Māori Relationship Board Meeting

Date:	**Wednesday, 11 December 2019**
Meeting:	**9.00am to Noon**
Venue:	**Te Waiora Meeting Room, DHB Corporate Office, Omahu Road, Hastings**

Board Members:

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

Apology:

In Attendance:

Member of the Hawke's Bay District Health Board (HBDHB) Board
Members of the Executive Leadership Team
General Manager Māori Health
Member of Hawke's Bay Consumer Council
Member of Hawke's Bay Clinical Council
Member of Ngāti Kahungunu Iwi Inc.
Member of Health Hawke's Bay Ltd (PHO)
Members of the Māori Health Service
Members of the Public

PUBLIC MEETING

Item	Section 1 : Routine	Time (am)
1.	Karakia	9.00
2.	Introductions/ Apologies	
3.	Whakawhanaungatanga	
4.	Interests Register	
5.	Minutes of Previous Meeting	
6.	Matters Arising – Review of actions	
7.	MRB Workplan	
8.	Māori Relationship Board Chair's update with October report to Board	
9.	Te Pìtau Health Alliance Update	
	Section 2: For Information / Discussion	
10.	VIP/Family Harm report – Bernard Te Paa	10.00
11.	Wairoa Integrated Health System – Chris Ash	10.20
12.	Corporate Performance Dashboard – Chris Ash	11.00
13.	**Section 4: Recommendation to Exclude the Public** Under Clause 32, New Zealand Public Health & Disability Act 2000	

PUBLIC EXCLUDED

	Section 5: Routine	Time (am)
14.	Minutes of the Previous Meetings - nil	11.10
15.	Matters Arising - Review of Actions - nil	
	Karakia Whakamutunga (Closing) – followed by light lunch	

NEXT MEETING:
Wednesday, 12 February 2020
Kahureremoana Room
Mihiroa Marae
Omahu Road, Hastings

Our shared values and behaviours

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGA TE TIRA PARTNERSHIP
TAUWHIRO CARE

HE KAUANUANU RESPECT

*Showing **respect** for each other, our staff, patients and consumers*

	✔	✘
Welcoming	Is polite, welcoming, friendly, smiles, introduce self Acknowledges people, makes eye contact, smiles	Is closed, cold, makes people feel a nuisance Ignore people, doesn't look up, rolls their eyes
Respectful	Values people as individuals; is culturally aware / safe Respects and protects privacy and dignity	Lacks respect or discriminates against people Lacks privacy, gossips, talks behind other people's backs
Kind	Shows kindness, empathy and compassion for others Enhances peoples mana	Is rude, aggressive, shouts, snaps, intimidates, bullies Is abrupt, belittling, or creates stress and anxiety
Helpful	Attentive to people's needs, will go the extra mile Reliable, keeps their promises; advocates for others	Unhelpful, begrudging, lazy, 'not my job' attitude Doesn't keep promises, unresponsive

ĀKINA IMPROVEMENT

*Continuous **improvement** in everything we do*

	✔	✘
Positive	Has a positive attitude, optimistic, happy Encourages and enables others; looks for solutions	Grumpy, moaning, moody, has a negative attitude Complains but doesn't act to change things
Learning	Always learning and developing themselves or others Seeks out training and development; 'growth mindset'	Not interested in learning or development; apathy "Fixed mindset, 'that's just how I am', OK with just OK
Innovating	Always looking for better ways to do things Is curious and courageous, embracing change	Resistant to change, new ideas; 'we've always done it this way'; looks for reasons why things can't be done
Appreciative	Shares and celebrates success and achievements Says 'thank you', recognises people's contributions	Nit picks, criticises, undermines or passes blame Makes people feel undervalued or inadequate

RARANGA TE TIRA PARTNERSHIP

*Working together in **partnership** across the community*

	✔	✘
Listens	Listens to people, hears and values their views Takes time to answer questions and to clarify	'Tells', dictates to others and dismisses their views Judgmental, assumes, ignores people's views
Communicates	Explains clearly in ways people can understand Shares information, is open, honest and transparent	Uses language / jargon people don't understand Leaves people in the dark
Involves	Involves colleagues, partners, patients and whanau Trusts people; helps people play an active part	Excludes people, withholds info, micromanages Makes people feel excluded or isolated
Connects	Pro-actively joins up services, teams, communities Builds understanding and teamwork	Promotes or maintains silo-working 'Us and them' attitude, shows favouritism

TAUWHIRO CARE

*Delivering high quality **care** to patients and consumers*

	✔	✘
Professional	Calm, patient, reassuring, makes people feel safe Has high standards, takes responsibility, is accountable	Rushes, 'too busy', looks / sounds unprofessional Unrealistic expectations, takes on too much
Safe	Consistently follows agreed safe practice Knows the safest care is supporting people to stay well	Inconsistent practice, slow to follow latest evidence Not thinking about health of our whole community
Efficient	Makes best use of resources and time Respects the value of other people's time, prompt	Not interested in effective user of resources Keeps people waiting unnecessarily, often late
Speaks up	Seeks out, welcomes and give feedback to others Speaks up whenever they have a concern	Rejects feedback from others, give a 'telling off' 'Walks past' safety concerns or poor behaviour

Māori Relationship Board Interest Register - August 2019

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
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	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 Wharariki 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
	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

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict (if any)	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by:	Date Declared
	Active	Adjunct Research Fellow, Women's Health Research Centre, University of Otago, Wellington	Health research involving data and/or participant recruitment from within HBDHB.	Declare a potential conflict of interest, if research ethics locality assessment requires MRB input.	The Chair	14.06.17
	Active	Director and Shareholder of Katoa Limited	An indigenous research organisation that undertakes research and work for organisations by Maori for Maori.	Declare any potential conflict of interest, prior an discussion on work undertaken for HBDHB and/or health service organisations.	The Chair	11.04.18
	Active	Evaluator for Ministry of Health innovation projects	Implemntaion projects such as: TToH & Te Taitimu Trust	Declare any potential conflict of interest, prior an discussion on work undertaken for HBDHB and/or health service organisations.	The Chair	14.08.19
	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	Trustee, Te Matua a Maui Trust		Will declare intertest prior to any discussions relating to specific topics	The Chair	19.08.19
	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	Te Pitau Board Member		Will not discuss or take part of discussions where this trust is or interest.	The Chair	15.07.19
	Active	NGO Council Chair		Will not discuss or take part of discussions where this trust is or interest.	The Chair	15.07.19
	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 9 OCTOBER 2019 IN THE TE WAIORA ROOM, DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS AT 9am

PUBLIC

Present:	Na Raihania (Chair) Ana Apatu Hine Flood Trish Giddens Dr Fiona Cram
Apologies	Ngahiwi Tomoana (Chair), Heather Skipworth (Chair), Lynlee Aitcheson-Johnson, Kerri Nuku, Beverley Te Huia
In Attendance:	Patrick Le Geyt (General Manager, Māori Health HBDHB) Wayne Woolrich (CEO Health Hawke's Bay) Tiwana Aranui (Kaumatua) Tanira Te Au (Kaumātua Kuia) Dr Andy Phillips, Hospital Commissioner Andre Le Geyt, Health Hawke's Bay ` Rachel Ritchie, Chair of Consumer Council
Minutes:	Jacqui Sanders-Jones, Board Administrator

KARAKIA

Tiwana Aranui opened the meeting with a Karakia

INTRODUCTIONS

Brief discussion of the Regional Transplant Hui 'Paetara O Te Ora' with recommendation for members to attend on 16 October at TTOH.

It was queried and then confirmed that no one is being funded from HBDHB to attend South Central Foundation, as part of the next NUKA contingent.

APOLOGIES

Ngahiwi Tomoana (Chair), Heather Skipworth (Deputy Chair), Lynlee Aitcheson-Johnson, Kerri Nuku, Beverley Te Huia

4. INTEREST REGISTER

No changes to the interest register were advised. 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 11 September 2019 were approved as a correct record of the meeting.

Moved: Trish Giddens

Seconded: Ana Apatu

Carried

- Brief discussion on item 11. Rangatahi Redesign, with **request to provide data on statement 'use of services by Rangatahi is low' through provision of utilisation rates broken down by ethnicity/gender. ACTION.**

- Further discussion on item 12. Mahi A Atua followed:

Hine Flood as Deputy Chair of Te Pìtau Health Alliance Governance Group ('Te Pìtau'), updated the committee with concerns that an appropriate Maori advisor had not been engaged with for the Mental Health Redesign work. Whilst recognising that Devante Consulting group are a well-respected company for service redesign, it was felt that they would not have the same understating of kaupapa Maori which is essential to this work.

MRB members suggested that Te Pìtau receive a presentation from Mahi A Atua consultants Mark & Diana Kopua to determine how they can assist with addressing equity within the Mental Health redesign work.

Further discussion resulted in suggestion that the redesign team work collaboratively with Mahi A Atua consultants. The management and project team need to engage with Mark and Diana Kopua first to really understand Mahi a Atua and how it fits with the wider programme, and builds this as a priority into the investment logic of the project. The above discussion will be taken to Te Pìtau Health Alliance Governance Group this afternoon.

Gisborne was given as an example of GPs referring their patients to the Mahi A Atua service. This led to discussion of an opportunity for HBDHB leading this in a similar model for Hawke's Bay consumers.

It was noted that there is a lot of really good work and innovative schemes within the community, which is unsupported through government funding.

Member noted that it's also important to engage with the Mental Health leaders and professionals of HBDHB.

Chair of Consumer Council keen to take this conversation to Consumer Council members to assist with gathering momentum and support of Mahi A Atua programme.

There was concern raised that there should be due diligence when having singular focus of the providers and models available, and not to just focus on one provider.

Evaluation report of the Mahi a Atua to be provided to members of MRB before workshop next month. ACTION Na.

Chair suggested November MRB mtg be used for the Mahi A Atua consultants to come to a wider forum of discussion and understanding, including Te Pìtau members and Consumers. ACTION Maori Health to organise a Workshop.

6. MATTERS ARISING FROM PREVIOUS MINUTES

Item 1 Wairoa River water Quality: Verbal update as agenda item

Item 2 Rangatahi recruitment to MRB: Decision waiting on iwi. **Patrick to take this forward with NKII.**

Item 3 After Hours Care Service update: removed from committee workplan by CEO.

Concern expressed at this update not coming to committees (as per request of the CEO, who will communicate progress through CEO office)

Item 4 Wairoa Community update: November item

Item 5 Mahi a Atua: MRB mtg be used for the Mahi A Atua consultants to come to a wider forum of discussion and understanding, including Te Pìtau members and Consumers. **Maori Health action.**

7. MRB WORK PLAN

The Work Plan was noted.

8. MRB CHAIR'S REPORT

A verbal update was provided by the Chair.

9. TE PITAU HEALTH ALLIANCE GOVERNANCE GROUP REPORT

Report agreed and no further comment made.

SECTION 3: FOR INFORMATION

10. TE ARA WHAKAWAIORA (TAW) - (ADULT HEALTH INDICATORS)

Patrick Le Geyt, General Manager Maori Health, explained the TAW programme, which identifies areas for review against national indicators.

This report focused on an amalgamation of ASH rate for 44 – 65 year olds, cardiovascular and smoking rates. These are all areas that contribute to premature mortality for Maori and are all preventable conditions.

Jill Garrett, Senior Commissioning Manager, spoke to the report around **44-65 year olds access rates**. To date, there has seen no significant change shown in the results. A task force has been organised to prioritise what areas need addressing, looking at tangible options for making a difference. Recommendations for detection, prevention and early intervention were presented within the paper, including ongoing measurement of readmission rates, screening and establishing better clinical pathways for the community and improved access to Primary Care. Discussion followed on how these measurements address each of the Long Term Conditions (LTC).

There was suggestion that the age bands focused on are expanded to include an earlier age group.

MRB members felt that the next steps and recommendations remain clinically based. Whanau wellness is the greater opportunity toward prevention of LTC.

Request to bring back a presentation on ASH rates and Whanau Wellness as a preventative model, and how these two factors link up. ACTION It was agreed that all targets need to have greater accountability in terms of actions and consequences for not delivering to target.

Dr Andy Phillips, Hospital Commissioner, spoke to the report with focus on **Cardiovascular**. Issues of a socio-economic nature impact on the rates of cardiovascular/heart disease. Actions required to address included:

- Prevention through supporting whanau to stop smoking, nutrition, reduce alcohol intake and physical activity
- Providing equitable and timely health care services
- Angiogram access and geographical access to treatment
- Improve heart services at HBDHB through increased FTE. Biggest constraint is in the diagnostic area capacity, due to the need for increased FTE.

Understood that increased FTE resources have been agreed by the CEO and are being taken forward with Executive Director of Provider Services.

Need to establish a good basic cardiology service at the HBDHB which takes into account future demand projections.

Brief discussion followed on recruitment to roles when there is a national shortage of professionals in clinical areas.

Prevention in Primary Care was highlighted by Andre le Geyt from Health HB. There is significant variability in performance targets across the Primary Care services. Performance accountability is a wider issue which needs to be addressed. There was brief discussion on current engagement with specific demographics and consideration of different approaches which work best for whanau. I.e. letters in the mail is ineffective.

Representation of accountabilities for each specific intervention should be considered with consequences identified, to ensure results against indicators.

Chair of Consumer Council felt strongly that engagement with whanau is key, by asking 'what and how' they can be engaged with and what makes accessing health facilities easier.

Smokefree target was reported by Bernard Te Paa, Executive Director of Health Improvement and Equity, and identified through the recommendations what needs to be actioned. Graphics showing levels of engagement show a good focus on keeping Smokefree with families.

Discussion followed on LMCs and their role in CO detection in the home. LMCs are not currently employed by DHBs (they are MoH funded) and therefore maintain no accountability toward the Smokefree target.

Is this diverting from the traditional role of the LMC and putting pressure on this workforce to take CO readings rather than the role they are there to do. It was noted that the highest risk area in Smokefree targets sits with young Maori women.

RECOMMENDATION

It is recommended that the **Màori Relationship Board**:

1. **Note** the contents of the report
2. **Endorse** the next steps and recommendations.

Adopted

11. WAIROA RIVER WATER QUALITY

Hine declared her conflict of interest to this item as Wairoa Council representative.

Bernard Te Paa, Executive Director of Provider Services provided an update on behalf of Nick Jones, Clinical Director for Health Improvement & Equity and Cameron Ormsby from Napier City Council, in regards to ongoing water issues in Wairoa. A submission on the resource consent application APP-123774 relating to the

Wairoa District Councils municipal wastewater treatment plants associated discharges to the environment has been lodged and copy of this will be circulated to MRB members.

ACTION: Bernard to circulate submission to Hawke's Bay Regional Council

12. To Waha

Charrissa Keenan, Programme Manager for Maori Health presented some whānau interview videos from To Waha which provided consumer insights into 'whānau voice', 'whānau led' and 'whānau centred service approaches'.

This was well received by MRB members and Charrissa and team were commeneded for their work on this project.

13. General Business

South Central Foundation visit (NUKA)

Discussion took place in regards to the next NUKA trip, but confirmed no HBDHB representatives attending this next contingent to South Central Foundation. With He Ngākau Aotea and iwi relationships being of such high importance, it was felt by some members that this is an essential part of forming an understanding of the whole concept of Person & Whanau Centred Care.

Response discussions included evidence of tangible actions resulting from those who have already been part of the NUKA experience and addressing implementation of the Strategic Plan (Clinical Services plan). There are already many NUKA aligned initiatives running within the DHB. Continued action on the voice heard from the community should be invested into.

NUKA CEO confirmed as coming to New Zealand in 2020, hosted by Waikato DHB. HBDHB have requested an opportunity to host them whilst in the country.

Chair of Consumer Council raised a point of using the learning from NUKA in ensuring the service is driven by the consumer and what they are needing. There needs to be co-design at the heart of LTC design of service with real opportunity for application of PWCC.

There being no further business for the public and public excluded section of the meeting, the meeting closed at 12.10pm

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 May 19 09.10.19	**Following resignation of G Mackey, new MRB member is to be appointed –** recommendation to be a rangatahi (young person) GM Māori Health to take this forward with NKII	Company Secretary Patrick Le Geyt & Chrissie Hape	June 19	In progress – awaiting response from iwi. There is a focus on recruitment of Rangatahi into this role.
2	14.08.19	**Wairoa Community** Quarterly report on Wairoa and their community health	Chris Ash	Nov 19 and quarterly	Agenda item for December
3	09.10.19	**Rangatahi Redesign** Request to provide data on statement 'use of services by Rangatahi is low' through provision of utilisation rates broken down by ethnicity/gender	Bernard Te Paa	Nov	Verbal update
4	09.10.19	**Te Ara Whakawaiora** Request to bring back a presentation on ASH rates and Whānau Wellness as a preventative model, and how these two factors link up.	Chris Ash	Dec	In progress – update early 2020

GOVERNANCE WORKPLAN PAPERS

Updated: 2 December 2019

MRB MEETING 11 DECEMBER 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
VIP/Family Harm report		Bernard Te Paa	Patrick le Geyt	3-Dec-19	11-Dec-19				18-Dec-19
Wairoa Community Health report to MRB only (quarterly Nov 19/March 20/June 20/Sept 20		Chris Ash	Emma Foster		11-Dec-19				
Corporate Performance Dashboard		Carriann Hall			11-Dec-19				18-Dec-19

MRB MEETINGS 2020	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Alcohol Harm Reduction Strategy (6 monthly update) **Feb -** Aug		Bernard TePaa	Rachel Eyre	28-Jan-20	12-Feb-20	12-Feb-20	13-Feb-20		26-Feb-20
MAP initiative evaluation summary		Patrick LeGeyt			11-Mar-20				
Wairoa Community Health report to MRB only (quarterly Nov 19/March 20/June 20/Sept 20		Chris Ash	Emma Foster		11-Mar-20				
HB Pasifika Youth Project - final reporting and recommendations		Bernard Te Paa			11-Mar-20		12-Mar-20		25-Mar-20
Ngatahi Vulnerable Children's Workforce Development - annual progress **Feb 20** (annual update)		John Burns	Russell / Bernice Gabriel	24-Mar-20	8-Apr-20	8-Apr-20	9-Apr-20		26-Feb-20
Wairoa Community Health report to MRB only (quarterly Nov 19/March 20/June 20/Sept 20		Chris Ash	Emma Foster		10-Jun-20				
Wairoa Community Health report to MRB only (quarterly Nov 19/March 20/June 20/Sept 20		Chris Ash	Emma Foster		9-Sep-20				

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board (MRB)**
	For the attention of: **HBDHB Board**
Document Owner:	Patrick Le Geyt (on behalf of MRB Chair)
Month:	October 2019
Consideration:	For Information
Reccomendation **That HBDHB Board:** **Note** the content of this report	

MRB met on 9 October 2019. An overview of issues discussed and recommendations at the meeting are provided below.

TE ARA WHAKAWAIORA (TAW) - (ADULT HEALTH INDICATORS)

This report focused on an amalgamation of ASH rate for 44 – 65 year olds, cardiovascular and smoking rates. These are all areas that contribute to premature mortality for Maori and are all preventable conditions.

MRB were very disappointed with the lack of any action and very little progress against Māori ASH rates 45-64 years. They were very concerned that these rates were getting worse over the last two years and that there had been very little attention and focused interventions. The members felt that the next steps needed greater attention and more work and whilst the recommendations remain clinically based, any *whanau wellbeing approaches* were not considered, which could be a missed opportunity toward prevention of Long Term Conditions.

It was agreed that all targets need to have greater accountability in terms of actions and consequences for not delivering to target. Representation of accountabilities for each specific intervention should be considered with consequences identified, to ensure results against indicators.

RECOMMENDATION

It is recommended that the **Màori Relationship Board**:

1. **Note** the contents of the Te Ara Whakawaiora (Adult Health) report
2. **Recommend** the TAW Champion (ASH Rates 45-64 years) provide an improved comprehensive plan on addressing the inequities for Māori to the Board.
3. **Endorse** the next steps and recommendations of the remaining TAW Adult Health report (cardiovascular and smoking).

Adopted

TO WAHA

Charrissa Keenan, Programme Manager for Maori Health presented some whānau interview videos following the To Waha oral health initiative, which provided valuable consumer insight into 'whānau voice', 'whānau led' and 'whānau centred service approaches'.

This was well received by MRB members and Charrissa and the team were commeneded for their work on this project.

SOUTH CENTRAL FOUNDATION VISIT (NUKA)

Discussion took place in regards to the next NUKA trip, but confirmed no HBDHB representatives attending this next contingent to South Central Foundation. With He Ngākau Aotea and iwi relationships being of such high importance, it was felt by some members that this is an essential part of forming an understanding of the whole concept of Person & Whanau Centred Care.

Response discussions included evidence of tangible actions resulting from those who have already been part of the NUKA experience and addressing implementation of the Strategic Plan (Clinical Services plan). There are already many NUKA aligned initiatives running within the DHB.

TE PĪTAU HEALTH ALLIANCE UPDATE

VERBAL

HAWKE'S BAY District Health Board Whakawāteatia	**Review of the HBDHB Violence Intervention Programme**
	For the attention of: **Māori Relationship Board**
Document Owners/Authors	Bernard Te Paa, Executive Director Health Improvement and Equity Dr Russell Wills, Paediatrician and Clinical Leader, Child Protection
Reviewed by	Patrick Le Geyt, General Manager Māori Health
Month	November 2019
Consideration	For discussion

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RECOMMENDATION

That the Māori Relationship Board:

1. **Discuss** the contents of this report, in particular the options given below.
2. **Support** the strategic direction for the HBDHB Violence Intervention Programme.
3. **Support** the multi-agency, iwi-partnered approach described in this paper.

EXECUTIVE SUMMARY

The Hawke's Bay region experiences the highest rate of family violence and child abuse in New Zealand. Hawke's Bay District Health Board (HBDHB) have had the Violence Intervention Programme operating within the organisation, with a view to better managing engagement with whānau/families who experience this issue, with a view to supporting those whānau/families to eliminating whānau/family violence. Given the rising rates of family violence, HBDHB are looking at how the Violence Intervention Programme could be amended to make it fit for purpose. This paper sets out a proposed way forward.

OVERVIEW

The HBDHB Haumaru Whānau/Violence Intervention Programme was established in 2002 as New Zealand's first DHB multi-pronged programme to increase awareness of and change practice in child and partner abuse. (See Appendix Three). The programme has been developed with the following key foci:

- Enhance policy development within the area
- Provide for multi-disciplinary training within health and beyond
- Ensure the development of resources that supports practice change, and;
- Engage in robust audit processes and provide feedback loops to enable continuous improvement

Nationally, the rates of child abuse have continued to increase despite the attention of successive government's attempts to address the issues associated with child abuse. In the Hawke's Bay, referrals for child abuse have continued to increase substantially, making it the busiest Oranga Tamariki region in the country. The rates of family violence have increased in Hawke's Bay since 2002 (See Appendix One) with the Eastern Police District having the highest rate of callouts for family harm in New Zealand. In 2017 there were 30 reports of concern for every 100 children in Hawke's Bay and 7,650 (around one in seven) individual children in Hawke's Bay were referred by Police to Oranga Tamariki. This is twice the national rate, with Māori featuring disproportionately amongst those statistics.

The causes of this violence are multi-faceted, and include, but are not limited to:

- the effects of colonisation resulting in the loss of Māori cultural identity which has created an intergenerational collective with disenfranchised grief and disconnection from their normalised cultural practice
- pockets of societal desensitisation and the increased normalisation of men's violence towards women and children
- an increase in social determinants not being realised creating a growing socio-economic gap
- increasing rates of fractured relationships, poor communication and problem solving skills potentially leading to isolation from usual support systems
- increased access and utilisation of alcohol and other drugs

The impacts of these issues are profound on whānau/families and children. Furthermore, the current health system and social services are struggling to meet the volume and complexity of intervention needed when family violence is present. Subsequently, the whānau/family are then left to manage these issues on their own, often with minimal (or delayed) input and support from agencies, NGO providers and community groups (if they have access to those entities) resulting in higher acuity and ultimately more complex health and social needs.

Kaimahi (workers) of various agencies and services are under immense pressure to deal with these stressful situations daily. They are also charged with making difficult decisions with often long lasting and life altering ramifications for whānau/families and individuals. Frequently, these decisions are made from limited information, usually agency heavy, with limited whānau voice partially due to minimal or sporadic engagement with whānau/families. This does not always result in the best outcomes, for either the whānau/family or the agencies involved.

While health and social service systems continue to navigate these tricky situations, HBDHB have continued to implement the HBDHB Violence Intervention Programme as a way to pro-actively engage with whānau/families to identify where there might be risks of harm within the family setting. This has been focussed on training HBDHB professionals to ask family violence screening questions, when engaging with all women over the age of 16 years or younger if there is a suspicion of family violence. While this has been somewhat helpful, given the increase of acuity and incidents being reported across agencies, and the evolving community needs, it is timely to review the HBDHB's current practice and health response. This may not require significant change from us in the short-term, due to the focussed nature of our work currently, but a radically different approach is needed to better understand and acknowledge the underlying causes of family violence to provide a better health response.

We envisage a tiered approach (yet to be determined) where long term aspirations include focusing on reflecting on what the HBDHB's role to date has been and what meaningful systemic change can be implemented for improved HBDHB support for better community outcomes. This will also require the HBDHB to clearly define our role along the health service continuum from point of entry, triaging, engagement practices, treatment options, referral processes and follow up, before discharging patients. This will aid in an improved approach towards consistent, cultural safe and unbiased healthcare practices.

DISCUSSION

The current HBDHB Violence Intervention Programme is based on six areas of focus, those being:

1. Management support and community collaboration
2. Staff support and supervision
3. Provision of resources to support the overall programme
4. Reorientation of the sector to focus on screening
5. Training
6. Monitoring and evaluation

This also enabled a strong intersector approach working with Oranga Tamariki and its various predecessors, New Zealand Police, and Non-government organisations who were locally focussed. All groups contributed to the development of each focus area, establishing a strong working relationship. Training was then developed and implemented that supported this collaborative working model, with a view to increasing screening for domestic violence, identification of violence and appropriate referrals, which did occur.

Additional initiatives were added over time, which improved the overall response by the health and social services sector, including the development and signing off of a Tripartite agreement between NZ Police, Oranga Tamariki and HBDHB in 2011.

The external review that was commissioned in 2011 asked *'How can Hawke's Bay DHB family violence/child protection programme enhance whānau ora?'*

The report found the following issues:

- HBDHB organisational culture was identified as a barrier to meeting the above identified objective
- There was low focus and prioritisation of Violence prevention across the organisation
- A lack of appropriate resourcing of the programme to meet the increased reported incidents
- A lack of auditing non-infrastructure practices and processes meant that issues related to the improvement of the services could not be fully substantiated
- A lack of IT systems meant that further development of the programme was not possible. There was a clear failure to capture patient voice and use this to influence practice

This paper supports Huirama's 2011 review recommendations that the HBDHB consult with our community when redeveloping our programme, thus privileging the voices of service users, whānau, hapū and iwi. HBDHB needs to look to provide a comprehensive range of services reflecting community need while being whānau centred.

With the aforementioned points in mind, this report makes the following recommendations:

1. An intersectoral approach to family violence prevention, which places Ngāti Kahungunu as an equal collaborative Tiriti partner (alongside other agencies). While the health sector has a vested interest in improving community outcomes related to family violence issues, a holistic and inclusive approach is required. Therefore, other sectors and agencies including but not limited to the Ministry of Social Development, Police, Local and Regional Councils, and Oranga Tamariki are also responsible. Therefore, the aim of reducing family violence needs to be led from those intersector agencies and iwi, supported by health. This intersector approach would include:
    a. Enabling Ngāti Kahungunu to provide cultural and strategic leadership in the development of this approach
    b. Holding agencies accountable by setting targets and publicly reporting of data from all agencies involved
    c. Partnering with Oranga Tamariki and the Ministries of Justice, Corrections and Social Development to implement individual strategies collaboratively with each other and iwi in Hawke's Bay, e.g. joint commissioning
    d. Facilitating partnerships between kaupapa Māori and mainstream, government and non-government agencies, health, education and social services
    e. Iwi-led attitudinal change and social marketing to recover traditional, non-violent roles for whānau, tāne and wāhine
    f. Building on existing early identification and early intervention for whānau at risk in community and primary care settings, e.g., WCTO, Family Start, Whānau Ora providers, social service NGOs
    g. Building on existing training programmes

2. Health should support a collective social harm approach: This may include:
    a. *A single Social Harm Prevention Strategy:* that brings all social harms together, including family violence and child abuse; alcohol and other drugs; smoking; homelessness, transience, poor quality housing and urban renewal; mental health promotion and suicide prevention.
    b. *Engagement of the Social sector leadership forum:* Already established intersector leadership forums should be engaged to drive this approach.
    c. *Better support for intervention and support services alongside of vetting services:* This should see the scoping and commissioning of family harm services that should be cross-sector funded, with clear associated accountabilities. This could see services provided within health services (secondary or primary care), but with the flexibility to move across the system and communities.

3. Continuation of a vetting and early intervention type service from within the HBDHB: The Haumaru Whānau team will continue to operate out of the Health Improvement and Equity Directorate, alongside Māori Health and Population Health teams, reporting to the General Manager Māori and, through him, to the Executive Director, Health Improvement and Equity (EDHIE). This offers an ideal opportunity to fully implement the recommendations of the Huirama report and the gaps identified in this report, as well as the internal review that has been undertaken by team management.

4. Iwi, Board and cross-sector, visibility and accountability: Family violence is a Government and HBDHB Board priority. It is also currently being discussed and actions developed from within the Matariki, Regional Economic Development forum. While health focussed actions should continue to be delivered in alignment with our contractual obligations, and reported as part of the Directorate reporting to Executive Leadership Team and Board, this needs to feed into development work being undertaken across the region. This should result in a whole of sector approach to reducing family harm, with the development of indicators that support the real tracking of improvement against current statistics, as identified within a range of reports

5. Cultural competence in child protection and family violence practice: There is little development from the Ministry on this, so how to bring cultural competence to practice will need to be worked out locally. This should align with the work carried out to develop He Ngākau Aotea, the organisational cultural responsiveness programme, engaging effectively with Māori, the Ngātahi programme and other relevant training programmes.

6. A review of the current funding is carried out with the support of the Ministry of Health: As previously stated, the increased incidence of family harm has not been met by an equivalent increase in resources for this team. The Ministry of Health or other agency partners should be made aware of the particular issues facing our region and challenged to resource the team appropriately.

7. Training that meets the needs of practitioners: Leaders and practitioners have repeatedly said that the current one-size-fits-all, eight-hour training does not meet their needs. This is reflected in falling enrolments and attendance, and that staff are not then changing practice on their return to their place of work. Attendance is already improved with tailored, brief training onsite in departments.

   The Ngātahi programme uses a model of change that offers a useful way forward:

ATTACHMENTS

- Appendix One: A History of the HBDB Violence Intervention Programme
- Appendix Two: Cultural competence in the VIP and the 2011 Huirama Review
- Appendix Three: The Violence Intervention Programme in 2019: current state
- References

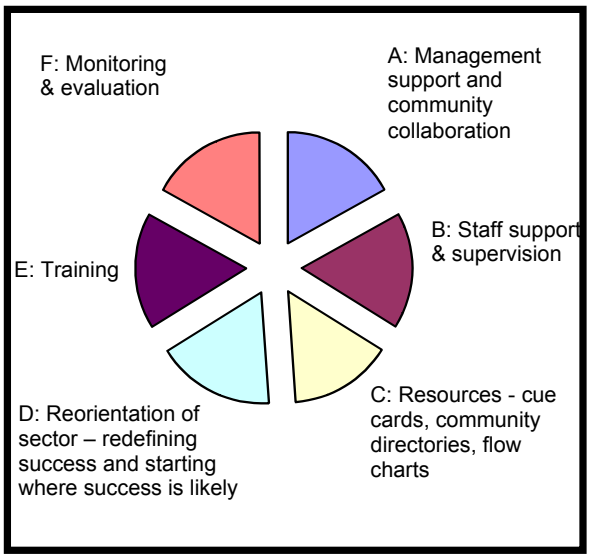
Appendix One: A history of the HBDHB Violence Intervention Programme

History of the programme

The HBDHB implemented its Child Protection Programme (CPP) and Family Violence Intervention Programme (FVIP) in 2001, in response to the tragic death of a child that resulted in an investigation into local child protection services[1]. Prior to the CPP being established, the DHB had a team of experienced paediatricians, a child abuse and neglect guideline[2] and *ad hoc* training in CP. DHB senior management supported the establishment of the CPP and the FVIP followed a year later with release of the New Zealand Family Violence Intervention Guidelines[3].

We used a comprehensive approach to changing clinical practice in child abuse and partner abuse, designed specifically for these issues and our service. Models drawn from included The Ottawa Charter for Health Promotion[4], Soft Systems Methodology[5], Force Field Analysis[6], the Commitment, Enrolment and Compliance Model[7], Total Quality Management[8], Organisational Learning[9], and Action Research[10] (figure 8).

Figure 8. Systems approach used by HBDHB to establish Child Protection and Family Violence Intervention Programme



Senior management support provides management expertise to the programme, a link to the DHB Executive Leadership Team, support for dedicated coordinator positions for both programmes and mandated training for all staff working with women and children. Support from senior clinicians adds to the credibility and effectiveness of the programme.

The programme involved community agencies from the outset. Staff from The Department of Child, Youth and Family Services (CYFS, later Child, Youth and Family and now the Ministry for Children Oranga Tamariki), New Zealand Police and non-governmental organisations including Women's Refuge and DOVE Hawke's Bay were involved in writing clinical policies and the training package, delivery of training, developing memoranda of understanding, clarifying referral pathways and in a reference group for the programmes that met quarterly.

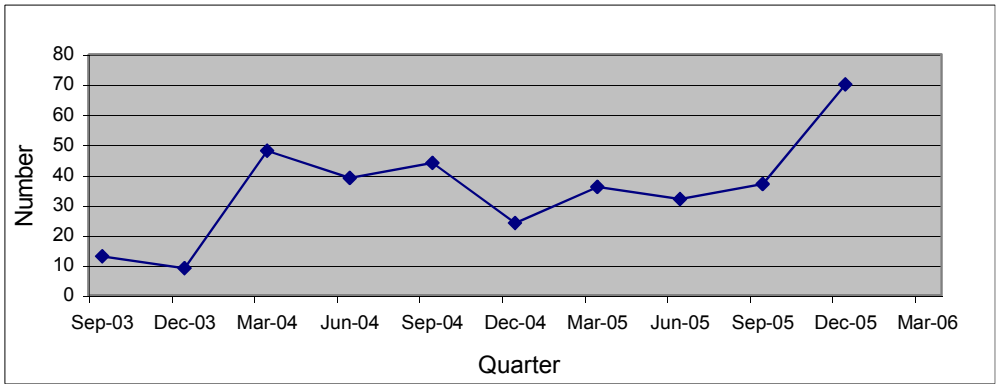
Support systems for staff include comprehensive child abuse and neglect and partner abuse policies informed by the national guidelines[Error! Bookmark not defined.], clinical supervision and VIP champions, opinion leaders who encourage and support colleagues in their practice. Resources were developed for staff including literature folders, posters, a community directory, a child abuse flipchart, laminated flowcharts, cue cards attached to staff identification badges and standardised documentation to record the history and findings when child or partner abuse is suspected or identified. Resources for patients, clients and families include posters and pamphlets in clinical and waiting areas advice patients that, "If family violence affects you, talk to us. We can help", wallet-sized safety plans and local agency support cards.

Partner abuse and child abuse are not problems that health professionals can "diagnose and treat" in the usual sense of medicine and nursing. Redefining success in partner abuse as empowerment and allowing the victim to control the actions they take are an important focus of the FVIP.

Training in child and partner abuse was mandatory in services primarily serving women and children for many years, though voluntary more recently. Training occurs only after the other systems, e.g. policy, documentation and supervision are in place. A full day of training is provided. The training has evolved over time and is now provided by Shine, a large stopping violence service based in Auckland, under contract to the Ministry of Health. Staff are taught to routinely include a question about partner abuse in their social history and the "dual assessment" model is taught. Training involves staff from the community agencies above, which allows opportunity for direct questioning and introduces clinicians to the staff to whom they will be making referrals. Refresher training is offered on a service-by-service basis annually and as necessary. Advanced training is offered annually to key senior staff and internal champions within each service.

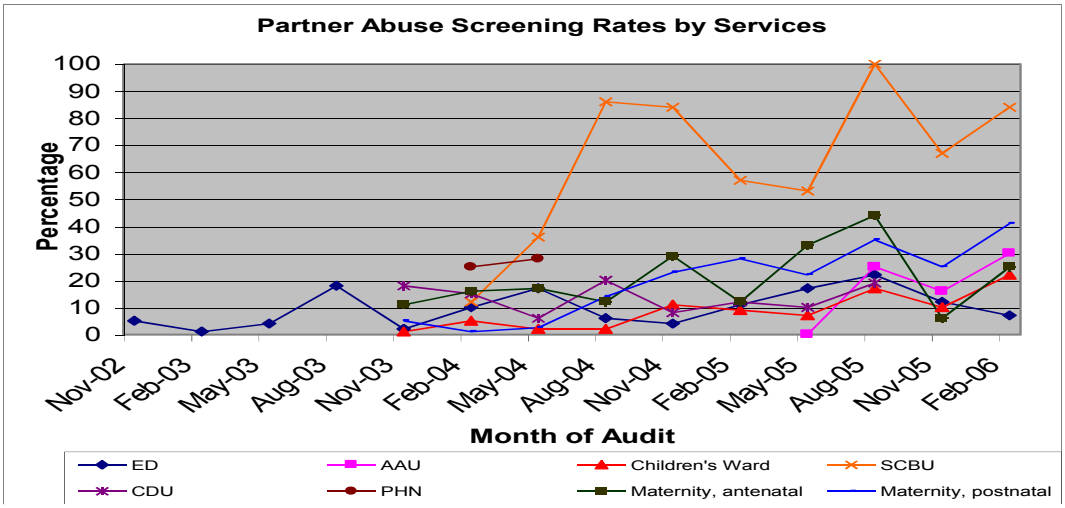
The programme is intensively monitored and evaluated, occupying approximately 80% of the 1.2 FTE programme coordinators' time. Early audits demonstrated a steady increase in routine screening for domestic violence (figure 10), identification of violence and appropriate referrals. Referrals to CYFS also increased (figure 9), and audits demonstrated increasing quality of referrals.

Figure 9.Child protection notifications from HBDHB to CYFS 2003-2006



The number of notifications from HBDHB to CYFS increased from ten per quarter to 70 per quarter.

Figure 10: Rates of screening for partner abuse within HBDHB Services (December 2002- February 2005)



ED=Emergency Department. CDU=Child Development Unit. AAU=Acute Assessment Unit. PHN=Public Health Nurses. SCBU=Special Care Baby Unit.

Documentation audits suggested that the quality of information within clinical records and referrals to CYFS increased, particularly for history/risk assessment and discharge summaries. CYFS also reported that notifications were appropriate and informative, and that interagency relationships strengthened. Removal of infants from delivery suite, which had become increasingly common and distressing, reduced to 1-2/ year.

Screening for partner abuse increased in most services, with rates between six percent and 100%, although considerable variability remained in the rate of screening between services. The number of women disclosing abuse also increased as did the amount of referral information provided.
A qualitative evaluation of the FVIP was performed to better understand the barriers and enablers for change. Sixty interviews with 85 staff were undertaken. Organisational barriers to routine questioning for partner abuse included lack of privacy to screen, lack of time/ being too busy and not knowing the outcomes of intervention. Personal barriers to questioning included discomfort with the question/ lack of confidence to ask, fear of offending the woman and forgetting to ask. Organisational enablers included feedback and supervision, prompts and refresher training. Personal enablers include personal determination, positive feedback from women regarding screening and staff developing their own “patter” with the intervention. Staff indicated that the more they asked the questions the more comfortable they become, and their level of comfort appeared to correlate to their rate of screening. Interviewee responses suggested that as they became more comfortable with asking the routine question for partner abuse, they became more proactive in seeking opportunities to ask and their rate of questioning increased.

The Violence Intervention Programme evolved over time

Several initiatives evolved from the core programme developed after 2002. These included:

- The Child Protection Alert System (CPAS)
- Antenatal alerts
- Vulnerable Pregnant Women’s Programme (later named the Maternal Wellbeing and Child Protection Multiagency Group (MWCP)
- Elder Abuse Programme

- Memorandum of Understanding between DHBs, Child, Youth and Family and NZ Police, with schedules for the care of children with non-accidental injury and the orientation and support of CYF liaison social workers within DHBs
- Placement of CYF liaison social workers within all 20 DHBs
- An agreed common template for Reports of Concern (ROCs) from Health to CYF
- A national programme of external audits of VIP programmes in all DHBs.

Child Protection Alert System

Vulnerable children are often transient and it is common for children to present with inflicted or suspicious injuries to multiple providers. James Whakaruru for example was seen by 42 health providers before his death. It is important therefore to have a system that automatically brings to health providers' attention previous concerns, so they can be taken into account when assessing the current presentation.

The Child Protection Alert System (CPAS) is an alert created on the National Medical Warning System (NMWS), attached to a child's National Health Index (NHI) number. This system is available to all DHB staff, for example when a child presents to the Emergency Department, and to primary care providers through their links to the DHB's patient information system (ECA in Hawke's Bay). Common alerts include allergic reactions to medicines and latex.

CPAS adds the words "Child Protection Alert: Contact XDHB" to the NMWS. A national policy requires that all reports of concern to Oranga Tamariki are assessed by a local multidisciplinary team to determine whether further abuse is likely. If so, a CPA is created on the NMWS and a brief summary of the concerns placed at the front of the child's file. When the alert is noted, the DHB that lodged the alert is contacted and the summary faxed to the clinician. Alerts are automatically removed when the child turns 18 and can be removed by the multidisciplinary team if the risk is thought to have abated, e.g., if a child is placed in permanent care. Parents are informed of the alert unless the team believes this will add risk to the child.

Unborn babies thought to be at risk of abuse can have an antenatal child protection alert placed on their mother's file. At birth the risk is re-assessed and transferred to the child's file if appropriate. The alert is usually removed from the mother's file unless the clinicians believe future pregnancy is likely and the risk is ongoing. The CPAS is subject to regular audits and review, and research is currently underway to assess the impact on care. A privacy impact assessment was required at its implementation. CPAS MDT chairs meet quarterly by videoconference to exchange data and lessons learnt, and to maintain quality. Research is currently being undertaken to evaluate the consistency of placement of alerts and the impact of the CPA system.

Maternal Wellbeing and Child Protection Multiagency Group

Each year around 10% of women delivering a baby in Hawke's Bay are identified to have multiple risks including domestic violence, drug use, major mental illness, transience and poor social supports. It is well established that infants of such mothers are at high risk of poor outcomes, and that culturally safe, high quality social supports tailored to the issues can transform outcomes for mothers and babies. Removal of infants at birth in the delivery suite had become common, was profoundly distressing for all concerned and was believed to be preventable by improved identification and management of social risks for pregnant women.

A multiagency group of senior practitioners involved in the care of vulnerable pregnant women was formed, led by a senior midwife and including representatives from Police, CYFS (now Oranga Tamariki) and social service NGOs to share information about vulnerable pregnant women and

intensively case-manage their care. Training was undertaken with LMC midwives in screening for domestic violence and courageous conversations. The group evolved over time and is currently led by a midwife seconded to the VIP coordinator role. The group typically manages 20 current cases and around 200 cases a year. The programme is currently under review and is likely to change.

Elder Abuse Programme

The Ministry of Health released the Family Violence Intervention Guidelines: Elder Abuse and Neglect[11] in 2007, with the expectation that elder abuse and neglect would be added to the existing workload of DHB Violence Intervention Programme coordinators. Unlike the programmes for domestic violence and child abuse, there was no national training package, quality improvement framework or funded programme leaders at a national or local level. HBDHB worked with Age Concern Hawke's Bay to develop elder abuse training for staff in adult medicine and surgery and for DHB social workers but it has been difficult to give the issue the same attention as child and partner abuse.

Memorandum of Understanding between DHBs, Child, Youth and Family and NZ Police

Memoranda of Understanding were written nationally and signed locally by DHBs, CYF and Police in 2011. The MOU commits all parties to meet regularly and abide by standard rules of engagement. Schedules sitting beneath the MOU address how children with non-accidental injuries will be cared for on wards, and how the parties will work together to ensure CYF liaison social workers in DHB swill be appointed, orientated, supported and managed. Meetings have occurred, though less frequently than envisaged in the MOU.

Placement of CYF liaison social workers within all 20 DHBs.

Communication between DHBs and CYF was recognised to be very variable and essential to improve outcomes, particularly for tamariki and whānau with complex issues. In 2011 CYF placed social workers at Practice Leader level in all 20 DHBs. The common experience is that, when the social worker is senior, present, well oriented and supported and has strong interpersonal skills/ emotional intelligence, communication is greatly strengthened and outcomes improved for tamariki and whānau. However it has been common for these senior practitioners to be "pulled back to site" when workloads increased, as is the case in Hawke's Bay currently (June-August 2019). When this occurs, inevitably, communications and relationships deteriorate between OT and the DHB, and whānau outcomes are affected.

An agreed common template for Reports of Concern (ROCs) from Health to CYF

The quality of information from DHBs to CYF within ROCs was very variable. A common template was agreed in 2014 for ROCs from Health. The template is widely used and there is general agreement that it has improved the quality of information in ROCs.

A national programme of external audits of VIP programmes in all DHBs.

Auckland University of Technology (Professor Jane Koziol-McLean) was contracted to provide an annual audit of VIP programmes in all 20 DHBs. The programme has evolved over time to raise standards and share successes.

Appendix Two: Cultural competence in the VIP and the 2011 Huirama Review

Cultural competence in the HBDHB Violence Intervention Programme.
The HBDHB Māori Health Unit (Bill Tuhiwai, Bill Stirling, Rapai Pohe) was involved in the design, delivery and evaluation of the VIP from the outset. MHU staff co-delivered the programme with VIP, CYFS and NGO staff until determining the other facilitators were doing a reasonable job, and withdrew to focus on other priorities. The MOH also included its own Māori and Pasifika staff in the design of the programme, which is reflected in sections on abuse and Māori, and abuse and Pasifika in the original and updated national guidelines, and in 2014 the Ministry's *Increasing Violence Intervention Programme (VIP) Programmes' Responsiveness to Māori*[12].

In 2011 Dr Wills contracted Tau Huirama, co-chief executive of Jigsaw to review the HBDHB VIP to answer the question, "How can Hawke's Bay DHB family violence/ child protection programme enhance whānau ora?" The review discussed Whānau Ora as a philosophy and practice model that emphasises "increasing whānau capacity for self-determination and communal wellbeing." (p3). Huirama noted that, "Services that use a whānau ora practice model work with families…in a way that build on family strengths so that whānau can take ownership of their own holistic needs. The model focuses on whānau as a whole, rather than dealing with individuals and their problems" (p4).

The review noted the following general principles whereby DHB Violence Intervention Programmes can support whānau ora:

- "Involving Māori (including service users) in further developing, implementing and evaluating the programme to make sure it is as responsive and effective as possible. For example, it is important from a service user perspective what conditions need to be put in place for Māori to feel supported and empowered in order to disclose experiences of violence and seek help
- Ensuring all staff are trained to work with Māori individuals and whānau in a way that helps them feel respected, safe, supported and well-informed. It is recommended that training is put in place to help health professionals understand what their role is in helping families achieve whānau ora. Clear policies and procedures need to be in place to guide day-to-day practice. Staff should feel confident to work with Māori and know what resources are available to them if they need further support.
- Putting an emphasis on working with individuals and families to tap into their whānau and/or community support networks in order to establish safe and nurturing environments for children and to address violence where it is identified
- Working closely with Iwi/ Whānau Ora/ Māori providers to ensure that good working relationships and clear referral and communication processes are in place to help individuals and whānau access the support they choose."

Huirama interviewed several kaupapa Māori providers, hapū and iwi representatives, and staff from the Māori Health Unit. Regarding the HBDHB VIP specifically, he recommended:

- Continuing strategies to increase the proportion of staff screening for partner violence and disclosure rates
- Dis-aggregating screening and disclosure rate data by ethnicity to ensure rates were similar and address disparities if not
- Qualitative evaluation from a Māori perspective, including service users, hapū, iwi and referral agencies, including kaupapa Māori organisations

- Build effective working relationships, referral and communication processes with community organisations and ensure DHB staff are aware of these organisations and know how to refer to them
- The cultural component of VIP training in 2011 was praised in several ways and constraints of completing training in one day acknowledged. Ways to improve the cultural component of training included
    - upskilling family violence champions in departments to work more effectively with Māori and champion this within departments
    - refresher training and in-service days to include a more thorough cultural component co-delivered with Māori Health, iwi and Māori providers.
    - Māori to be represented on the training team, and increase Māori engagement in training design and delivery
    - Integrate tikanga into the programme
- Require the Māori Health Unit's (what we would now call Engaging Effectively with Māori) training as a pre-requisite before attending VIP training
- The VIP training strengthen staff's knowledge of whānau ora and tikanga during core and refresher training. Resources and examples (in appendices) were provided to include in training
- Include kaupapa Māori organisations in the training team, so staff could hear how these organisations include tikanga in practice and how whānau ora and tikanga are part of the solution to family violence
- Highlight DHB-approved Māori agencies in the pre-reading resource
- Continue the focus on tackling myths about violence for Māori, without denying the reality that Māori are over-represented as perpetrators and victims, discussing the statistics in the context of traditional parenting and whānau relationships, and colonisation
- VIP staff and kaumatua doing ward rounds together
- Cultural supervision for VIP staff.

Appendix Three: The Violence Intervention Programme in 2019: current state

What's going well that we need to continue?

Some services continue to do well
Some of the original VIP focus areas have a consistent level of performance with screening for intimate partner violence. For example, Maternity rates are <70%. There is evidence of invested champions with supportive leadership who are connected to a number of social harm responses. The Maternity service delivery model means there are numerous opportunities throughout the patient's journey for screening and intervention to occur. Other support systems for staff include service specific social work and a generally more visible VIP team in their service areas.

Other services continuing to do well with screening and disclosure for family violence include public health nurses and the Special Care Baby Unit.

Offering shorter, tailored training has increased uptake across the health services
Radiology, audiology and dental have received briefer sessions and information reflective of their roles and responsibilities allowing them to be engaged in the VIP without becoming overwhelmed with information that they won't utilise in their roles.

Family violence, child protection and social harms feature prominently in the 2018/19 HBDHB Annual Plan.
The visibility of these issues in strategic discussions and at senior leadership level has increased gradually over the last 18 months. This is supporting the team's growth, development of the individual programmes, and the conversation about the need for a coordinated response to social harm. This is promising given the need for further focus on the VIP's strategic direction and need for an inter-sectorial approach if VIP is going to be sustainable and meet the needs of our community.

Identified barriers

1. Culture: our organisational culture does not provide a foundation on which to build and grow brief intervention skills for identifying and responding to social harm.

Dangerous practice
In areas where we have seen increased numbers of patient presentations and acuity, we are also identifying increased levels of professionally dangerous practice. For example, 'I'm here to save lives' and 'that's a social worker's job'. Professional dangerousness is reinforced by messaging organisation-wide that sets the tone of us being over-run, under-resourced and planning for worse to come. We are more often hearing a silo approach to patient care, whereby actions not undertaken by a previous service, provide an excuse for the next one along to not do anything either, i.e. 'They should have done it (ROC) before they came to us; if they had we would have picked up a problem'.

Vicarious trauma and burnout
Through training we have identified a workforce showing signs of vicarious trauma and burnout. This manifests itself as a de-sensitisation to patient needs, especially in acute areas, and a narrowing of care provision. This is most evident in disclosure rates of family harm, even when screening rates are high.

Cultural competence
We have not developed clear goals or vision for being responsive to our community, especially those with the most vulnerabilities. This is especially evident when working with Māori and Pacific people and this ultimately impacts on uptake and implementation of the VIP. Cultural competence is not woven through the VIP and this continues to be detrimental to those most in need of the programme. Workforce feedback shows weakness especially in engagement cross-culturally and

understanding of the patient's experience. For example, it is common to have clinicians in training who have very little understanding or knowledge of the inequity in our community and their role in addressing this. The restricted timeframes offered to delivery learning to clinicians does not afford us opportunity to address stereotypes, prejudices and unpack professional dangerousness.

Lack of leadership and accountability lets people "off the hook"
A significant proportion of the workforce are not engaged in any VIP training. Doctors of any level are not required to attend, and other parts of the workforce are also not routinely participating (allied health professions and care associates). Attendance at training and screening and disclosure rates are not KPIs for clinical or managerial leaders. This makes it very difficult to challenge leaders about the culture and responsibility for addressing social harm.

Our partnerships with senior leaders have often come about because of an individual's passion for this particular area of work as opposed to it being built into the directorate's plan and expectations, KPIs and accountabilities for leaders. Leadership changes therefore have a disproportional effect on progress and development of the VIP.

As the workload has increased, staff have become less responsive and more inward-looking, both in the DHB and among some referral agencies.
Hawke's Bay now experiences some of the highest reported levels of poverty, addictions and violence in the country, in addition to high acute volumes and complexity. Our staff are highly exposed to this and, with stretched resources and little time for debrief and reflective practice, we are seeing evidence that they are becoming desensitised to those they are treating and supporting. Some services are more affected than others, particularly those with very high acute and social complexity, both in the DHB and among our referral agencies.

This has weakened relationships with our key stakeholders. We have not had a consistent DHB Oranga Tamariki liaison in place for over four years and the MoU between OT, Police and the DHB does not hold sway in the manner in which it used to. This is evident in how as a health service we try to advocate and connect with our partners to improve outcomes for whānau, but experience delay, rejection of our risk assessment and tension with our statutory child protection colleagues.

Community services' workload has increased faster than capacity so expectations do not always meet. Our referrals to other services do not always result in timely and appropriate interventions for patients and clients. We have had to rethink our capacity to offer more (e.g., the Pregnancy and Parenting Service), or offer a different pathway (e.g., referral back to GP, WCTO provider or NGO social service).

Poor communication between DHB services leads to wasted opportunities to link training, planning and strategizing
Siloes in delivery of training programmes results in missed opportunities to develop cultural awareness and responses especially in relation to social harm, and link the areas of learning. For example, Relationship Centred Practice, VIP and Engaging Effectively with Māori training are complementary programmes that could be brought together.

VIP continues to experience significant isolation from related planning and strategizing. It is not uncommon to see family violence and child protection mentioned in plans and actions without any prior consultation with the VIP team. For example, the inclusion of family violence and child protection skills in all social work position profiles without prior discussion of what basic skills looks like was a missed opportunity to have a widespread impact on practice.

2. <u>Resourcing</u>
Resourcing of the programme restricts its work to either training and frontline support or planning and quality improvement. There is not the capacity to do both and an attempt to do so often weakens both areas.

3. Auditing and data collection are manual, under-resourced, inaccurate and late, which limits their effectiveness

Auditing and data collection is under-resourced and often inaccurate in many services. The clinical audit for FVRQ (family violence routine question) continues to produce misleading data. As of 31 July 2019, our clinical audit results indicate an overall screening rate of 46% and disclosure rate of 10%, with little variation over the last three years. When examined more closely however, this includes review of 10 patient's records per service for 9 months of the year and a completion rate of less than 75%. For a service such as Emergency Department who see up to 160 patients a day, a sample size of 10 is insignificant. The interpretation of the FVRQ is inconsistent and this is evident in documentation (A common question is, 'does 'FVRQ +' on the paperwork mean, 'yes, there is violence' or 'yes, I have screened'?).

The vast majority of the auditing is manually completed and may require input from up to three different areas. The time-lapse between intervention and evaluation is therefore significant. For example, an increase in frontline support to ED between August and November last year was evaluated for the period 1 December 2018 to 13 January 2019. The majority of the records required were not received until the end of March and audit finally finished in July 2019, with still some records missing. The value of any feedback, especially in relation to individual patient care is significantly diminished by this stage.

4. IT systems

IT systems are not enabling a seamless and easy process for clinicians. In acute settings this is reported as a significant barrier to practice. Across the DHB we have several different processes for documenting and accessing information related to family harm and child protection and therefore interpretations of roles and responsibilities also follow a varied approach.

A recent complaint by a patient to HDC as a result of privacy breach has to a large extent occurred because of the time consuming and part paper-based, part-electronic processes we have for documenting family harm.

5. Patient experience is not captured so does not inform practice

Evaluation of the programme is not capturing patient experience and we therefore continue to deliver a service we cannot be certain is meeting the needs of our community.

We have recently commissioned a small piece of work to connect with tangata whaiora to understand their experience of accessing health care when family violence and child protection have been a feature in their presentation. We hope this can set a precedent for future evaluations away from the current data focus. The money for this was identified as a result of an under spend and is not something we can resource on a permanent basis.

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HAWKE'S BAY District Health Board Whakawāteatia	**Wairoa Integrated Health System**
	For the attention of: **Māori Relationship Board**
Document Owner	Chris Ash, Executive Director of Planning & Funding
Document Author(s)	Emma Foster, Deputy Executive Director of Planning & Funding Laurie Te Nahu, Health Gains Advisor Charrissa Keenan, Programme Manager Māori Health Lisa Jones, Business Intelligence Strategic Advisor
Reviewed by	Claire Caddie, Service Director Community, Women & Children Jill Lowrey, Nurse Director Community, Women & Children Wietske Cloo, Deputy Service Director, Community, Women & Children Sonya Smith, Manager of Wairoa Health Centre Karyn Bousfield, Nurse Director Primary Care Andre Le Geyt, Maori Health Manager Health Hawke's Bay
Month/Year	December 2019
Purpose	The purpose of this report is to provide an update on planned activity and actions for implementing an integrated health system for Wairoa.
Previous Consideration Discussions	November 2018 Board meeting March 2019 Te Pītau Health Alliance (Hawke's Bay) Governance Group meeting
Summary	Key Issues/Actions
Contribution to Goals and Strategic Implications	Whānau Ora, Hāpori Ora, August 2019, Ngā Hua Pūnaha: 1. Pūnaha Ārahi Hāpori/Community-Led System 2. He Paearu Teitei me ōna Toitūtanga/High Performing and Sustainable System 3. He Pauora Hōhou Tangata, Hōhou Whānau/Embed Person and Whānau –Centred Care 4. Māori Mana Taurite/Equity for Māori as a Priority 5. Ngā Kaimahi Tōtika/Highly Skilled and Capable Workforce 6. Pūnaha Tōrire/Digitally-Enabled Health System Clinical Services Plan 2018: 1. Place-based planning 2. Evolving primary healthcare 3. Working with whānau to design the services they need 4. Relevant and holistic responses to support mental wellbeing. 5. Keeping older people well at home and in their communities Specialist management of long term conditions based in the community 7. Kaupapa Māori Models of Health

Impact on Reducing Inequities/Disparities	The mahi in Wairoa is based on the Localities planning approach and utilising the HB Health Equity Framework's Planning and Commissioning Pathway, which are closely aligned. This will enable us to develop actions and monitoring systems across all activities with a health equity driven approach.
Consumer Engagement	The Wairoa Community Partnership Group is led, owned and delivered in Wairoa, for Wairoa, by Wairoa. The purpose of this group is: *United leadership for a joined up community led, Government partnered approach to community design, investment and decision making that will influence 'that all whānau across the Wairoa district are thriving'* This has set the scene for any redesign and activity undertaken in Wairoa, with whānau voice increasingly at the centre of everything that occurs, and a feedback and check in loop to make sure that we have heard correctly.
Other Consultation /Involvement	As above
Financial/Budget Impact	Nil at this stage
Timing Issues	N/A
Announcements/ Communications	Communications to whānau will be through the *Whānau-voice led, Quality and health improvement cycle (*as set out in attachment 2) as an ongoing process that is part of our ongoing planning and commissioning pathway, in line with the HB Health Equity Framework. The purpose of this cycle is to provide structure to all parts of the system of their role in responding to whānau voice. It also allows whānau to see that we will action and listen to what they tell us.

RECOMMENDATION:

It is recommended that the Māori Relationship Board:

1. **Note** this update on activity and planned actions.

HAWKE'S BAY
District Health Board
Whakawāteatia

Wairoa Integrated Health System

Author:	**Emma Foster, Charrissa Keenan, Laurie Te Nahu, Lisa Jones**
Date:	**December 2019**

The purpose of this paper is to provide the Māori Relationship Board with an update on planned activity and actions from a Wairoa health system perspective, and in particular, to shape the response to the clinical quality and risk issues that have been identified over the past 6-12 months.

Why are we doing this?

Numerous reports have identified the health burden experienced by whānau in Wairoa. Data shows that people living in Wairoa are at greater risk of mortality and morbidity than people living in other Hawke's Bay localities. Further analysis of the data, which includes whānau feedback, describes a health system (services, processes, workforce, pathways etc) that is not delivering equitable health outcomes for people in Wairoa.

The information gathered so far has identified a number of whanau and health system themes that are summarised below:

Whānau preferences and priorities	**Health system issues in Wairoa**
Wairoa whānau want: • A high quality health system that they can trust. • Access to primary care services when they need it. • To be respected, listened to and heard. • To have one clinical connection in relation to their health care - they don't want to repeat their story or to deal with a different person each time they touch the system. • Transportation to health services in Hastings, when they need it, in a timely and convenient way. • Access to safe urgent and emergency care	Wairoa whānau experience: • An unclear, fragmented care model, resulting in waste and distrust with the community. • Largely unplanned and poorly coordinated services. • Service priorities determined from Hastings. • Inconsistencies in the workforce to meet the clinical requirements, leading to a mixed model of primary, emergency and hospital level care. • Inadequate community engagement to fully understand preferences, requirements and priorities. • On occasion, adverse events and poor clinical outcomes for whanau, as evidenced through clinical reporting and complaints processes.

Community engagement

In July 2019, two hui were held with Clinicians across the health sector, and other partners. The purpose of the hui was to start conversations about what works well and what doesn't from a clinical perspective. We opened the first hui with a whānau/patient story to help our clinicians to hear and understand the experience of Wairoa whānau when they interact with the Hawke's Bay health system. Feedback from the whānau who shared their story and from the clinicians in the room has been very positive, with whānau describing the value of being respected, heard and having a sense of action from the clinical teams. Clinician's described the real value in listening and connecting with the koha of the story, and its place in re-setting our collective focus on quality systems and standards of care.

A number of service gaps and strengths were identified at the hui (a summary is appended).

Main themes and areas for improvement include: workforce, navigation, the model of care, acute services, transport, traditional Māori health services, and older people services.

Areas that participants reported are currently working well include: maternity services, strong Māori workforce, assertion of bilingual application, strong community leadership through the Community Partnership Group, and community and provider desire for engagement and change.

Whāngaia Ngā Pā Harakeke was established to test and develop responses to family harm that meet the needs of whānau when they want it where they want it. This initiative's lead agency is the NZ Police in partnership with Ngāti Kahungunu Wairoa Taiwhenua Incorporated. Key to the success of this way of working is the Iwi and whānau voice, whereby NZ Police will āta whakarongo and support them to access what it is that they need. The feedback from the whānau hui in October will also support our future integrated model of care design and changes required.

A successful approach for working with whanau in Wairoa

In a precursor to engaging more intensively with the Wairoa Community, the Māori Health Leadership team partnered with the Population Health Unit's Health Protection Officers. This partnership focussed on working with rural marae to undertake assessments of how water supplies were operating, and sought to enquire into issues around sustainable safe water supplies and to identify areas where improvements could be made, and included maintenance of water filtration and UV lighting systems. The Māori health team managed the liaison and coordination with respective marae trustee members and coordinated the visits with Health Protection Officers. Further detail is outlined in attachment 4. Key points noted from whānau is that water needs to be kept clean and safe.

A pathway forward

It is critical that the whole of the health system is considered when reviewing and reorganising health care and services for Wairoa. Working with whānau and communities is necessary to achieve this, and to understand the environmental issues that are impact directly on their health and well-being. Outlined below are areas where key improvements are being made.

Mechanisms for improving health system response (Akina, He Kauanauanu)

We recognised a theme out of adverse event reviews and complaints, alongside general feedback from whānau, where whānau often recognise subtle signs of patient deterioration even when vital signs are normal, and the opportunity to act on this is missed. In response, we have asked the Health Quality and Safety Commission to support us in implementing their Kōrero Mai programme. This is a co-designed patient/whānau escalation process which empowers whānau to raise concerns through an agreed pathway to ensure their voice is heard clearly and acted on, when a whānau member is increasingly unwell with subtle signs of deterioration that clinicians may have missed. The HBDHB Quality Team and Wairoa leadership team are committed to this priority initiative.

Building a high quality, clinically skilled, and safe health workforce (Tauwhiro)

We have heard from whānau that the workforce in Wairoa need more support in ongoing clinical skill and professional development. We have implemented a new training programme for Wairoa that includes locally delivered courses around patient assessment and recognising the deteriorating patient. We have introduced the Early Warning Score (EWS) specific to Wairoa to support clinical decision-making and escalation of concerns. Nurses have been supported to spend time in the emergency department in Hastings to refine skills and gather valuable experience.

We have commenced planning for the nursing workforce, to develop a workforce plan and training requirements that will ensure a sustainable and well supported nursing team across services.

Building a health system whānau trust (He Kauanuanu, Tauwhiro)

We have heard from Wairoa whānau that they don't trust our health system. It is simply not good enough that local people do not feel able to have confidence in their health services. In response, we have made some changes to the clinical governance structure in Wairoa. We have prioritised the introduction of RADAR and training for its use in Wairoa. This is an incident reporting tool that will contribute to continuous quality improvement and provide data for local clinical governance. We have agreed a process to implement what we have heard from whānau into quality improvement initiatives, and then – critically, in terms of building trust and confidence - communicating back to whanau to let them know what we have changed as a result (see appendix 1).

Building a health workforce whānau can trust (He kauanuanu, Tauwhiro)

We have heard that whānau want to have access to primary care services and to have consistency of care. We know that doctors are often not in Wairoa long enough to build trust and relationships. We have listened to that and are working actively with our primary care providers to build a system that is large enough to attract high quality staff that want to stay in Wairoa. But we are also committed to growing Wairoa people into roles. Alongside this, we are looking at best utilisation of expanded roles so that whanau have access to the broader variety of health care professionals, to enable access and right skill-set for the care that is required. We are working towards one primary care system, with one patient management system, and one referral pathway for specialist service and with a shared highly skilled workforce across the Wairoa health system.

Supporting whānau and community priorities

We have heard that Methamphetamine is a real issue for Wairoa whānau, with Wairoa nannies and mokopuna bearing the brunt of the impact. We have listened to that and we are working through the Community Partnership Group to support a whānau led initiative for Wairoa nannies and mokopuna to get respite and support.

We have heard that whānau are worried about how their people who work in Affco can access primary care services. We have listened to this and are working with Affco to see how we can support them to work on their health policies and develop an outreach nurse-led service on site.

CO-DESIGN SOLUTIONS

We plan to commence working with the community and whānau in the development of the model for care for Wairoa. But we recognise that in order to do this, it requires a clear understanding and application of the principles and practices for working with the Wairoa community.

Aligned with the HBDHB organisational values, and the incorporation of He Ngākau Aotea, the next steps of this journey to co-design policy, system, and service solutions must be underpinned by:

1. Bi-cultural/Māori design, incorporating best practice that works for Māori
2. Addressing the underlying causes of health inequity, with an explicit commitment to remove barriers to access to care
3. Whānau at the centre – incorporating whānau priorities and preferences
4. Building capacity, capability, and collaboration – a workforce that is cohesive, and understands and supports the whānau they serve
5. Contributing to an equity culture that can address structural and institutional bias.

The Health System actions over the next 6 months include**:**

1. Working in partnership with whānau to agree the future landscape for acute and specialist services.
2. Continued engagement with local communities and public health to address environmental concerns such as water supplies.
3. Working in partnership with whānau to understand what a traditional Māori primary health/navigation model is, and how to implement it.
4. Agreeing our workforce specifications and requirements across the Wairoa system and plan for this.
5. Development of an integrated performance dashboard with a strong quality and safety and equity lens - allowing us to measure if we are making a difference and provide evidence of improving care and outcomes.
6. Building a Wairoa Health Service commissioning process using the Wairoa Integrated Health Service Commissioning framework (attachment 3) as a basis for change.
7. Ensuring that the next steps (Provision) are in line with the HB Health Equity Frameworks' Planning and Commissioning Pathway:
    - Pou Tuarua: Putting Solutions into Place (policy, system and service solutions)
    - Pou Tuawha: Monitor Progress and Measure Effectiveness

RECOMMENDATION:

It is recommended that the Māori Relationship Board:

1. **Note** this update on activity and planned actions.

ATTACHMENTS:

- What do we know from Wairoa community/whanau and clinicians
- Whānau-voice led, quality and health improvement cycle (working name)
- Wairoa Integrated Health Service Commissioning Framework

What do we know from Wairoa community/whānau/Clinicians

Workforce

- GP's never in Wairoa long enough to build trust
- Grow our own workforce /workforce pipeline for Wairoa people
- Māori faces make a big difference
- Good midwifery services
- Rural workforce models don't need to be totally clinically focussed

Navigation

- Links between services not well set up/ poor co-ordination/ joining up social and health sector
- No advocacy and support services
- Community education – what services are there, such as advocacy (kaiāwhina) to accompany to specialist/GP visits?
- Need navigation through services e.g. cancer

Model of care

- More flexible hours to access GP's
- Lack of continuity of care between secondary and primary care (e.g. cancer patients)
- Little specialist support for cancer patients (no ability to communicate through skype etc.)
- Poor systems in place for managing referrals from Hastings
- Lack of co-ordination of health services through GP providers and NGO's/ get rid of competitive model
- Poor early detection of disease/conditions /presenting late

Acute Services

- Poor clinical assessments
- Late assessment – e.g. stroke, heart, sepsis
- Not listening to patient and whānau
- Timeliness of transfer to Hastings
- Issues with Airport to get flights in and out

Patient experience

- Not listening to patient and whanau/ empower whanau to speak out
- Adherence to kawa and tikanga at Wairoa hospital would be a good starting point/
- Disrespecting Māori tikanga
- Institutional barriers to care across the system
- Inappropriate conversations in patient presence / Judgement due to appearance
- No visibility of Drs in Wairoa Hospital/ Respectful communication with patients such as introducing your self

Community feeling

- Lack of community trust in clinical services
- GP's are never in Wairoa long enough to build trust and relationship
- Wairoa has high prevalence of cancer, poor outcomes and early deaths
- Lack of leadership of Health care provision and health sector in Wairoa
- Disconnected services

Gaps in Services

- Lack of health promotion and health literacy services
- Lack of education / and approaches to wellbeing / Health messages don't relate to us
- Education on a patient's health condition and how to self–manage/ Smoking cessation
- Behavioural therapy / addiction services / support for families affected by suicide
- Transport barriers to secondary services/ access to services delivered closer to home / transport issues to primary care / telemedicine/Men's Health services /Rongoa Māori /traditional Māori health services
- No 24 hour care for Older people /No rehab for older people
- No Emergency Contraception at Pharmacy
- Limited pharmacy hours
- Youth services /Structured Daily activity that is community driven

Environments

- Listening to the views of people from localities within Wairoa District
- Water needs to be "kept clean and safe".

Whānau voice led quality and improvement process

Commissioning of Services for Wairoa[1]

Key Interventions	Shared Workloads	Risk stratification & care planning	Community links	Referral Management	Integrated Clinical Records	Clinical Pathways
Protection	Put in place monitoring, research and evaluation mechanisms to track the progress of health and social sector organisations against this expectation	Health practitioners using and analysing administrative data to inform their practice; using evidence based innovations, and tailoring professional development in delivering equitable health-care	Develop place-based-planning with the community and the whānau at the centre of all services	Strengthen performance improvement, monitoring and accountability mechanisms to ensure that the organisation is on track to achieve equity of health outcomes for Māori	Require the development of clinical guidelines and decision-making tools that focus on achieving health equity for Māori	Ensure that clinical practice aligns with Code-of –Rights which includes Māori models of health and wellbeing, clinical pathways, guidelines and tools, and health innovation
Participation	Build and maintain a health workforce responsive to the healthcare needs and aspirations of Māori	Health organisations are committed to building relationships with Māori to collaboratively design, implement and evaluate initiatives that ensure delivery of high quality health care that meets their needs and aspirations	Establish community level plans that promote and build healthy, safe and resilient whānau	Work with other Māori health organisations to benefit Māori and ensure iwi leaders have meaningful representation	Regulatory authorities will have appropriate representation of Māori at all levels of governance to ensure genuine partnership and participation	Support community initiatives that meet the health needs and aspirations of Māori, individuals, and whānau
Partnership	Establish arrangements for health sector organisations, both providers and funders, holding them accountable for delivering equitable outcomes	Health practitioners are committed to supporting community initiatives that meet the health needs and aspirations of Māori individuals and whānau	Bringing local leaders together, to address health and social issues and improve outcomes for individuals and whānau	Actively seek out partners beyond the health sector to all for better service integration, planning and support for Māori	Equitable health outcomes requires performance data to be analysed by ethnicity, deprivation, age, gender, disability and location, measuring progress toward achieving health equity for Māori	Share individual contributions of fellow colleagues to the organisations performance in achieving health performance for Māori
Equity	Set the expectation that equity is an integral component of quality, and health leaders have expertise in health equity as a core competency	The organisation actively partners with providers beyond the health sector to allow equitable service integration, planning and support for communities and whānau	Communities are activated with the tools and support to take ownership of their local service network	Ensure that all the operating policies align with the health equity intent of the legislative, regulatory and system policy frameworks	Support a system that focusses on clinical pathways of care that ensure equitable health outcomes for Māori	Use evidence-based innovations that achieve health equity for Māori

[1] *Māori Health Gains Advisor, February, 2019, Te Puni Tumatawhanui, HBDHB*

WAIROA INTEGRATED HEALTH SYSTEM - ENVIRONMENT

Engagement Update

A precursor to engaging more intensively with the Wairoa Community, Māori Health Leadership team partnered with the Population Health Unit, Health Protection Officers. This partnership focussed on working with rural marae to undertake assessments of how water supplies were operating, and sought to enquire into issues around sustainable safe water supplies and to identify areas where improvements could be made, and included maintenance of water filtration and UV lighting systems. Māori health team managed the liaison and coordination with respective marae trustee members and coordinated the visits with Health Protection Officers. These marae received Government funding for water supply upgrades over the past five years.

Marae involved;

- Kaiuku Marae – Mahia.
- Waipapa-A-Iwi Marae – Mohaka.
- Tangoio Marae, Maungaharuru Tangitu Trust.
- Environmental Conservation & Outdoor Education Trust – Opouahi Camping Ground.
- Whakaki Marae – Ngā Te Ipu.

Coordination Team and Assessors;

- Laurie Te Nahu – Health Gains Advisor, Health Improvement and Equity Directorate.
- Matt Molloy – Contractor, Drinking Water Assessor/Auditor, Population Health Unit.
- Cameron Ormsby – Health Protection Officer, Population Health Unit.
- Marcus Hyde-Hills – Drinking Water Technician/Advisor, Population Health Unit.
- Maree Rohleder – Health Protection Team Leader, Population Health Unit.

Example of Marae Reports

Ngā Maara A Ngata – Kahungunu Marae inspection, 17 September, 2019

The Kahungunu Marae (649 Putere Road, Wairoa) was visited on the 17 September 2019 by Matt Molloy, Marcus Hyde-Hills and Laurie Te Nahu (Hawkes Bay District Health Board), and we were met onsite by Wayne Taylor (021-0866-7893 waynetaylor@xnet.co.nz) and Isobel Thompson (027-550-0253 issybel579@hotmail.com) (Marae Trustee).

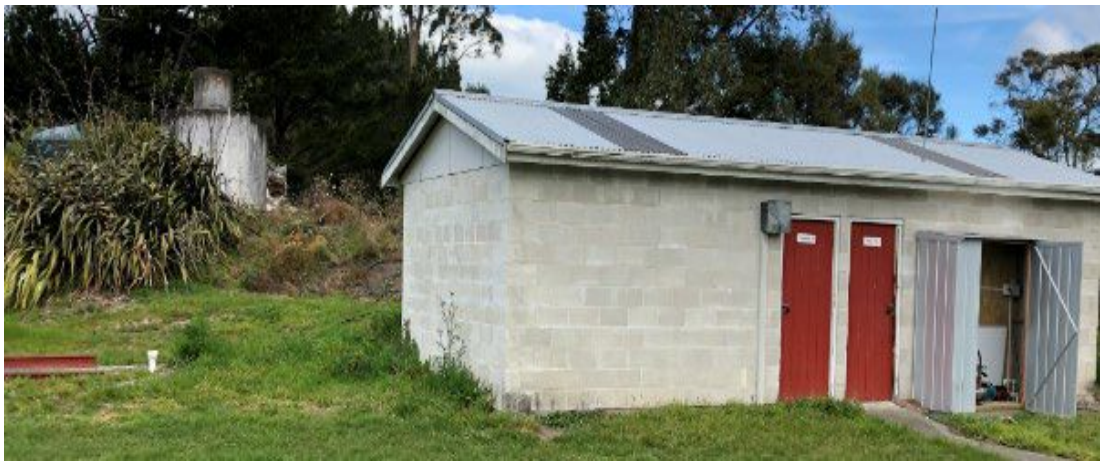
A site walk over was done and a summary of findings is outlined below;

Water is sourced from the western half of the roof of the main marae building. The water runs to a holding tank next to the building. Soot and dust from the roof would be collected and flushed into the tank. The concrete holding tank appears to have a loose fitting lid and some unsecured holes on the top. However as this is a raw water tank these are not considered to be critical.



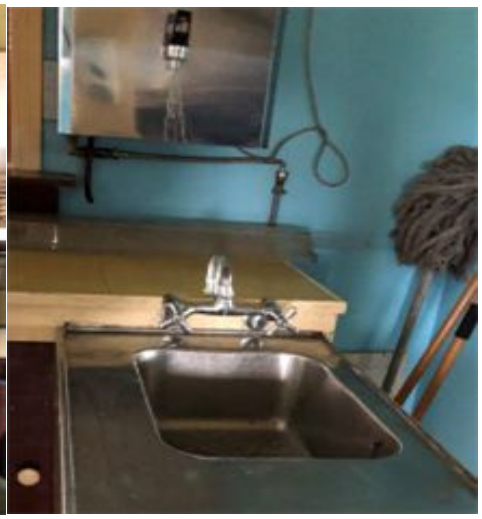

Water is pumped from the holding tank to an existing concrete 20,000L holding tank behind the toilet block. The pump shed is located next to the toilet block. The original configuration had the concrete tank providing water directly to the Marae and toilet block under gravity.

A housing for two filters has been added to the pump shed, but at the time of the visit the filters had not been connected, but it was obvious that this was to occur. In addition there are plans to have a UV disinfection system installed as part of the upgrade and this is supported.



At the time of the visit works were being undertaken to install a green 30,000L plastic water tank. The intention is to use the existing concrete tank to supply untreated water to a community garden and the green plastic tank will be used to supply treated water to the buildings (marae and toilet facilities).

Currently the operation of the water supply is undertaken by the Marae with maintenance and repairs being contracted to a local plumber. There is an intention to upgrade the main marae building. Speaking with Isobel, there was an appreciation that the water needed to be "kept clean and safe". At the marae there are two outside taps, and inside there are two sinks and two electric ZIP water heaters mounted on the wall.



Possible Improvements

- Consider the Installation of a first flush diverter before the roof water enters the storage tank (see below for details)
- Investigate sealing holes in the top of the roof holding tank and add a lip for the lid to sit on.
- Assess the need for the tanks to have a regular cleaning and removal of sediment (a regular inspection program will assist with this).
- Install a UV disinfection system on the drinking water line at the pump shed. This will ensure that any bugs that are present in the roof water are appropriately treated and further ensure the safety of the drinking water.
- Investigate the need for a backflow preventer on the untreated garden watering tank to ensure there is no possibility of untreated water making its way into the treated water system/tank.
- Develop a maintenance, inspection and cleaning schedule, including keeping documentation.

The Team can assist with technical advice in relation to these activities

Note

The Kahungunu Marae is classified as a specified self-supply which means the water is only provided to a single property owned by the supplier. This means that the requirements of the Health Act to comply with the Drinking Water Standards are currently not applicable. This may change in the future with a new drinking water regulator being recommended. There is a general requirement under the Building Act that dwellings/buildings should have a supply of potable water but this is not defined nor enforced by the respective councils across NZ in a consistent manner.

During discussions, "*Debi Thompson quoted that this is a great initiative by the HBDHB, in particular, the data and information for the betterment and wellbeing for future generation. This information is a well needed example of what, why and how the Marae Committee can maintain what needs to be done about the essential components provided by the Marae*".

Mauri ora!

HAWKE'S BAY District Health Board Whakawāteatia	**Corporate Performance Report**
	For the attention of: **HBDHB Board**
Document Owner	Chris Ash, Executive Director, Planning & Funding Carriann Hall, Executive Director, Financial Services
Document Author(s)	Jenny Cawston, Project Manager, Financial Services Kate Rawstron, Head of Planning & Strategic Projects
Reviewed by	Executive Leadership Team (informally by email)
Month/Year	November 2019
Purpose	For Information/Monitoring
Previous Consideration Discussions	Not previously considered
Summary	The Corporate Performance Report aims to provide enhanced strategic and operational oversight to aid the Board and senior management to monitor and manage the Hawke's Bay health system's overall performance, using a 'balanced scorecard' approach around our HB Health Strategy goals
Contribution to Goals and Strategic Implications	To monitor key performance indicators across the HB health system including HB Health Strategy goals.
Impact on Reducing Inequities/Disparities	The Corporate Performance Report will monitor equity across the majority of indicators where data is available.
Consumer Engagement	Nil
Other Consultation /Involvement	Executive Leadership Team, Senior Managers, Business Intelligence, Planning and Funding Directorate
Financial/Budget Impact	Nil
Timing Issues	Not applicable
Announcements/ Communications	Not applicable

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the new format for monitoring HB health sector corporate performance and its contents and provide feedback
2. **Approve** the use of the Corporate Performance Report for monitoring and managing corporate performance

HAWKE'S BAY
District Health Board
Whakawāteatia

Corporate Performance Report

Author:	**Jenny Cawston**
Designation:	**Project Manager, Financial Services**
Date:	**21 November 2019**

CORPORATE PERFORMANCE REPORT

A new format has been developed for presenting key performance indicator reports. The Corporate Performance Report aims to provide enhanced strategic and operational oversight to aid the Board and senior management to monitor and manage the Hawke's Bay health system's overall performance. It is aligned to the Hawke's Bay Health Strategy and the health system goals and will be reported quarterly. This is the first time the new format has been used and we would like feedback from the Board and senior management on improvements. Please also note, that some sections are still under development or awaiting data and will be available in future reports.

The Corporate Performance Report is appended to this report.

To give systematic visibility and support our goal of achieving equity for Māori, Pasifika & those with unmet need, all indicators are reported by ethnicity where data is available. Where there is a target, for ease of interpretation a RAG status (i.e. red, amber, green) has been provided. Consideration may wish to be given to setting targets for any indicators without targets. Where possible, indicators have a trendline covering a three-year period commencing 1 July 2017, with quarterly markers shown in red.

Using a balanced scorecard approach allows us to consider the interaction of metrics, rather than considering them in isolation. The report talks to specific actions, but we aim to bring more of the 'so what', exception reporting and actions as we develop this report.

HBDHB ANNUAL PLAN PERFORMANCE MEASURES

Also included in this new format is a new Performance Measures report (see page 4). Performance measures are a subset of the total Corporate Dashboard, are agreed as part of our Annual Plan, and form our statutory non-financial monitoring and reporting as a DHB to the Ministry of Health and the Crown. This report looks at our overall performance for the quarter and reports by exception areas where further focus and discussion is required.

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the new format for monitoring HB health sector corporate performance and its contents and provide feedback
2. **Approve** the use of the Corporate Performance Report for monitoring and managing corporate

ATTACHMENTS:

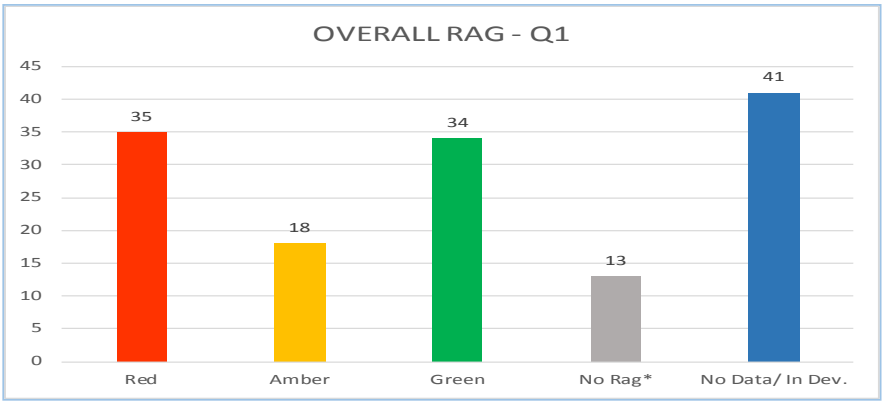
- Corporate Performance Report

CORPORATE PERFORMANCE REPORT – Quarter 1 2019/2020

OURHEALTH HAWKE'S BAY Whakawāteatia

CPR AT A GLANCE

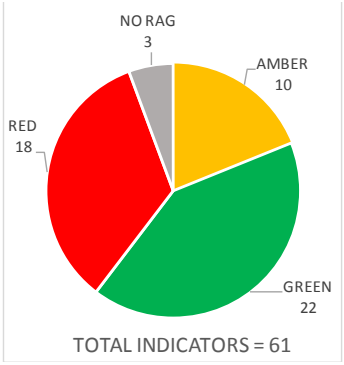
TOTAL OF 141 Performance Measures
90 Annual Plan Performance Measures
+ 4 Financial Measures
+ 47 Local Performance Measures



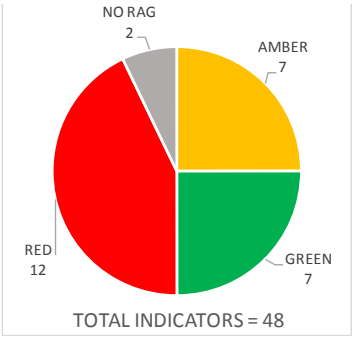
* No target set to determine RAG

BREAKDOWN BY SYSTEM GOAL

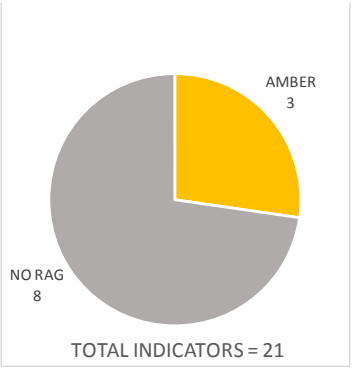
Pūnaha ārahi hāpori
Community led system



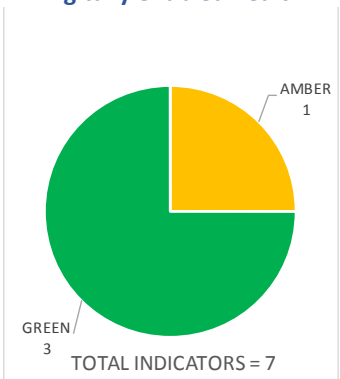
He rauora hōhou tangata, hōhou whānau
Embed person & whānau centred care



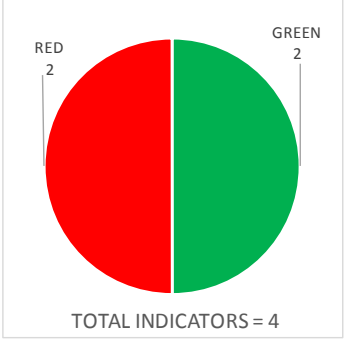
Ngā kaimahi tōtika
Highly skilled & capable workforce



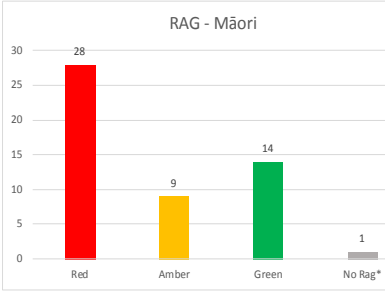
Pūnaha tōriri
Digitally enabled health



He paearu teitei me ōna toiūtanga
High performing health system



Māori mana taurite
Equity for Māori, Pasifika & those with unmet need

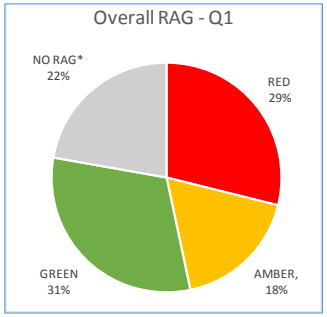


ACROSS ALL AVAILABLE INDICATORS

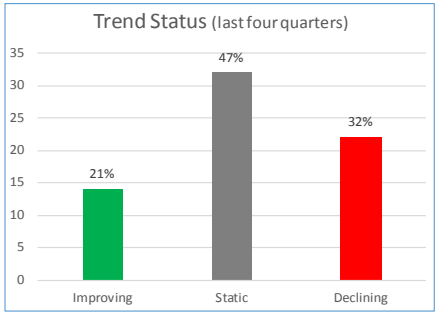
Please note: the preceding diagram has only counted indicators with a RAG status in the Corporate Performance Report and does not present a complete picture of overall performance at this stage. The RAG is used for indicators with targets and many indicators do not have targets. For example, person and whanau centred care and highly skilled workforce are affected by this. Consideration may wish to be given to setting targets for any indicators without targets

HBDHB ANNUAL PLAN PERFORMANCE MEASURES – Quarter 1 2019/2020

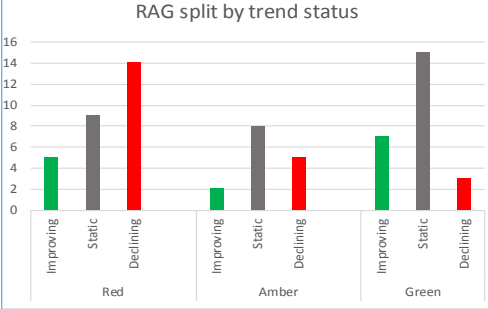
OVERALL PERFORMANCE



* No target set to determine RAG



Note: Includes RED, AMBER & GREEN status only

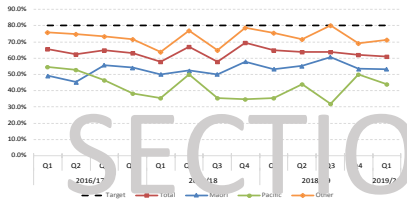


Equity Gap - Top 5	Difference*
Amber RAG	
Total acute hospital bed days per capita	-58%
Green RAG	
Reduce ASH 45-64 - ASH rate per 100,000 45-64	-108%
Number of Māori babies who live in a smoke-free household at 6 weeks post-natal	-51%
Better access to acute care for older people (non-urgent and semi urgent attendances at the Regional Hospital ED) - 75-79 years	-44%
% of children caries free at 5 years of age	-31%

* Difference between Māori and Total as a %

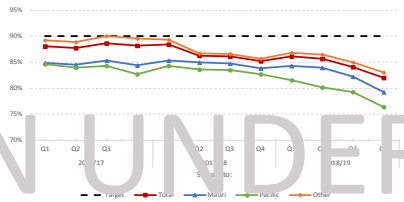
EXCEPTION REPORTING

PRIMARY CARE ENROLMENTS - % of pregnant women booked with a Lead Maternity Carer by week 12 of their pregnancy



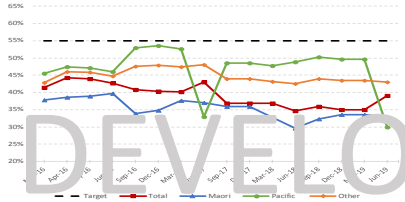
- He Korowai Manaaki is undertaking a RCT in primary care practices in Hawke's Bay
- Focuses on providing women who are pregnant early access to necessary screening, health checks, and engagement with LMC
- Investigation required to understand further the barriers which are preventing sustained improvement In this

LONG-TERM CONDITIONS - % of eligible population will have had a CVD risk assessment in the last 5 years



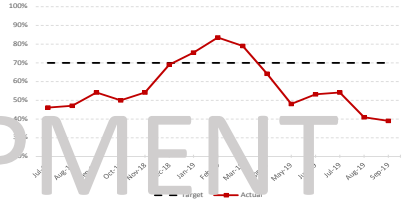
- Revised remuneration structure for practices
- Practices encouraged to ID assessments via file review - where limited resource IP to complete
- HHB discussing collaboration with Heinz Watties and National Heart Foundation regarding a CVD screening pilot they are running – analysis of assessments done outside of GP to ID definite unmet need and plan to reach into those areas

LONG-TERM CONDITIONS - Proportion of people with diabetes who have had a good or acceptable glycaemic control (HbA1C indicator)



- Health HB currently reviewing data to establish why the annual screening rates are low and consider practical steps to improve uptake
- HHB working collectively with the Diabetes Specialist Team, hospital services, primary care to review the collective diabetes services for opportunities for improvement

QUICKER ACCESS TO DIAGNOSTICS - % of people accepted for non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks



- Industrial action and reduced access to specialist resource impacted on production schedule
- NBSP in place for 12 months - significant increase in demand over the predicted MoH model
- Weekly clinical forum reviews referral numbers, sessions booked and back fill opportunities.
- Clinical lead is piloting an increase in points per session to facilitate an increase in throughput

POSITIVE PERFORMANCE

CHILD HEALTH - ≥95% of obese children identified in the Before School Check (B4SC) will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions

ACHIEVED: 100% Total
100% Māori
100% Pasifika

This has been achieved through improving referral pathways into Active Families by informing B4SC nurses of the programme. And collective action and link to broader approach to reducing childhood obesity across government agencies, NGOs, communities, schools, families and whānau.

PLANNED CARE - % of patients waiting over 120 days for treatment ESPI 5

ACHIEVED: 35% reduction (since peak in Q2 18/19)

The number of patients breaching ESPi 5 has gone from a high of 539 in February to 298 at end of October by ongoing review from referral out to intervention. A further reduction in the coming quarter is not expected however, due to reduced capacity over the Christmas holiday period.

OURHEALTH HAWKE'S BAY
Whakawāteatia

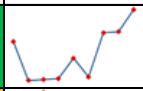
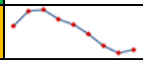
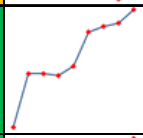
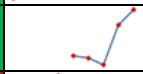
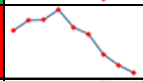
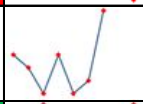
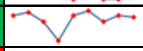
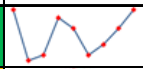
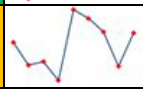
Corporate Performance Report

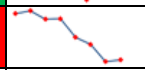
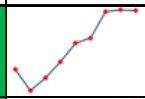
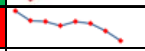
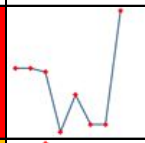
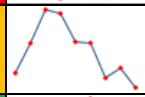
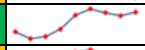
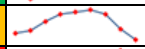
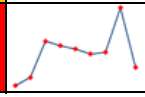
Quarter 1 (1 July - 30 September 2019)

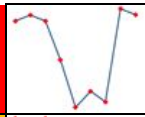
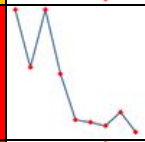
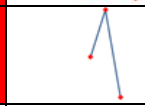
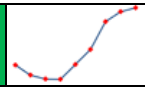
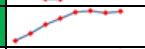
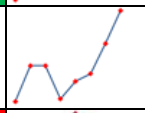
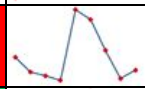
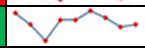
Key	
Green	Target achieved or exceeded
Amber	Within 0-5% of target
Red	More than 5% below target
*	HBDHB Annual Plan
**	DHB Annual Plan & Te Ara Whakawaiora

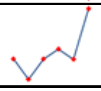
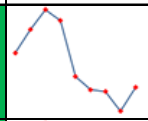
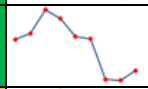
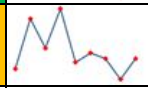
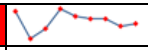
Health System Goal	Focus Area	Indicator	Target	Baseline	Māori Mana Taurite Equity for Māori, Pasifika & Unmet Need			Trendline (Quarterly markers, commencing Q1 2017/18)	Action Commentary Reason not achieving target and planned actions to get on track (for indicators in red only)
					Māori	Pasifika	Total	Total Population	
	Primary care enrolments	% of HB population enrolled in the PHO *	≥90%	98%	99.3%	93.0%	98.4%		
		% of Wairoa population enrolled in PHO	90%	99.1%	n/a	n/a	99.1%		
		% of Central Hawke's Bay population enrolled in PHO	90%	94.7%	n/a	n/a	94.7%		
		Number of general practices with closed books					7		Of 25 practices, 18 are either taking new patients or taking new patients under certain conditions.
		% of new-borns enrolled in general practice by 6 weeks of age *	≥55%		64.0%	86.0%	76.0%		
		% of new-borns enrolled in general practice by 3 months of age *	≥85%	90.0%	82.0%	93.0%	91.0%		
		% of pregnant women booked with a Lead Maternity Carer by week 12 of their pregnancy *	80%	64.0%	53.0%	44.0%	61.0%		He Korowai Manaaki is undertaking a randomised control trial in primary care practices in HB and focuses on providing women who are pregnant early access to necessary screening, health checks, and engagement with LMC.
	System-wide pharmacy services	Placeholder. To be developed in 2020. Will include community, general practice and hospital pharmacy							
	Immunisation	% of 8 month olds will have their primary course of immunisation (6 week, 3 month & 5 month events) on time *	≥95%	92.0%	88.8%	100%	92.6%		Slight increase potentially due to measles outbreak reminding parents/caregivers of the importance of immunisation. The usual issues of housing, lack of availability of appointments at primary care practices, children not being opportunistically immunised continue. Health HB (PHO) is working with maternity services to ensure accurate enrolment of pregnant mothers which should see an improvement in infants being enrolled early - this will hopefully improve timeliness of immunisation at 6 weeks.
		% of 4 year olds fully immunised *	≥95%	91.0%	89.5%	92.6%	90.9%		This group of children remains the most challenging for timely immunisation and is resource intensive with no extra capacity. The Immunisation Team work closely with B4SC, primary care, the Child Health Team and other partners to immunise this group on time. Measles is assisting us to encourage immunisation but the vaccine shortage is taking time away from our day to day delivery of service.
		% of boys and girls fully immunised - HPV vaccine *	≥75%	76.0%	85.6%	75.0%	73.8%		
		% of 65+ year olds immunised - influenza vaccine *	≥75%	58.0%	52.8%	45.6%	59.8%		

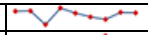
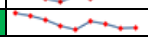
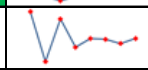
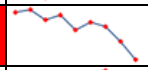
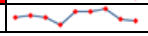
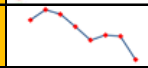
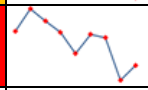
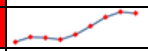
12

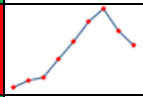
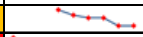
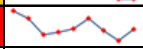
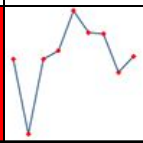
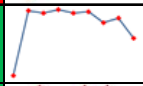
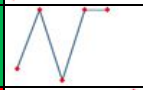
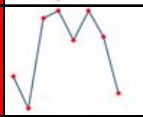
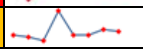
									Community pharmacies contribute significantly to delivery of this service. As at June 2019, influenza delivered in the community setting showed a 63% increase on 2018, with an increase of 2.7 % for Māori and 1.1% for Pacific. Most vaccines delivered by occupational health providers continue to be under-reported due to not being entered onto the National Immunisation Register. The influenza vaccine shortage complicated the campaign – whether this contributed to the coverage is unknown.
	Oral health	% of children caries free at 5 years of age **	≥61%	62.0%	43.0%	28.0%	62.0%		Recent participation in the national Pasifika oral health research project, which we are awaiting results, will help with future service planning. A dedicated kaiawhina is working with kohanga reo and Pasifika nests.
		Mean 'DMFT' score at year 8 *	≤0.73	76.0%	0.94	1.16	0.76		The community oral health service has a preventive approach and is currently reviewing its risk criteria for recall.
		% of pre-school children enrolled in and accessing community oral health services**	95%	tbc	78.0%	77.5%	95.7%		There has been improvement with quadruple enrolment, but access to service remains an issue with a high DNA rate for this group. There is a current audit on DNA processes in the service being carried out. A dedicated Kaiawhina is working with kohanga reo and Pasifika nests.
		% of enrolled preschool and primary school children overdue for their scheduled examinations *	≤10%	10%	10.0%	13.0%	10.0%		The service is aware that this is close to the target level cut-off, and is working to ensure that priority is given to those most at need.
		% utilisation of DHB funded dental services by adolescents for school Year 9 up to and including 17 years*	≥85%	tbc			62.4%		This year the MOH has given much better access to data, next year will be able to target specific schools which have low utilisation levels.
	Child health	% of infants exclusively or fully breastfed at 3 months **	≥60%	57%	43.1%	57.7%			Focus is on achieving good breastfeeding rates upon discharge. Implementing breastfeeding plan, focusing on investing in a whānau approach to support wāhine and pepe wellbeing.
		% of obese children identified in the Before School Check (B4SC) will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions **	≥95%	96.0%	100.0%		100%		
	Screening	% of women aged 50-69 years who received breast screening in the last two years *	≥70%	74.0%	70.0%	69.0%	73.0%		
		% of women aged 25-69 years who have had a cervical screening in the past 3 years *	≥80%	76.0%	74.8%	74.8%	74.3%		Focus has been on improving the coverage for Māori and Pacific and in particular women who are unscreened or underscreened. It has been reported by some women (non-priority group) that the cost of having a smear within general practice is prohibitive, plus the availibility of appointments suitable to their needs. We continue to encourage general practices to commence recalling women at 32months with the aim of screening on time.
		% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking *	≥95%	96%	97.5%	94.4%	97.4%		
		% 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 *	≥90%	85%	84.2%		88.2%		Results highlight that further training is required for midwives & LMCs on using quit smoking advice documentation.

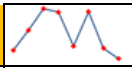
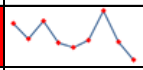
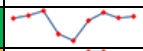
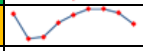
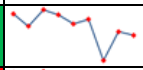
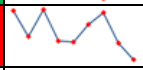
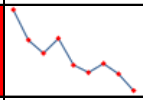
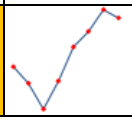
Pūnaha Ārahi Hāpori - Community Led System	Better help for smokers to quit	Number of Māori babies who live in a smoke-free household at 6 weeks post-natal *	≥21.9%	45%	22.2%	40.3%	45.0%		
		% of PHO enrolled patients who smoke who have been offered help to quit by a health practitioner in the last 15 months *	≥90%	85%	76.0%	75.0%	79.4%		Health HB introduced a new incentive strategy on 1 July 2019 and increased independent nurses from two to three nurses. Independent nurses have indicated many patients are hard to reach due to incorrect contact details or no money on their phones. Dr John McMenamin (MoH Smokefree Champion) has shared weekly quick tips for smoking cessation conversations with the PHO.
	ASH	Reduce the difference between Māori and other rate for Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 0 - 4 years **	Māori ≤8313	8750	8710	8732	7915		A targeted approach for ED presentations for this cohort is still being worked up. More recently a decision has been prioritised to collaborate with all areas that inform ASH rates and aim for collective impact in addresssing the drivers.
		Reduce ASH 45-64 - ASH rate per 100,000 45-64 years **	Māori ≤ 9341	9328	9833	7783	4734		Significant progress has been made in respiratory support in primary care as well as diabetes. An ASH task force has just been established. It is multidisciplinary and across a care continuum. The focus will be narrow – Māori and Pasifika ASH – reducing in the areas of cardiac, pulmonary and cellulitis the top 3 ASH conditions.
	Long term conditions	% of eligible population will have had a CVD risk assessment in the last 5 years *	≥90%	86%	79.2%	76.4%	82.0%		A revised remuneration structure for practices aims to increase Cardio Vascular Disease assessments undertaken in general practice. A large number of assessments can be completed through file review. Practices have been encouraged to complete this work. PHO is discussing collaboration with the Heinz Watties Occupational Health Nurse and the National Heart Foundation regarding a CVD screening pilot they are undertaking. This will allow for an analysis of assessments carried out outside of general practice so effort can be put into areas where there is definite unmet need. There are plans to reach into the community once those gaps have been identified
		Proportion of people with diabetes who have had a good or acceptable glycaemic control (HbA1C indicator) *	≥60%	42%	33.0%	30.0%	39.0%		Health HB is currently reviewing the data available to establish why the annual screening rates are low and develop practical steps to improve the uptake. HHB are working collectively with the Diabetes Specialist Team, hospital services, primary care to review the collective diabetes services for opportunities for improvement.
		Proportion of population seen by Mental Health and Addiction Services - child & youth (0-19 years) *	≥4.3%	5.3%	4.2%	1.9%	3.8%		CAFS has developed a Pasifika cultural pathway that allows collaboration between Pasifika navigators and the CAFS team. This is aimed at improving engagement of Pasifika clients with mental health services.
		Proportion of population seen by Mental Health and Addiction Services - adult (20-64 years)*	≥5.4%	5.3%	10.3%	3.5%	5.4%		
		Proportion of population seen by Mental Health and Addiction Services - older adult (65+)	≥1.15%	1.1%	1.4%	1.1%	1.0%		
		% of zero-19 year olds seen within 3 weeks of non-urgent referral - Addictions (provider arm & NGO)**	≥80%	75.0%	79.0%	78.9%	74.1%		CAFS had a vacancy for an AoD clinician and have now appointed someone who will start in January 2020. This should increase CAFS capacity to see patients with AoD challenges within 3 weeks.

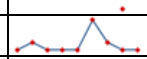
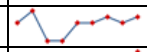
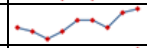
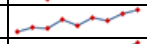
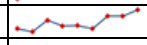
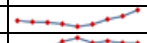
	Mental health	% of zero-19 year olds seen within 3 weeks of non-urgent referral - Mental health provider arm **	≥80%	67.0%	70.6%	-	73.8%		CAFS appointed an Intake and Triage Co-ordinator who will process referrals in real time. Additionally, CAFS is trialling some improvements that streamline the intake and triage process which increases CAFS capacity and capability to see patients timely.
		% of zero-19 year olds seen within 8 weeks of non-urgent referral - Addictions (provider arm & NGO) **	≥95%	92.0%	90.4%	100.0%	92%		
		% of zero-19 year olds seen within 8 weeks of non-urgent referral - Mental health provider arm **	≥95%	89.0%	82.4%	-	88.1%		Clinicians are encouraged to remind their patients of their upcoming appointments. A system is in place where the administration team reminds families of their upcoming appointments . Community support worker and the kaitakawaenga support the hard to reach families to attend appointments.
		% of clients with an open referral to MH&A services of greater than 12 months have a wellness plan *	≥95%	99.3%	-	-	78.8%		There is some system discreprency in the way clinicains report the presence of a "Go To Plan" in the patient management system (ECA). They have to create or update the plan in one screen ("Whānau Tahi") and then navigate to a different screen to insert the date - this inevitably leads to under-reporting of the presence of "Go To Plans" as the second step (putting the date in) is sometimes omitted by clinicians. A fix has been requested via Information Services to automatically write the date into the required field in ECA when the clinician creates or updates the "Go To Plan" in Whānau Tahi.
		% of audited files meet acceptable practice - wellness plans *	≥95%	89.0%					
		% of clients discharged from adult inpatient MH&A services have a transition (discharge) plan *	≥95%	64.3%	-	-	72.4%		Senior staff in NRR working with staff to re-embed Primary Nursing Model and responsibilities whilst working alongside CMHTs
		% of audited files have a transition (discharge) plan of acceptable standard *	≥95%		Data available Q2				
		% of clients discharged from community MH&A will have a transition (discharge) plan *	≥95%	78.5%	Data available Q2				
		% of audited files have a transition (discharge) plan of acceptable standard *	≥95%	97.0%	Data available Q2				
		Total self-harm hospitalisations and short stay ED presentations for <24 year olds per 10,000 *	Māori ≤ 75	80	88	27	75		We need investigate and look for reasons /themes for these presentations (possibly poor levels of engagement) and from there should be able to make a plan to counter the reasons identified.
		% of ED presentations for 10-24 year olds which are alcohol related *	Māori ≤14.3%	14.6%	14.1%	11.1%	14.1%		
		Rate of s29 orders per 100,000 population **	Māori ≤10% reduction	395	420	123	120		This continues to be of concern especially for Māori. MH&A are appointing a new DAMHS and this will be a focus area. National review of the MHA is also pending and reducing restrictive practice is a project under the HQSC Quality Improvement Framework.
		Number of hours mental health clients spent in seclusion	0	1569	210	0	424		Significant work has gone into seclusion reduction, including targeted work for Māori (received national award for this) with very good results. Current YTD Hrs = 1,5667 which is about a 20% reduction.
		% of all DHB inpatient service users seen with at least one outcome collection (HoNOS)	80%	95%			89.0%		

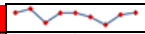
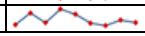
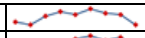
		% of all DHB community service users seen with at least one outcome collection (HoNOS)	80%	78%			75.0%		
	Reduce incidence of first episode of rheumatic fever	Acute rheumatic fever initial hospitalisation rate per 100,000 * (12 month measure)	≤1.5 per 100,000	tbc			5		Root Cause Analysis (RCA) is performed on all cases to identify programme failure or wider system issues. This involves a multidisciplinary team including kaiawhina. RCA identified that all cases were either Māori or Pacific, all have a family history of rheumatic fever, all school aged (4-15 years) and cases were widespread throughout region and not just where sore throat swabbing schools exist. Household crowding was a factor in some but not all cases and similarly for poor health literacy. Two missed opportunities for sore throat swabbing occurred both at a school and in primary care and have been followed up. In future there is an opportunity for a more integrated school delivery model that targets children with a family history of RF for more intense follow up. This would require a service review and redesign, and cost benefit analysis. An application was made for de bono consultancy assistance but was unsuccessful. There is an opportunity to learn from the Northland service review example. NB. Our small number of cases overall does mean there are variations in our DHB rate from year to year
	Older people	Better access to acute care for older people - Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) - 75-79 years *	≤130	127.5	184.40	66.70	128.00		Māori are accessing ED due to a range of factors including: cost of GP visits, lack of appointments and continuity of care at GP practice, proximity of location of ED, lack of cultural competency in GP practice, entrenched systemic behaviours that result in Māori accessing ED as the default behaviour.
		Better access to acute care for older people - Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) - 80-84 years *	≤170	169.1	179.20	275.00	159.10		As above for both ethnic cohorts.
		Better access to acute care for older people - Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) - 85+ years *	≤225	227.5	228.6	166.7	226.1		
		Better community support for older people - % of people having home assessments who have indicated loneliness *	≤23%	tbc	Data not available currently				
		Better community support for older people - rate of carer stress: informal helper expresses feelings of distress = YES, expressed as a % of all home care assessments *	≤26%	tbc	Data not available currently				
		Better community support for older people - Acute readmission rate for 75+ year olds *	≤11%	12.3%	12.8%	8.8%	12.4%		The CNSs Gerontology receive a listing of patients attending hospital 2+ per month and visits are made to these patients to identify and respond to any issues that may lead to readmission. The time delay between discharge from hospital and acceptance follow up by CNS, EngAGE, community, Geriatrician and enrolment to GP services is dependent on resource and can cause delays and require readmission. Hoki ki te kainga implementation in Dec 2019 will provide 6 weeks of intensive restorative therapy post discharge.

		Increased capacity and efficiency in needs assessment and service coordination services - Conversion rate of Contact Assessment (CA) to Home Care Assessment where CA scores are four-six for assessment urgency *	tbc	tbc	Data not available currently					
		Clients with a Change in Health, End-stage, Signs and Symptoms (CHESS) score of four or five at first assessment *	11%	tbc	Data not available currently					
		Average age of first entry to aged residential care		82.8			83.6			
		Aged residential care occupancy rate		90.0%			92.0%			
		% of older patients given a falls risk assessment *	≥90%	91.1%			91.0%			
		% of older patients assessed as at risk of falling receive an individualised care plan *	≥90%	92.4%			92.0%			
	Amenable mortality	Relative rate between Māori and Non-Māori Non-Pasifika (NMNP)*	≤2.15	2.45	2.53					Work is in the early stages to focus on cardiology DNAs and why whānau DNA. As well as being integral part of improving access to cancer care.
	Urgent care	% of patients admitted, discharged or transferred from ED within 6 hours *	≥95%	88%	81.2%	84.6%	76.8%			Extended ED delays for admitted patient population, due largely to high levels of hospital occupancy and facility constraints.
		Number of ED presentations			3,606	608	10,973			
		Admissions from ED - conversion rate			Data available Q2					
		Placeholder: Urgent care in primary care - to be developed								
	Fewer missed outpatient appointments	Did not attend (DNA) rate across first specialist assessments **	Total ≤5%, Māori & Pasifika ≤9%	Total 5.9%, Māori 11.3%, Pasifika 13.3%	10.4%	11.3%	5.8%			Attendance at outpatient appointments during school holidays continue to be more difficult for Māori and Pacific populations. A number of tangi this quarter has impacted on Māori attendance. Many patients that DNA, have verbally confirmed they are attending.
	Faster cancer treatment	% of patients who receive their first cancer treatment (or other management) within 31 days from date of decision to treat *	≥85%	85%			83.5%			
		% of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks *	≥90%	95%			77.6%			Periods of industrial activity have affected particular workforce availability, access to specialist clinical resources, and the overall level of complex acutiy and high occupancy of the hospital population in the time period leading up to and including the 4th quarter. The weekly stakeholder case management forum attends to specific patients and environment pressures. The elective surgical capacity is under review to enable increased production flow.
		% of services report YES (that more than 90% of referrals within the service are processed in 15 calendar days or less) ESPI 1 *	100%	68%			83.3%			
		% of patients waiting over four months for a FSA ESPI 2 *	0%	30%			29.0%			ESPI2 FSAs have been stable for the last few months as the Communities, Women and Children and Medical directorates reduced their waitlists (both current and overdue). These two directorates overdues are almost at zero. The Surgical directorate has increasing waitlists due to a significant capacity/demand mismatch. Where departments have not been able to match capacity to demand, focus has been on ensuring high priority/risk patients are seen.

Whānau - Embed Person and Whānau Centred Care	Planned care	% of patients in Active Review with a priority score above the Treatment Threshold ESPI 3 *	0%				0.0%		
		% of patients waiting over 120 days for treatment ESPI 5 *	0%	27%			20.0%		The number of patients breaching ESPi 5 has gone from a high of 539 in February to 298 at end of October. This has plateaued and is expected to increase over Christmas and January holidays where there is reduced capacity.
		% of patients prioritised using an approved national or nationally recognised prioritisation tool ESPI 8 *	100%				100.0%		
		Ophthalmology: Number of patients waiting more than or equal to 50% longer than the intended time for an ophthalmology appointment *	0%						
		Acute readmission rates to hospital	≤11.8	11.9%	11.6%	11.6%	11.9%		
	Cardiovascular	% of ACS patients undergoing coronary angiogram, door to cath, within 3 days **	>70%	61%	70.0%		60.3%		Angiogram capacity is 2x0.5 day sessions per week. Capacity is not flexible due to shared facility with Radiology. Often patients waiting for angiogram exceed the available diagnostic cardiac cath lab time, requiring the HBDHB to rely on other regions for procedures. This has proved challenging due to their individual constraints, and demand surpasses capacity. Also, HB geographical isolation makes road transport to other facilities non-viable, flight availability becomes another constraint for service delivery to meet this target
		% of ACS patients who undergo coronary angiogram have pre-discharge assessments of LVEF *	≥85%	66%	61.5%	100%	71.2%		This was recognised as an area of improvement, although not an outlier within the regional performance, and we have had overall improvement. However recent reductions in the echo department workforce has confounded our ability to meet this target. Angiogram does not typically include LV gram by HBDHB cardiologists, and we are working on this.
		% of patients presenting with acute coronary syndrome who undergo coronary angiography have completion of ANZACS QI ACS and cath/PCI registry data collection within 30 days of discharge **	>95%	97%	83.3%	100%	98.0%		Overall completing of the registry is above target. This activity is absorbed within the senior nursing team and can have lag times created by reprioritisation to work.
		% of patients presenting with acute coronary syndrome who undergo coronary angiography have completion of ANZACS QI ACS and cath/PCI registry data collection within 3 months **	>99%	100%	100.0%	100.0%	100.0%		
		Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance all ACS patients who undergo coronary angiogram should be prescribed at discharge aspirin, a second anti-platelet agent, statin and an ACE/ARB (four classes) and those with LVEF<40% should also be on a beta blocker (five classes) *	>85%	55%	75.0%	-	66.7%		Variance in practise in this area is around the use of ACEi/ARB medication combinations and HBDHB is not an outlier within the regional performance. These are prescribed in accordance with guidelines on a case by case basis (per clinical lead cardiologist and TAS meetings).
	Stroke	% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission *	≥80%	73%	75.0%	-	47.0%		During the last quarter the hospital was extremely busy and medical was repeatedly well over capacity with medical outliers in the ATR unit hindering effective patient flow. Also there appears to be a problem with coding which is under investigation.
		% of potentially eligible stroke patients who are thrombolysed 24/7 *	10%	9%	7.0%	-	9.0%		

He Rauora Hōhou Tangata, Hōhou		% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway *	80%	80%	73.0%	-	75.0%		See above
		% of stroke patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge *	≥60%	tbc	69.0%	-	-		
	Quicker access to diagnostics	% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks) *	≥95%	92%	-	-	88.0%		Non-compliance is due to a mismatch in capacity and demand. There is a continued level of acute presentations and Faster Cancer Treatment demand. Radiology continue to use national radiology service improvement methodology to forecast and plan workload. Radiologist resourcing is currently an issue and we have continued to utilise strategies such as outsourcing and use of locums to minimise the effect on compliance. 11.7% more CTs were performed in 2018/19 compared to 2017/18 within same level of resourcing. To achieve MoH target, an increase in capacity is required.
		% of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks) *	≥90%	90%	-	-	93.0%		
		% accepted referrals for elective coronary angiography completed within 90 days *	≥95%	100%			93.8%		
		% of participants to have received their colonoscopy within 45 calendar days of their FIT result being recorded in the NBSP information system *	≥95%	NA					
		% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive) *	≥90%	95%	-	-	91.5%		
		% of people accepted for non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 calendar days) *	≥70%	69%	-	-	39.0%		Industrial action and reduced access to specialist resource (gastroenterologists, general surgeons, and anaesthetists) has impacted on the production schedule. The NBSP has been in place for 12 months and there is a significant increase in demand over the predicted MoH model. A weekly clinical forum reviews actual referral numbers, sessions booked and opportunity to back fill session gaps. The group looks at the production plan 4 weeks in advance to allow for the necessary lead time required of bowel prep for colonoscopies. The clinical lead is piloting an increase in the points per session to facilitate an increase in throughput. Locum resources are contracted as they become available.
		% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date *	≥70%	55%	-	-	42.8%		Same as above. Plus the surveillance waiting list is checked and reprioritised on a regular basis in order to maximise opportunities on scheduled sessions and to ensure clinical risk is mitigated.
	Hospital stay	Length of stay - acute *	tbc	2.31	-	-			
		Length of stay - elective *	tbc	1.59	-	-			
		Total acute hospital bed days per capita (per 1,000 population) *	≤390	410	649	521	410		To mitigate the daily bed occupancy for all patients and ethnicities, reviews of all patients with a stay greater than 10 days have been increased from once per week to twice weekly with a focus on noting ACC claim opportunities to increase revenue streams.
		Patient occupancy rates - overall			Data available Q2				

		Patient occupancy rates - HB Soldiers' Memorial Hospital			Data available Q2				
		Patient occupancy rates - Wairoa			Data available Q2				
		Patient occupancy rates - CHB			Data available Q2				
		Patients not in home ward			Data available Q2				
	Patient experience	Number of SAC 1 and 2 serious adverse care events					20		A number of these event investigations are still in progress so may be downgraded to a SAC 3.
		Number of grade 3 patient pressure injuries - hospital		4			0		
		Number of grade 4 patient pressure injuries - hospital		0			0		
		Number of grade 3 patient pressure injuries - community		3			4		
		Number of grade 4 patient pressure injuries - community		2			4		
		Number of hospital acquired MDRO infections		1			4		
		Number of surgical site infections		0			1		
		Number of HAI staphylococcus aureus BSIblood infections		5			8		
		Number of compliments		196			242		
		Number of complaints		119			155		
		Placeholder: % of clinical staff who have clinical orientation at a local level							
		Number of patients that answer 'NO' to the inpatient experience survey question 'Did a member of staff tell you about medication side effects to watch for when you went home' *	≥17%	22%					
	Ethnicity profile	% of staff who are Māori - DHB	16.66%	14.54%	15.6%				
		% of staff who are Māori or Pasifika - DHB	1.76%	1.51%		1.5%			
		% of staff who are Māori or Pasifika - general practice	26%	3.7%	10.5%	2.6%	13.1%		Workforce development strategies are in progress to improve Maāori and Pacific workforce targets. These targets reflect the population served
		Placeholder: % of staff who are Māori or Pasifika - aged residential care, Māori health providers - to be developed							
		Placeholder: % of staff who are Māori or Pasifika - total DHB, general practice, aged residential care, Māori health providers - to be developed							
	Recruitment	% turnover of staff - DHB		2.9%			3.2%		
		% of job applications received Māori- DHB		21.0%	19.6%				
		% of job applications received Pasifika- DHB		1.6%		2.4%			
		% of applicants who were interviewed v applied Māori- DHB		35.6%	33.8%				
		% of applicants who were interviewed v applied Pasifika- DHB		14.3%		22.2%			
		% of interviewees who were hired v interviewed Māori- DHB		50.0%	52.0%				
		% of interviewees who were hired v interviewed Pasifika- DHB		100.0%		0.0%			

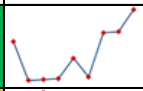
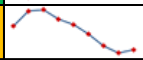
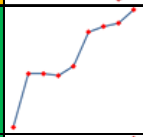
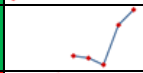
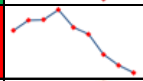
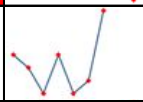
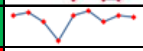
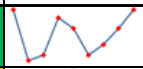
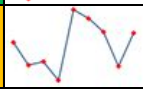
Ngā Kaimahi Tōtik	Staff wellbeing	% of employees with 1-2 years annual leave owing	15%	23.9%			24.9%		Comprehensive actions in place to address excess leave and ensure staff take their leave entitlement. Seeing some improvements in this.
		% of employees with 2+ years annual leave owing	0%	5.2%			5.2%		
		% of sick leave taken		2.6%			3.8%		
		% of staff who have had influenza vaccination					63.8%		
		Number of staff using EAP services		48			89.00		
		Average days lost due to injuries		19.29			20.27		
		Number of employee events reported			Data available Q.2				
		Number of employee near miss events reported			Data available Q.2				
		Number of verbal abuse events reported by staff		20			12		
		Number of physical abuse/assaults against staff reported		19			16		
		Number of hazard events reported		8			7		
Pūnaha Tōrire - Digitally Enabled Health System	Improving the quality of identity data within the NHI and data submitted to national collections	New NHI registrations in error *	>1% and ≤3%	5.1%			1.70%		
		Recording of non-specific ethnicity in new NHI registrations *	>0.5% and ≤2%	1.3%			1%		
		Update of specific ethnicity value in existing NHI records with a non-specific value *	≤2%	0.1%			0%		
		Invalid NHI data updates *	tbc	NA			-		
		NPF collection has accurate dates and links to NNPAC, NBRS and NMDS for FSA and planned inpatient procedures *	≥90% and ≤95%	NA			-		
		National collections completeness *	≥94.5% and ≤97.5%	NA			92%		
		Assessment of data reported to the national minimum set (NMDS) *	≥75%	84.1%					
He Paearu Teitei Me Ōna Toiūtanga - High Performing and Sustainable System	Financial performance		**Budget**	**Sep-19**	**Dec-19**	**Mar-20**	**Jun-20**	**Year end forecast**	
			$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	
		Income	50,948	52,044				614,548	Based on the result for the month of September 2019, the year end forecast is $15.3m deficit, which is $2.4m adverse to plan.
		Less expenditure	51,069	52,421				629,897	
		Financial Performance	**-121**	**-377**				**-15,349**	
		Other performance measures							
		Capital spend	1,769	1,446				21,695	
		Employees (FTE)	2,515	2,504				2,502	
		Case weighted discharges	2,679	2,756				29,239	

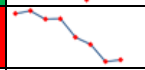
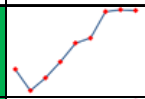
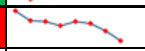
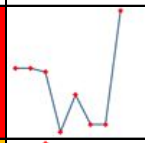
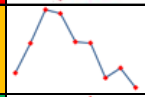
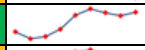
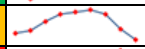
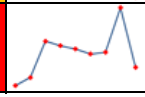
Corporate Performance Report

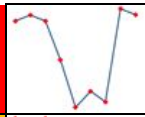
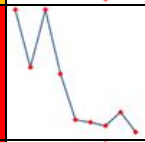
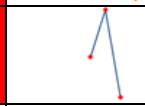
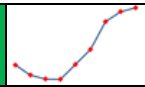
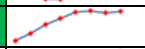
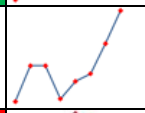
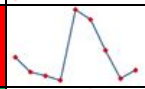
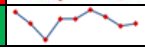
Quarter 1 (1 July - 30 September 2019)

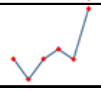
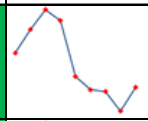
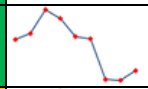
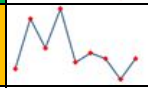
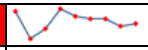
Key	
Green	Target achieved or exceeded
Amber	Within 0-5% of target
Red	More than 5% below target
*	HBDHB Annual Plan
**	DHB Annual Plan & Te Ara Whakawaiora

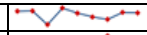
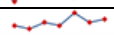
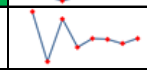
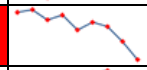
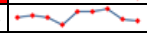
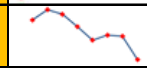
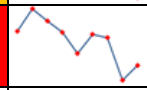
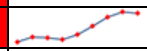
Health System Goal	Focus Area	Indicator	Target	Baseline	Māori Mana Taurite Equity for Māori, Pasifika & Unmet Need			Trendline (Quarterly markers, commencing Q1 2017/18)	Action Commentary Reason not achieving target and planned actions to get on track (for indicators in red only)
					Māori	Pasifika	Total	Total Population	
	Primary care enrolments	% of HB population enrolled in the PHO *	≥90%	98%	99.3%	93.0%	98.4%		
		% of Wairoa population enrolled in PHO	90%	99.1%	n/a	n/a	99.1%		
		% of Central Hawke's Bay population enrolled in PHO	90%	94.7%	n/a	n/a	94.7%		
		Number of general practices with closed books					7		Of 25 practices, 18 are either taking new patients or taking new patients under certain conditions.
		% of new-borns enrolled in general practice by 6 weeks of age *	≥55%		64.0%	86.0%	76.0%		
		% of new-borns enrolled in general practice by 3 months of age *	≥85%	90.0%	82.0%	93.0%	91.0%		
		% of pregnant women booked with a Lead Maternity Carer by week 12 of their pregnancy *	80%	64.0%	53.0%	44.0%	61.0%		He Korowai Manaaki is undertaking a randomised control trial in primary care practices in HB and focuses on providing women who are pregnant early access to necessary screening, health checks, and engagement with LMC.
	System-wide pharmacy services	Placeholder. To be developed in 2020. Will include community, general practice and hospital pharmacy							
	Immunisation	% of 8 month olds will have their primary course of immunisation (6 week, 3 month & 5 month events) on time *	≥95%	92.0%	88.8%	100%	92.6%		Slight increase potentially due to measles outbreak reminding parents/caregivers of the importance of immunisation. The usual issues of housing, lack of availability of appointments at primary care practices, children not being opportunistically immunised continue. Health HB (PHO) is working with maternity services to ensure accurate enrolment of pregnant mothers which should see an improvement in infants being enrolled early - this will hopefully improve timeliness of immunisation at 6 weeks.
		% of 4 year olds fully immunised *	≥95%	91.0%	89.5%	92.6%	90.9%		This group of children remains the most challenging for timely immunisation and is resource intensive with no extra capacity. The Immunisation Team work closely with B4SC, primary care, the Child Health Team and other partners to immunise this group on time. Measles is assisting us to encourage immunisation but the vaccine shortage is taking time away from our day to day delivery of service.
		% of boys and girls fully immunised - HPV vaccine *	≥75%	76.0%	85.6%	75.0%	73.8%		
		% of 65+ year olds immunised - influenza vaccine *	≥75%	58.0%	52.8%	45.6%	59.8%		

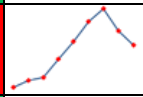
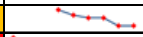
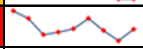
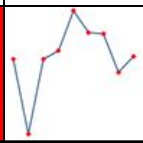
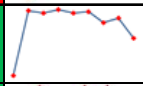
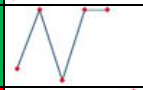
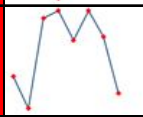
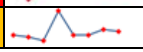
									Community pharmacies contribute significantly to delivery of this service. As at June 2019, influenza delivered in the community setting showed a 63% increase on 2018, with an increase of 2.7 % for Māori and 1.1% for Pacific. Most vaccines delivered by occupational health providers continue to be under-reported due to not being entered onto the National Immunisation Register. The influenza vaccine shortage complicated the campaign – whether this contributed to the coverage is unknown.
	Oral health	% of children caries free at 5 years of age **	≥61%	62.0%	43.0%	28.0%	62.0%		Recent participation in the national Pasifika oral health research project, which we are awaiting results, will help with future service planning. A dedicated kaiawhina is working with kohanga reo and Pasifika nests.
		Mean 'DMFT' score at year 8 *	≤0.73	76.0%	0.94	1.16	0.76		The community oral health service has a preventive approach and is currently reviewing its risk criteria for recall.
		% of pre-school children enrolled in and accessing community oral health services**	95%	tbc	78.0%	77.5%	95.7%		There has been improvement with quadruple enrolment, but access to service remains an issue with a high DNA rate for this group. There is a current audit on DNA processes in the service being carried out. A dedicated Kaiawhina is working with kohanga reo and Pasifika nests.
		% of enrolled preschool and primary school children overdue for their scheduled examinations *	≤10%	10%	10.0%	13.0%	10.0%		The service is aware that this is close to the target level cut-off, and is working to ensure that priority is given to those most at need.
		% utilisation of DHB funded dental services by adolescents for school Year 9 up to and including 17 years*	≥85%	tbc			62.4%		This year the MOH has given much better access to data, next year will be able to target specific schools which have low utilisation levels.
	Child health	% of infants exclusively or fully breastfed at 3 months **	≥60%	57%	43.1%	57.7%			Focus is on achieving good breastfeeding rates upon discharge. Implementing breastfeeding plan, focusing on investing in a whānau approach to support wāhine and pepe wellbeing.
		% of obese children identified in the Before School Check (B4SC) will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions **	≥95%	96.0%	100.0%		100%		
	Screening	% of women aged 50-69 years who received breast screening in the last two years *	≥70%	74.0%	70.0%	69.0%	73.0%		
		% of women aged 25-69 years who have had a cervical screening in the past 3 years *	≥80%	76.0%	74.8%	74.8%	74.3%		Focus has been on improving the coverage for Māori and Pacific and in particular women who are unscreened or underscreened. It has been reported by some women (non-priority group) that the cost of having a smear within general practice is prohibitive, plus the availibility of appointments suitable to their needs. We continue to encourage general practices to commence recalling women at 32months with the aim of screening on time.
		% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking *	≥95%	96%	97.5%	94.4%	97.4%		
		% 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 *	≥90%	85%	84.2%		88.2%		Results highlight that further training is required for midwives & LMCs on using quit smoking advice documentation.

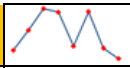
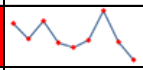
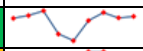
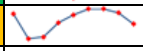
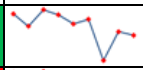
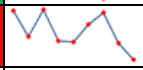
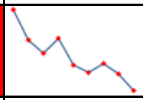
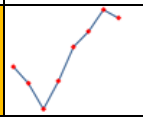
Pūnaha Ārahi Hāpori - Community Led System	Better help for smokers to quit	Number of Māori babies who live in a smoke-free household at 6 weeks post-natal *	≥21.9%	45%	22.2%	40.3%	45.0%		
		% of PHO enrolled patients who smoke who have been offered help to quit by a health practitioner in the last 15 months *	≥90%	85%	76.0%	75.0%	79.4%		Health HB introduced a new incentive strategy on 1 July 2019 and increased independent nurses from two to three nurses. Independent nurses have indicated many patients are hard to reach due to incorrect contact details or no money on their phones. Dr John McMenamin (MoH Smokefree Champion) has shared weekly quick tips for smoking cessation conversations with the PHO.
	ASH	Reduce the difference between Māori and other rate for Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 0 - 4 years **	Māori ≤8313	8750	8710	8732	7915		A targeted approach for ED presentations for this cohort is still being worked up. More recently a decision has been prioritised to collaborate with all areas that inform ASH rates and aim for collective impact in addresssing the drivers.
		Reduce ASH 45-64 - ASH rate per 100,000 45-64 years **	Māori ≤ 9341	9328	9833	7783	4734		Significant progress has been made in respiratory support in primary care as well as diabetes. An ASH task force has just been established. It is multidisciplinary and across a care continuum. The focus will be narrow – Māori and Pasifika ASH – reducing in the areas of cardiac, pulmonary and cellulitis the top 3 ASH conditions.
	Long term conditions	% of eligible population will have had a CVD risk assessment in the last 5 years *	≥90%	86%	79.2%	76.4%	82.0%		A revised remuneration structure for practices aims to increase Cardio Vascular Disease assessments undertaken in general practice. A large number of assessments can be completed through file review. Practices have been encouraged to complete this work. PHO is discussing collaboration with the Heinz Watties Occupational Health Nurse and the National Heart Foundation regarding a CVD screening pilot they are undertaking. This will allow for an analysis of assessments carried out outside of general practice so effort can be put into areas where there is definite unmet need. There are plans to reach into the community once those gaps have been identified
		Proportion of people with diabetes who have had a good or acceptable glycaemic control (HbA1C indicator) *	≥60%	42%	33.0%	30.0%	39.0%		Health HB is currently reviewing the data available to establish why the annual screening rates are low and develop practical steps to improve the uptake. HHB are working collectively with the Diabetes Specialist Team, hospital services, primary care to review the collective diabetes services for opportunities for improvement.
		Proportion of population seen by Mental Health and Addiction Services - child & youth (0-19 years) *	≥4.3%	5.3%	4.2%	1.9%	3.8%		CAFS has developed a Pasifika cultural pathway that allows collaboration between Pasifika navigators and the CAFS team. This is aimed at improving engagement of Pasifika clients with mental health services.
		Proportion of population seen by Mental Health and Addiction Services - adult (20-64 years)*	≥5.4%	5.3%	10.3%	3.5%	5.4%		
		Proportion of population seen by Mental Health and Addiction Services - older adult (65+)	≥1.15%	1.1%	1.4%	1.1%	1.0%		
		% of zero-19 year olds seen within 3 weeks of non-urgent referral - Addictions (provider arm & NGO)**	≥80%	75.0%	79.0%	78.9%	74.1%		CAFS had a vacancy for an AoD clinician and have now appointed someone who will start in January 2020. This should increase CAFS capacity to see patients with AoD challenges within 3 weeks.

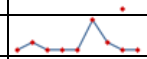
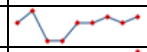
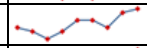
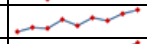
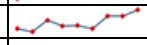
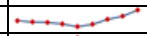
	Mental health	% of zero-19 year olds seen within 3 weeks of non-urgent referral - Mental health provider arm **	≥80%	67.0%	70.6%	-	73.8%		CAFS appointed an Intake and Triage Co-ordinator who will process referrals in real time. Additionally, CAFS is trialling some improvements that streamline the intake and triage process which increases CAFS capacity and capability to see patients timely.
		% of zero-19 year olds seen within 8 weeks of non-urgent referral - Addictions (provider arm & NGO) **	≥95%	92.0%	90.4%	100.0%	92%		
		% of zero-19 year olds seen within 8 weeks of non-urgent referral - Mental health provider arm **	≥95%	89.0%	82.4%	-	88.1%		Clinicians are encouraged to remind their patients of their upcoming appointments. A system is in place where the administration team reminds families of their upcoming appointments . Community support worker and the kaitakawaenga support the hard to reach families to attend appointments.
		% of clients with an open referral to MH&A services of greater than 12 months have a wellness plan *	≥95%	99.3%	-	-	78.8%		There is some system discreprency in the way clinicains report the presence of a "Go To Plan" in the patient management system (ECA). They have to create or update the plan in one screen ("Whānau Tahi") and then navigate to a different screen to insert the date - this inevitably leads to under-reporting of the presence of "Go To Plans" as the second step (putting the date in) is sometimes omitted by clinicians. A fix has been requested via Information Services to automatically write the date into the required field in ECA when the clinician creates or updates the "Go To Plan" in Whānau Tahi.
		% of audited files meet acceptable practice - wellness plans *	≥95%	89.0%					
		% of clients discharged from adult inpatient MH&A services have a transition (discharge) plan *	≥95%	64.3%	-	-	72.4%		Senior staff in NRR working with staff to re-embed Primary Nursing Model and responsibilities whilst working alongside CMHTs
		% of audited files have a transition (discharge) plan of acceptable standard *	≥95%		Data available Q2				
		% of clients discharged from community MH&A will have a transition (discharge) plan *	≥95%	78.5%	Data available Q2				
		% of audited files have a transition (discharge) plan of acceptable standard *	≥95%	97.0%	Data available Q2				
		Total self-harm hospitalisations and short stay ED presentations for <24 year olds per 10,000 *	Māori ≤ 75	80	88	27	75		We need investigate and look for reasons /themes for these presentations (possibly poor levels of engagement) and from there should be able to make a plan to counter the reasons identified.
		% of ED presentations for 10-24 year olds which are alcohol related *	Māori ≤14.3%	14.6%	14.1%	11.1%	14.1%		
		Rate of s29 orders per 100,000 population **	Māori ≤10% reduction	395	420	123	120		This continues to be of concern especially for Māori. MH&A are appointing a new DAMHS and this will be a focus area. National review of the MHA is also pending and reducing restrictive practice is a project under the HQSC Quality Improvement Framework.
		Number of hours mental health clients spent in seclusion	0	1569	210	0	424		Significant work has gone into seclusion reduction, including targeted work for Māori (received national award for this) with very good results. Current YTD Hrs = 1,5667 which is about a 20% reduction.
		% of all DHB inpatient service users seen with at least one outcome collection (HoNOS)	80%	95%			89.0%		

		% of all DHB community service users seen with at least one outcome collection (HoNOS)	80%	78%			75.0%		
	Reduce incidence of first episode of rheumatic fever	Acute rheumatic fever initial hospitalisation rate per 100,000 * (12 month measure)	≤1.5 per 100,000	tbc			5		Root Cause Analysis (RCA) is performed on all cases to identify programme failure or wider system issues. This involves a multidisciplinary team including kaiawhina. RCA identified that all cases were either Māori or Pacific, all have a family history of rheumatic fever, all school aged (4-15 years) and cases were widespread throughout region and not just where sore throat swabbing schools exist. Household crowding was a factor in some but not all cases and similarly for poor health literacy. Two missed opportunities for sore throat swabbing occurred both at a school and in primary care and have been followed up. In future there is an opportunity for a more integrated school delivery model that targets children with a family history of RF for more intense follow up. This would require a service review and redesign, and cost benefit analysis. An application was made for de bono consultancy assistance but was unsuccessful. There is an opportunity to learn from the Northland service review example. NB. Our small number of cases overall does mean there are variations in our DHB rate from year to year
	Older people	Better access to acute care for older people - Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) - 75-79 years *	≤130	127.5	184.40	66.70	128.00		Māori are accessing ED due to a range of factors including: cost of GP visits, lack of appointments and continuity of care at GP practice, proximity of location of ED, lack of cultural competency in GP practice, entrenched systemic behaviours that result in Māori accessing ED as the default behaviour.
		Better access to acute care for older people - Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) - 80-84 years *	≤170	169.1	179.20	275.00	159.10		As above for both ethnic cohorts.
		Better access to acute care for older people - Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) - 85+ years *	≤225	227.5	228.6	166.7	226.1		
		Better community support for older people - % of people having home assessments who have indicated loneliness *	≤23%	tbc	Data not available currently				
		Better community support for older people - rate of carer stress: informal helper expresses feelings of distress = YES, expressed as a % of all home care assessments *	≤26%	tbc	Data not available currently				
		Better community support for older people - Acute readmission rate for 75+ year olds *	≤11%	12.3%	12.8%	8.8%	12.4%		The CNSs Gerontology receive a listing of patients attending hospital 2+ per month and visits are made to these patients to identify and respond to any issues that may lead to readmission. The time delay between discharge from hospital and acceptance follow up by CNS, EngAGE, community, Geriatrician and enrolment to GP services is dependent on resource and can cause delays and require readmission. Hoki ki te kainga implementation in Dec 2019 will provide 6 weeks of intensive restorative therapy post discharge.

		Increased capacity and efficiency in needs assessment and service coordination services - Conversion rate of Contact Assessment (CA) to Home Care Assessment where CA scores are four-six for assessment urgency *	tbc	tbc	Data not available currently					
		Clients with a Change in Health, End-stage, Signs and Symptoms (CHESS) score of four or five at first assessment *	11%	tbc	Data not available currently					
		Average age of first entry to aged residential care		82.8			83.6			
		Aged residential care occupancy rate		90.0%			92.0%			
		% of older patients given a falls risk assessment *	≥90%	91.1%			91.0%			
		% of older patients assessed as at risk of falling receive an individualised care plan *	≥90%	92.4%			92.0%			
	Amenable mortality	Relative rate between Māori and Non-Māori Non-Pasifika (NMNP)*	≤2.15	2.45	2.53					Work is in the early stages to focus on cardiology DNAs and why whānau DNA. As well as being integral part of improving access to cancer care.
	Urgent care	% of patients admitted, discharged or transferred from ED within 6 hours *	≥95%	88%	81.2%	84.6%	76.8%			Extended ED delays for admitted patient population, due largely to high levels of hospital occupancy and facility constraints.
		Number of ED presentations			3,606	608	10,973			
		Admissions from ED - conversion rate			Data available Q2					
		Placeholder: Urgent care in primary care - to be developed								
	Fewer missed outpatient appointments	Did not attend (DNA) rate across first specialist assessments **	Total ≤5%, Māori & Pasifika ≤9%	Total 5.9%, Māori 11.3%, Pasifika 13.3%	10.4%	11.3%	5.8%			Attendance at outpatient appointments during school holidays continue to be more difficult for Māori and Pacific populations. A number of tangi this quarter has impacted on Māori attendance. Many patients that DNA, have verbally confirmed they are attending.
	Faster cancer treatment	% of patients who receive their first cancer treatment (or other management) within 31 days from date of decision to treat *	≥85%	85%			83.5%			
		% of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks *	≥90%	95%			77.6%			Periods of industrial activity have affected particular workforce availability, access to specialist clinical resources, and the overall level of complex acutiy and high occupancy of the hospital population in the time period leading up to and including the 4th quarter. The weekly stakeholder case management forum attends to specific patients and environment pressures. The elective surgical capacity is under review to enable increased production flow.
		% of services report YES (that more than 90% of referrals within the service are processed in 15 calendar days or less) ESPI 1 *	100%	68%			83.3%			
		% of patients waiting over four months for a FSA ESPI 2 *	0%	30%			29.0%			ESPI2 FSAs have been stable for the last few months as the Communities, Women and Children and Medical directorates reduced their waitlists (both current and overdue). These two directorates overdues are almost at zero. The Surgical directorate has increasing waitlists due to a significant capacity/demand mismatch. Where departments have not been able to match capacity to demand, focus has been on ensuring high priority/risk patients are seen.

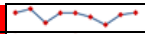
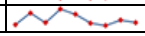
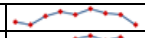
Whānau - Embed Person and Whānau Centred Care	Planned care	% of patients in Active Review with a priority score above the Treatment Threshold ESPI 3 *	0%				0.0%		
		% of patients waiting over 120 days for treatment ESPI 5 *	0%	27%			20.0%		The number of patients breaching ESPi 5 has gone from a high of 539 in February to 298 at end of October. This has plateaued and is expected to increase over Christmas and January holidays where there is reduced capacity.
		% of patients prioritised using an approved national or nationally recognised prioritisation tool ESPI 8 *	100%				100.0%		
		Ophthalmology: Number of patients waiting more than or equal to 50% longer than the intended time for an ophthalmology appointment *	0%						
		Acute readmission rates to hospital	≤11.8	11.9%	11.6%	11.6%	11.9%		
	Cardiovascular	% of ACS patients undergoing coronary angiogram, door to cath, within 3 days **	>70%	61%	70.0%		60.3%		Angiogram capacity is 2x0.5 day sessions per week. Capacity is not flexible due to shared facility with Radiology. Often patients waiting for angiogram exceed the available diagnostic cardiac cath lab time, requiring the HBDHB to rely on other regions for procedures. This has proved challenging due to their individual constraints, and demand surpasses capacity. Also, HB geographical isolation makes road transport to other facilities non-viable, flight availability becomes another constraint for service delivery to meet this target
		% of ACS patients who undergo coronary angiogram have pre-discharge assessments of LVEF *	≥85%	66%	61.5%	100%	71.2%		This was recognised as an area of improvement, although not an outlier within the regional performance, and we have had overall improvement. However recent reductions in the echo department workforce has confounded our ability to meet this target. Angiogram does not typically include LV gram by HBDHB cardiologists, and we are working on this.
		% of patients presenting with acute coronary syndrome who undergo coronary angiography have completion of ANZACS QI ACS and cath/PCI registry data collection within 30 days of discharge **	>95%	97%	83.3%	100%	98.0%		Overall completing of the registry is above target. This activity is absorbed within the senior nursing team and can have lag times created by reprioritisation to work.
		% of patients presenting with acute coronary syndrome who undergo coronary angiography have completion of ANZACS QI ACS and cath/PCI registry data collection within 3 months **	>99%	100%	100.0%	100.0%	100.0%		
		Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance all ACS patients who undergo coronary angiogram should be prescribed at discharge aspirin, a second anti-platelet agent, statin and an ACE/ARB (four classes) and those with LVEF<40% should also be on a beta blocker (five classes) *	>85%	55%	75.0%	-	66.7%		Variance in practise in this area is around the use of ACEi/ARB medication combinations and HBDHB is not an outlier within the regional performance. These are prescribed in accordance with guidelines on a case by case basis (per clinical lead cardiologist and TAS meetings).
	Stroke	% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission *	≥80%	73%	75.0%	-	47.0%		During the last quarter the hospital was extremely busy and medical was repeatedly well over capacity with medical outliers in the ATR unit hindering effective patient flow. Also there appears to be a problem with coding which is under investigation.
		% of potentially eligible stroke patients who are thrombolysed 24/7 *	10%	9%	7.0%	-	9.0%		

He Rauora Hōhou Tangata, Hōhou		% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway *	80%	80%	73.0%	-	75.0%		See above
		% of stroke patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge *	≥60%	tbc	69.0%	-	-		
	Quicker access to diagnostics	% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks) *	≥95%	92%	-	-	88.0%		Non-compliance is due to a mismatch in capacity and demand. There is a continued level of acute presentations and Faster Cancer Treatment demand. Radiology continue to use national radiology service improvement methodology to forecast and plan workload. Radiologist resourcing is currently an issue and we have continued to utilise strategies such as outsourcing and use of locums to minimise the effect on compliance. 11.7% more CTs were performed in 2018/19 compared to 2017/18 within same level of resourcing. To achieve MoH target, an increase in capacity is required.
		% of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks) *	≥90%	90%	-	-	93.0%		
		% accepted referrals for elective coronary angiography completed within 90 days *	≥95%	100%			93.8%		
		% of participants to have received their colonoscopy within 45 calendar days of their FIT result being recorded in the NBSP information system *	≥95%	NA					
		% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive) *	≥90%	95%	-	-	91.5%		
		% of people accepted for non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 calendar days) *	≥70%	69%	-	-	39.0%		Industrial action and reduced access to specialist resource (gastroenterologists, general surgeons, and anaesthetists) has impacted on the production schedule. The NBSP has been in place for 12 months and there is a significant increase in demand over the predicted MoH model. A weekly clinical forum reviews actual referral numbers, sessions booked and opportunity to back fill session gaps. The group looks at the production plan 4 weeks in advance to allow for the necessary lead time required of bowel prep for colonoscopies. The clinical lead is piloting an increase in the points per session to facilitate an increase in throughput. Locum resources are contracted as they become available.
		% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date *	≥70%	55%	-	-	42.8%		Same as above. Plus the surveillance waiting list is checked and reprioritised on a regular basis in order to maximise opportunities on scheduled sessions and to ensure clinical risk is mitigated.
	Hospital stay	Length of stay - acute *	tbc	2.31	-	-			
		Length of stay - elective *	tbc	1.59	-	-			
		Total acute hospital bed days per capita (per 1,000 population) *	≤390	410	649	521	410		To mitigate the daily bed occupancy for all patients and ethnicities, reviews of all patients with a stay greater than 10 days have been increased from once per week to twice weekly with a focus on noting ACC claim opportunities to increase revenue streams.
		Patient occupancy rates - overall			Data available Q2				

		Patient occupancy rates - HB Soldiers' Memorial Hospital			Data available Q2				
		Patient occupancy rates - Wairoa			Data available Q2				
		Patient occupancy rates - CHB			Data available Q2				
		Patients not in home ward			Data available Q2				
	Patient experience	Number of SAC 1 and 2 serious adverse care events					20		A number of these event investigations are still in progress so may be downgraded to a SAC 3.
		Number of grade 3 patient pressure injuries - hospital		4			0		
		Number of grade 4 patient pressure injuries - hospital		0			0		
		Number of grade 3 patient pressure injuries - community		3			4		
		Number of grade 4 patient pressure injuries - community		2			4		
		Number of hospital acquired MDRO infections		1			4		
		Number of surgical site infections		0			1		
		Number of HAI staphylococcus aureus BSIblood infections		5			8		
		Number of compliments		196			242		
		Number of complaints		119			155		
		Placeholder: % of clinical staff who have clinical orientation at a local level							
		Number of patients that answer 'NO' to the inpatient experience survey question 'Did a member of staff tell you about medication side effects to watch for when you went home' *	≥17%	22%					
	Ethnicity profile	% of staff who are Māori - DHB	16.66%	14.54%	15.6%				
		% of staff who are Māori or Pasifika - DHB	1.76%	1.51%		1.5%			
		% of staff who are Māori or Pasifika - general practice	26%	3.7%	10.5%	2.6%	13.1%		Workforce development strategies are in progress to improve Maāori and Pacific workforce targets. These targets reflect the population served
		Placeholder: % of staff who are Māori or Pasifika - aged residential care, Māori health providers - to be developed							
		Placeholder: % of staff who are Māori or Pasifika - total DHB, general practice, aged residential care, Māori health providers - to be developed							
	Recruitment	% turnover of staff - DHB		2.9%			3.2%		
		% of job applications received Māori- DHB		21.0%	19.6%				
		% of job applications received Pasifika- DHB		1.6%		2.4%			
		% of applicants who were interviewed v applied Māori- DHB		35.6%	33.8%				
		% of applicants who were interviewed v applied Pasifika- DHB		14.3%		22.2%			
		% of interviewees who were hired v interviewed Māori- DHB		50.0%	52.0%				
		% of interviewees who were hired v interviewed Pasifika- DHB		100.0%		0.0%			

ka - Highly Skilled and Capable Workforce

12

Ngā Kaimahi Tōtik	Staff wellbeing	% of employees with 1-2 years annual leave owing	15%	23.9%			24.9%		Comprehensive actions in place to address excess leave and ensure staff take their leave entitlement. Seeing some improvements in this.
		% of employees with 2+ years annual leave owing	0%	5.2%			5.2%		
		% of sick leave taken		2.6%			3.8%		
		% of staff who have had influenza vaccination					63.8%		
		Number of staff using EAP services		48			89.00		
		Average days lost due to injuries		19.29			20.27		
		Number of employee events reported			Data available Q.2				
		Number of employee near miss events reported			Data available Q.2				
		Number of verbal abuse events reported by staff		20			12		
		Number of physical abuse/assaults against staff reported		19			16		
		Number of hazard events reported		8			7		
Pūnaha Tōrire - Digitally Enabled Health System	Improving the quality of identity data within the NHI and data submitted to national collections	New NHI registrations in error *	>1% and ≤3%	5.1%			1.70%		
		Recording of non-specific ethnicity in new NHI registrations *	>0.5% and ≤2%	1.3%			1%		
		Update of specific ethnicity value in existing NHI records with a non-specific value *	≤2%	0.1%			0%		
		Invalid NHI data updates *	tbc	NA			-		
		NPF collection has accurate dates and links to NNPAC, NBRS and NMDS for FSA and planned inpatient procedures *	≥90% and ≤95%	NA			-		
		National collections completeness *	≥94.5% and ≤97.5%	NA			92%		
		Assessment of data reported to the national minimum set (NMDS) *	≥75%	84.1%					
He Paearu Teitei Me Ōna Toiūtanga - High Performing and Sustainable System	Financial performance		**Budget**	**Sep-19**	**Dec-19**	**Mar-20**	**Jun-20**	**Year end forecast**	
			$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	
		Income	50,948	52,044				614,548	Based on the result for the month of September 2019, the year end forecast is $15.3m deficit, which is $2.4m adverse to plan.
		Less expenditure	51,069	52,421				629,897	
		Financial Performance	**-121**	**-377**				**-15,349**	
		Other performance measures							
		Capital spend	1,769	1,446				21,695	
		Employees (FTE)	2,515	2,504				2,502	
		Case weighted discharges	2,679	2,756				29,239	

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:

14. Minutes of Previous Meeting (public excluded) - nil

15. Matters Arising – Review Actions (public excluded) - nil

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).