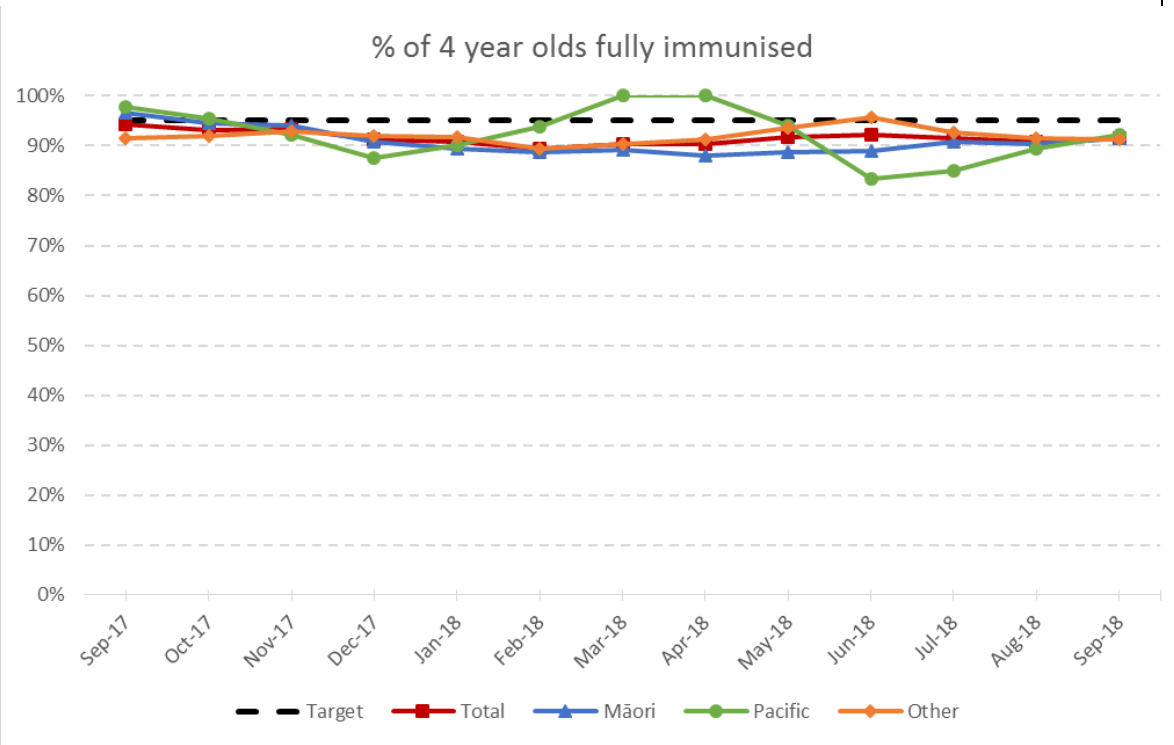
18

19 October to December 2017 . Source: National Immunisation Register, MOH

20 April to June 2018. Source: National Immunisation Register, MOH

21 July to September 2018. Source: National Immunisation Register, MOH

Increase Immunisation – 4 Years % of 4 year olds fully immunised					
Key Performance Measures	Baseline [22]	Previous result [23]	Actual to Date[24]	Target 2018/19	Trend direction
Total	94.0%	92.2% (U)	91.4% (U)	≥95%	▼
Māori	93.0%	89% (U)	91.5% (U)	≥95%	▲
Pacific	96.0%	83.3% (U)	92.1% (U)	≥95%	▲
Other	86.0%	95.7% (F)	91.3% (U)	≥95%	▼



Data Source: National Immunisation Register

Comments:
HBDHB remain pleased with the 4 year old coverage with equity maintained. This cohort is the hardest to make progress with due to all the factors that have affected the younger age bands coverage but more so that we seem to have more children coming in from overseas needing catch up immunisations in this cohort. Although we try, capacity of our team is an issue and the focus remains on the 8 month and 2 year coverage first and foremost. We do have really good collaboration between B4SC and ourselves providing each other with details of children that we were unaware of within our area which helps eliminate children falling through the gaps.

22 October to December 2017 . Source: National Immunisation Register, MOH

23 April to June 2018. Source: National Immunisation Register, MOH

24 July to September 2018. Source: National Immunisation Register, MOH

Increase Immunisation - Influenza % of 65+ year olds immunised – flu vaccine					
Key Performance Measures	Baseline [25]	Previous result [26]	Actual to Date[27]	Target 2018/19	Trend direction
Total	59.1%	59.1% (U)	58.1% (U)	≥75%	▼
Māori	56.3%	56.3% (U)	53% (U)	≥75%	▼
Pacific	51.5%	51.5% (U)	51.7% (U)	≥75%	▲
Other	60%	60% (U)	59.4% (U)	≥75%	▼

Data Source: National Immunisation Register

Comments:
Coverage for influenza immunisation has not improved over the previous year according to the coverage report on datamart, although the rate will be higher than this as immunisations given through occupational health providers are not on NIR. We have a large number of pharmacies vaccinating in HB which should be making access easier. We also have 2 Māori providers and 1 rural nurse led health centre with contracts providing influenza immunisation to the eligible population. Health HB have run their Whanau wellness programme again this year and the HBDHB immunisation team presented at these sessions and provided influenza immunization to those who wanted them.

25 6 months to September 2017 . Source: National Immunisation Register, MOH

26 6 months to September 2017. Source: National Immunisation Register, MOH

27 6 months to September 2018. Source: National Immunisation Register, MOH

Better rates of breastfeeding – 3 months
% of infants that are exclusively or fully breastfed at 3 months

Key Performance Measures	Baseline [28]	Previous result [29]	Actual to Date[30]	Target 2018/19	Trend direction
Total	51.3%	51.3% (U)	51.7% (U)	≥70%	▲
Māori	41.0%	41% (U)	35.6% (U)	≥70%	▼
Pacific	42.6%	42.6% (U)	34.5% (U)	≥70%	▼
Other	-	-	-	≥70%	*

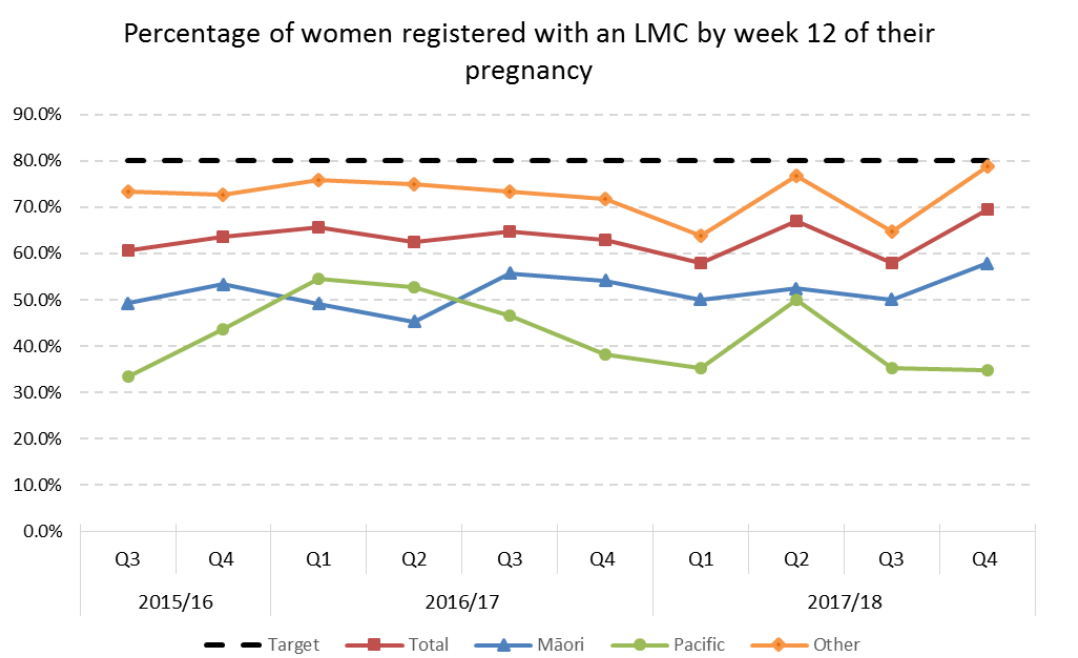
Data Source: Well Child Tamariki Ora

Comments:
HBDHB is aware of the declining trend in the breastfeeding rate in particular for Māori at 3 months which is reflective of a declining trend of breastfeeding on discharge from hospital and at 2 weeks. Some factors that appear to be related to this trend are higher than average complications i.e. SCBU admissions and also increased staffing/workload pressures for Midwifery services which has reduced the ability of time spent supporting mothers to establish breastfeeding. In response, a one off support PVS from Population Health is being used as a pilot approach to increase community midwifery breastfeeding support in the home of .9FTE for Māori and Pacific mothers on discharge and Te Tai Whenua O Heretaunga have recruited within the last month to a 1 FTE Breastfeeding support position funded via Māori Health for Well Child Tamariki services. A similar contract has also been established up in Wairoa with Kauhungunu Executive. An ongoing concern is a restructure of Plunket services locally to a centralised service which has not yet allowed the local office to appoint their similar Māori health funded contract for a 1 FTE lactation Consultant. Interviews conducted with 50 Māori Mama from last year's birth cohort recently for the Kaupapa Māori Maternal Wellbeing program has identified breastfeeding issues/lack of support as one of the highest priority areas that will need to be addressed and strongly embedded by development of this new program over the next 6 months.

28 6 months to December 2017
29 6 months to December 2017
30 6 months to June 2018.

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES

More pregnant women under the care of a Lead Maternity Carer (LMC) % of women booked with an LMC by week 12 of their pregnancy					
Key Performance Measures	Baseline [31]	Previous result [32]	Actual to Date [33]	Target 2018/19	Trend direction
Total	67.1%	57.9% (U)	69.6% (U)	≥80%	▲
Māori	52.4%	50% (U)	57.9% (U)	≥80%	▲
Pacific	50.0%	35.3% (U)	34.8% (U)	≥80%	▼
Other	76.9%	64.8% (U)	78.9% (U)	≥80%	▲



Comments:
The ongoing fluctuation of bookings by week 12 of pregnancy is evident here with a rise in all ethnicities except Pacific island. As a DHB our top 5 to thrive campaign continues with the intent through the MOH MQS programme to refresh and target both Māori and Pacifica women to support ease of access to a midwife early in pregnancy. Interviews with Māori women who have had a baby in the last 12 months has been completed with good feedback on what would work to support better access. The development of a Hapu Mama maternal programme is coming together with the intent of having this set up by mid next year. Ongoing collaboration with primary care colleagues, LMCs and resource centres across the district supporting visibility and responsiveness to a positive pregnancy tests continues, this is a particular focus and ongoing project within the Maternity quality and safety programme.

31 October to December 2017.
32 January to March 2018.
33 April to June 2018

CVD Risk Assessments
Improved management of long-term conditions (CVD, Acute heart health, Diabetes, and Stroke)
% of the eligible population will have had a CVD risk assessment in the last 5 years

Key Performance Measures	Baseline [34]	Previous result [35]	Actual to Date [36]	Target 2018/19	Trend direction
Total					
Māori					
Pacific					
Other					

Source: Ministry of Health

*Data has not been supplied by the ministry yet. Data and chart will be added in time for the board report

34 5 years to December 2016. Source: Ministry of Health

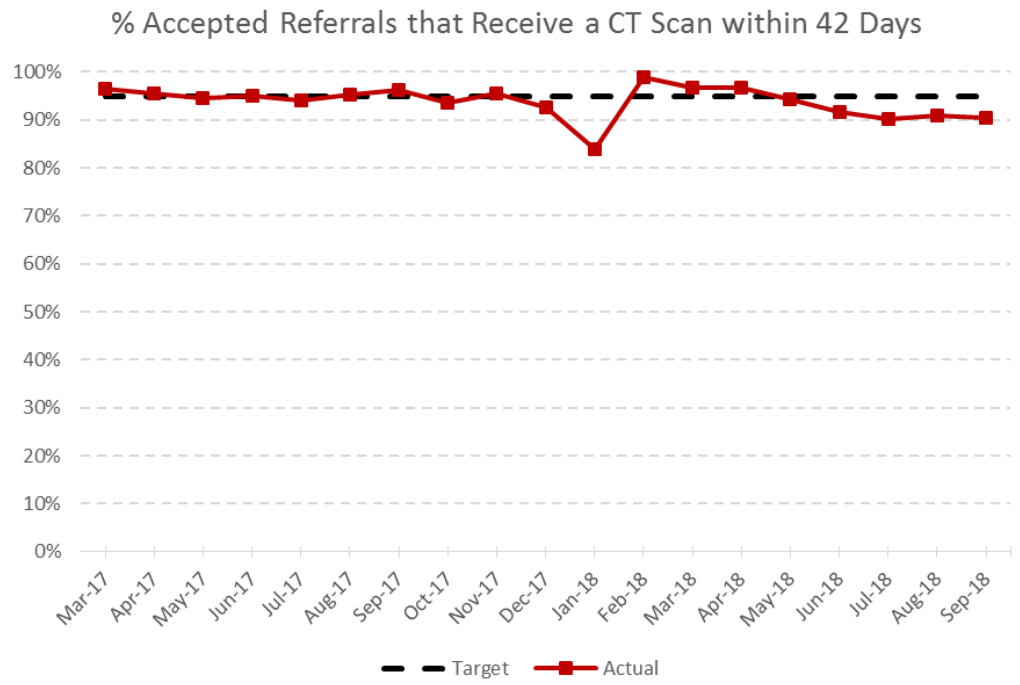
35 5 years to June 2017. Source: Ministry of Health

36 5 years to September 2017 . Source: Ministry of Health

Less waiting for diagnostic services - CT

% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks)

Key Performance Measures	Baseline [37]	Previous result [38]	Actual to Date [39]	Target 2018/19	Trend direction
Total	92.5%	92% (U)	91% (U)	≥95%	▼
Māori	-	-	-	≥95%	*
Pacific	-	-	-	≥95%	*
Other	-	-	-	≥95%	*



Comments:

The Ministry submission has been delayed due to issues at the Ministry - comments will be added in time for the board report

18

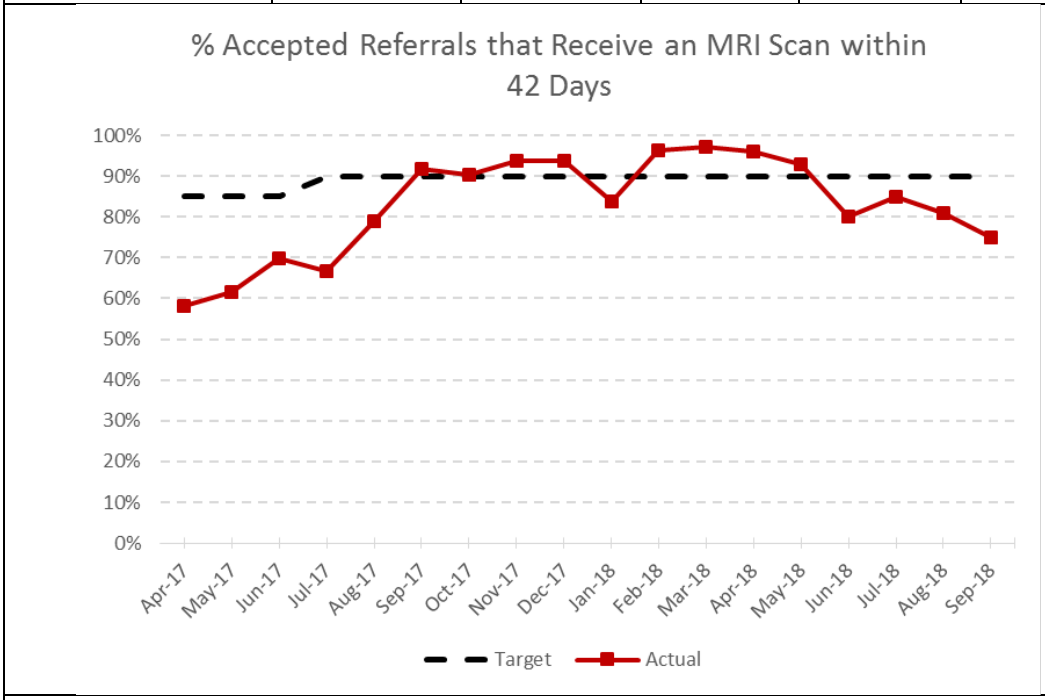
37 December 2017. Source: Ministry of Health

38 June 2018. Source: Ministry of Health

39 September 2018 . Source: Ministry of Health

Less waiting for diagnostic services - MRI
% of accepted referrals for MRI scans who receive their scans within 42 days (six weeks)

Key Performance Measures	Baseline [40]	Previous result [41]	Actual to Date [42]	Target 2018/19	Trend direction
Total	93.8%	80% (U)	75% (U)	≥90%	▼
Māori	-	-	-	≥90%	*
Pacific	-	-	-	≥90%	*
Other	-	-	-	≥90%	*



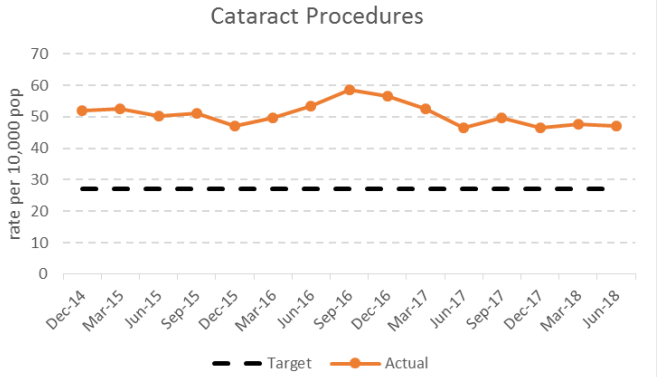
Comments:

The Ministry submission has been delayed due to issues at the Ministry - comments will be added in time for the board report

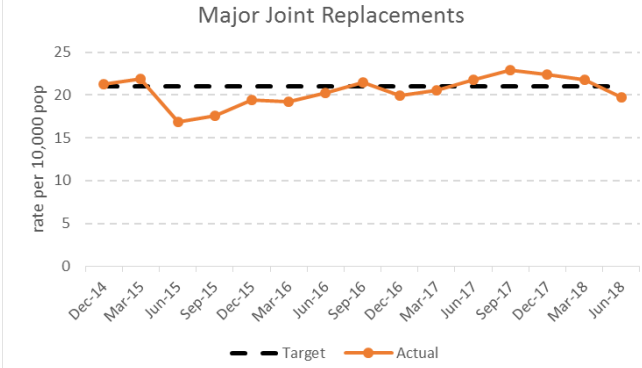
40 December 2017. Source: Ministry of Health
41 June 2018. Source: Ministry of Health
42 September 2016. Source: Ministry of Health

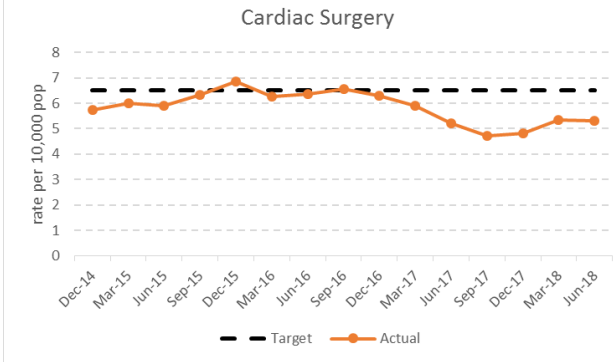
OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT SERVICES

Equitable access to surgery -Standardised intervention rates for surgery per 10,000 population					
Key Performance Measures	Baseline[43]	Previous result[44]	Actual to Date [45]	Target 2018/19	Trend direction
Major joint replacement	22.4	21.78 (F)	19.77 (U)	≥21	▼
Cataract procedures	46.6	47.54 (F)	47.04 (F)	≥27	▼
Cardiac procedures	4.8	5.36 (U)	5.32 (U)	≤6.5	▼
Percutaneous revascularization	11.9	11.64 (U)	12.67 (F)	≥12.5	▲
Coronary angiography services	36.4	35.91 (F)	38.09 (F)	≥34.7	▲



Source: Ministry of Health

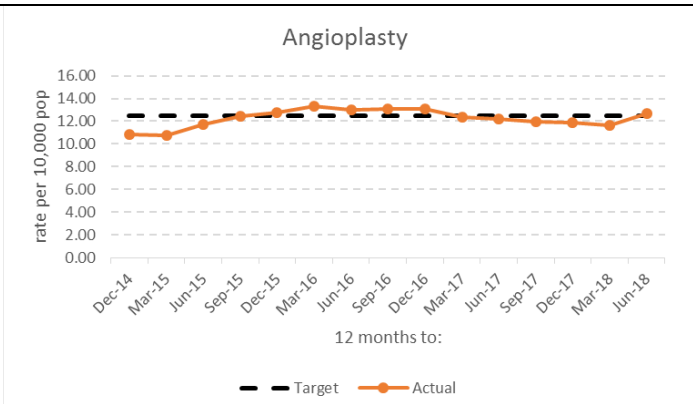


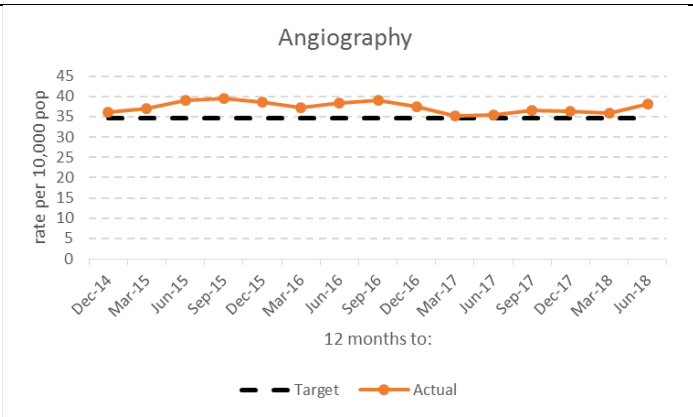


43 12 months ending December 2017. Source MoH

44 12 months ending March 2018. Source MoH

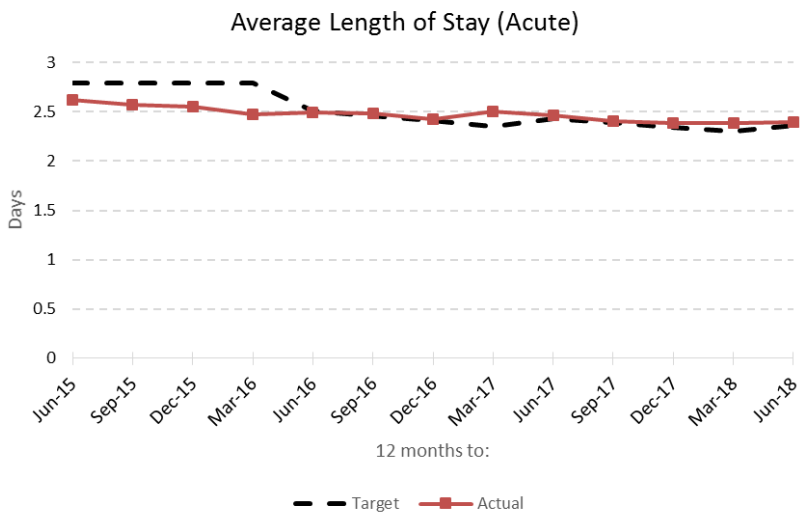
45 12 months ending June 2018. Source MoH



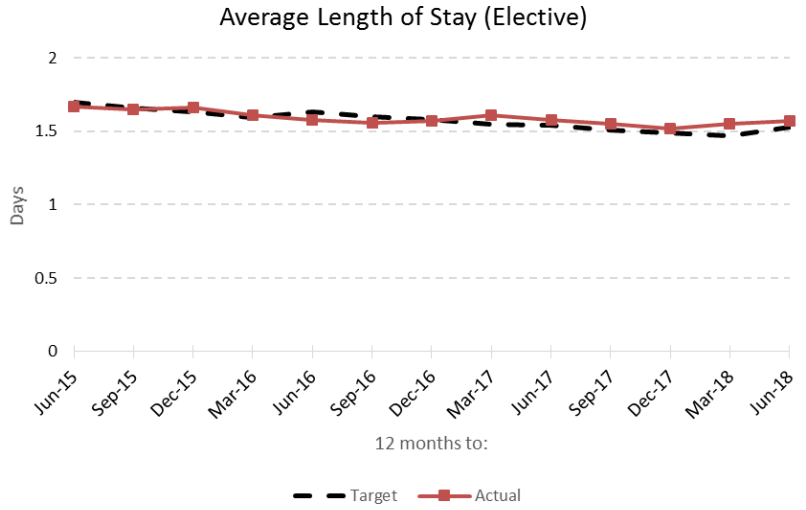


Comments:
The reason for the low standard intervention rates for Cardiac surgery is because we do not have enough referrals for surgery. HBDHB manages all patients referred for surgery and does not have a large waitlist, while there are at times capacity constraints this does not impact on the standard intervention rates, the number of referrals do.

Shorter stays in hospital Length of stay (days)					
Key Performance Measures	Baseline [46]	Previous result [47]	Actual to Date [48]	Target 2018/19	Trend direction
Acute	2.39	2.39 (U)	2.4 (U)	≤2.3	▼
Elective	1..52	1.55 (U)	1.57 (U)	≤1.45	▼



Source: Ministry of Health



Comments:

Acute - The quarter April to June had elevated acute presentations via ED and clinics/GPs with complexity and high acuity. All wards were sitting at over 90% occupancy due to Surgery postponements affected by high electives, with waiting time for acute surgery delayed at times due to high volumes. In order to help, A2 was open to 10 beds and we are recruiting to permanent staff so those beds can be open 7 days per week (In this period only budgeted 5 days a week). Casual and relief nursing pool were increased by 10 FTE to ensure all beds can be resourced. Plans for high care rooms in x2 surgical wards being worked up to ensure these patients coming in increasing numbers are kept under close Senior RN care- this should decrease any rapid responses or post-operative complications that increase LOS.

46 12 months to September 2016. Source: Ministry of Health

47 12 months to August 2017. Source: Ministry of Health

48 12 months to September 2017 .Source: Ministry of Health

18

Elective – HBDHB had higher case weights leading to longer stays e.g. increasing bowel cancers requiring complex surgery and often HDU (high dependency unit) stays then to wards and this always lengthens stay. Lighter cases that turn over in 24 hours were not done generally in this period as no theatre or ward capacity was available due to the above. Outsourcing was capped from April and these are smaller case weights but they were all just put into a waiting pool. Going forward HBDHB is looking at making elective We aim to change Lap Cholecystectomy cases to day cases (no overnight stay) were as currently the stay is 24 hours, we will trial with one General Surgeon to being with. HBDHB also have an acute Lap Cholecystectomy pathway developed to ensure these patients are not sitting in an acute beds for 3-4 days waiting for surgery. Instead those that meet the criteria will be sent home with specific instructions and return to a dedicated acute list for this procedure.

Quicker access to diagnostics					
Key Performance Measures	Baseline [49]	Previous result [50]	Actual to Date[51]	Target 2018/19	Trend direction
% accepted referrals for elective coronary angiography completed within 90 days	87.8%	94.4% (U)	97.5% (F)	≥95%	▲
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive),	93.5%	96% (F)	94% (F)	≥90%	▼
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)	59.0%	55% (U)	54% (U)	≥70%	▼
% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date	68.0%	78% (F)	60% (U)	≥70%	▼
Comments: The Ministry submission has been delayed due to issues at the Ministry - comments will be added in time for the board report					

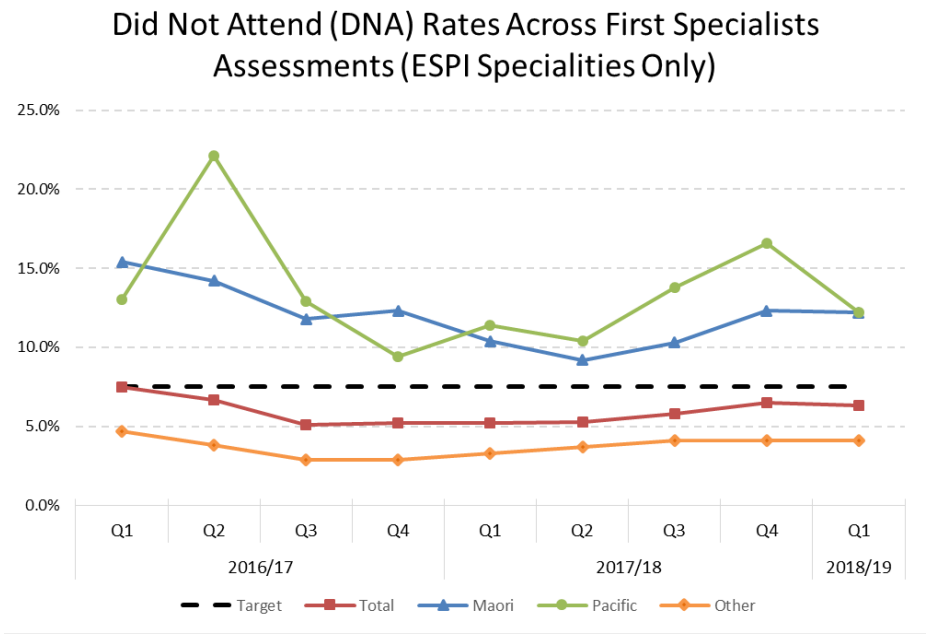
18

49 December 2017.

50 June 2018.

51 September 2018

Fewer missed outpatient appointments ***Did not attend (DNA) rate across first specialist assessments***					
Key Performance Measures	Baseline [52]	Previous result [53]	Actual to Date [54]	Target 2018/19	Trend direction
Total	5.3%	6.5% (U)	6.3% (F)	≥7.5%	▼
Māori	9.2%	12.3% (F)	12.2% (U)	≥7.5%	▼
Pacific	10.4%	16.6% (F)	12.2% (U)	≥7.5%	▼
Other	0.037	4.1% (U)	4.1% (F)	≥7.5%	—

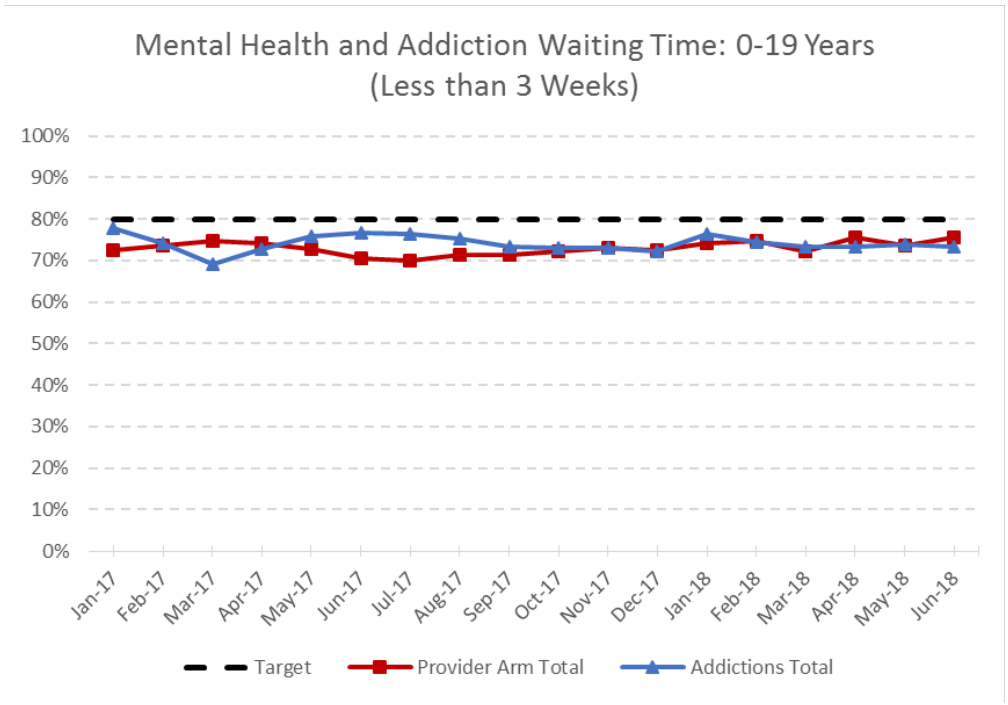


Source: HBDHB

Comments:
The overall total DNA continues to remain below the target rate of 7.5%, however the inequity with Māori and Pacific is still apparent. Māori and Pacific DNA levels sit at three times the level of Other, showing that barriers remain, preventing Māori and Pacific from utilising the HBDHB services in the same way as the rest of our population. The fluctuations in DNA levels over the last 3 months is a reflection of stretched resourcing across Outpatient Booking and Kaitakawaenga, resulting in less resource available to actively chase up those patients that are difficult to reach. The loss of the evening calling by our Switchboard continues to have a negative impact on DNA, and outpatient bookers workloads have been at levels where prioritising the calling of patients to attend appointments has not always possible. Over the last quarter the Pacific DNA result for September has dropped to 7%, this is the lowest level recorded over the last year. Although Pacific figures vary considerably with low numbers it is worth noting that additional training was recently given to the Pacific Navigator to assist in a more efficient targeted approach to the Pacific population. Hopefully we continue to see this positive impact on the Pacific DNA rate into the next quarter. Focus is going into capturing the 'real story' with plans for Kaitakawaenga to survey people who have DNA'd especially in the worst areas of General Surgery and Dental

52 October to December 2016. Source: Ministry of Health
53 July to September 2016. Source: Ministry of Health
54 October to December 2016 . Source: Ministry of Health

Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds					
Key Performance Measures	Baseline [55]	Previous result [56]	Actual to Date [57]	Target 2018/19	Trend direction
Mental Health Provider Arm: Age 0-19					
<3 weeks					
Total	72.5%	73.4% (U)	75.7% (U)	≥80%	▲
Māori	76.4%	78.7% (U)	80.2% (F)	≥80%	▲
Pacific	82.6%	91.3% (F)	100% (F)	≥80%	▲
Other	70.2%	68.7% (U)	71.3% (U)	≥80%	▲
<8 weeks					
Total	91.2%	92.7% (U)	93.2% (U)	≥95%	▲
Māori	94.1%	94.4% (U)	94.6% (F)	≥95%	▲
Pacific	91.3%	100% (F)	100% (F)	≥95%	—
Other	88.7%	91% (U)	91.8% (U)	≥95%	▲
Addictions (Provider Arm & NGO): Age 0-19					
<3 weeks					
Total	72.1%	73.8% (U)	73.2% (U)	≥80%	▼
Māori	61.1%	64.9% (U)	66.7% (U)	≥80%	▲
Pacific	100.0%	100% (F)	100% (F)	≥80%	—
Other	85.7%	86.9% (F)	81.8% (F)	≥80%	▼
<8 weeks					
Total	95.6%	93.4% (U)	98.2% (F)	≥95%	▲
Māori	94.1%	94.4% (U)	94.6% (F)	≥95%	▲
Pacific	100.0%	100% (F)	100% (F)	≥95%	—
Other	100.0%	100% (F)	100% (F)	≥95%	—



Source: Ministry of Health

Comments:
In the last quarter we have had a reduction in our workforce that has impacted our ability to

18

5512 months to December 2016

56 12 months to June 2018

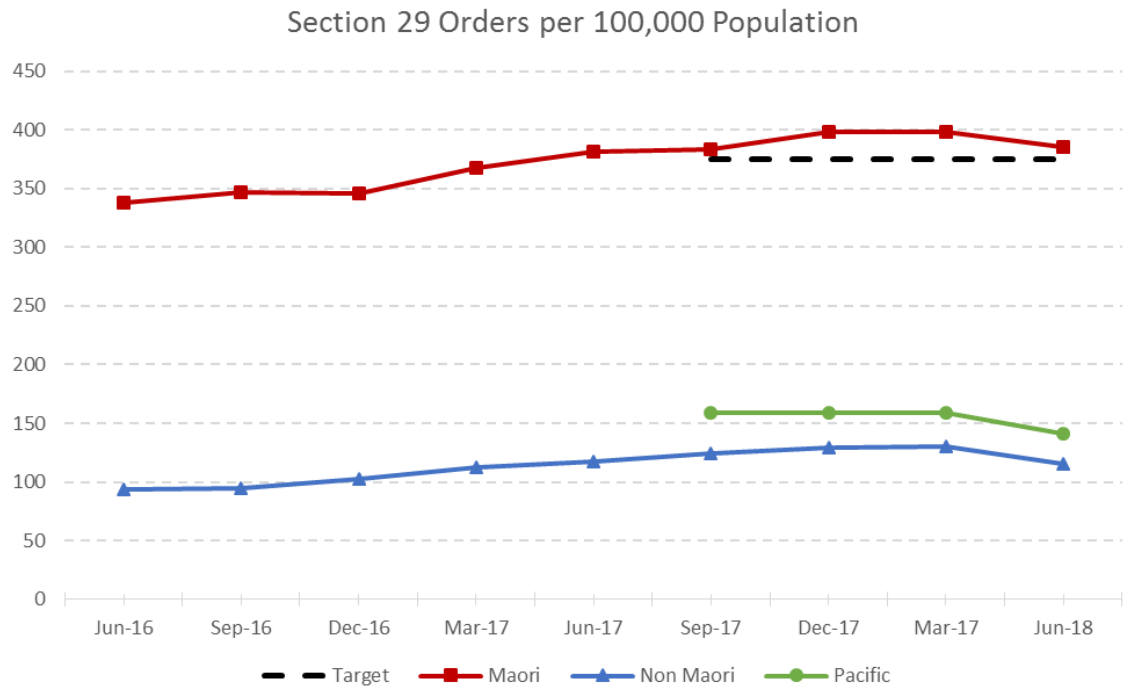
57 12 months to September 2018

meet the target. We have put in a number of short term mitigation strategies in place: Firstly the utilisation of the FTE underspend to purchase packages of care from outsourced clinicians, this is currently not reflected in our target data. Secondly the DHB have deployed non clinical capacity to follow up first time appointments to decrease DNAs and ensure the first time appointments are utilised. Lastly the DHB have actively recruited staff with FTE commencing in January 2019.

Increasing consumer focus, More equitable use of Mental Health Act: Section 29 community treatment orders

Rate of s29 orders per 100,000 population

Ethnicity	Baseline [58]	Previous result [59]	Actual to Date [60]	Target 2018/19	Trend direction
Non- Māori	129	130 (F)	115 (F)	-	▲
Māori	398	398 (U)	385 (U)	≤375	▲
Pacific	159	159 (F)	141 (F)	-	▲



Data Source: Ministry of Health

Comments:
We have completed a Mental Health Indicator Review that has provided us with challenging but encouraging information on the status of this mental health indicator. The review recognises that being placed under s29 of the Mental Health Act is compounded by the complexity of social, family and health factors. The differences in the population rates of these underlying factors may be a significant driver of compulsory treatment and is an important component of any strategies to reduce the rate. We are considering the report recommendations.

58 12 months to December 2017
59 12 months to March 2018
60 12 months to June 2018

RECOMMENDATION:
It is recommended that the Māori Relationship Board, Pasifika Health Leadership Group and the HBDHB Board:

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

ATTACHMENT:

- HBDHB Quarterly Performance Monitoring Dashboard Q3 (not available at this time)

HAWKE'S BAY
District Health Board
Whakawāteatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

20. Minutes of Previous Meeting
21. Matters Arising – Review Actions

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

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

19