Māori Relationship Board Meeting

Date:	**Wednesday, 9 August 2017**
Meeting:	**9.00am to 12.00pm**
Venue:	**Te Waiora (Boardroom), District Health Board Corporate Office, Cnr Omahu Road & McLeod Street, Hastings**

Board Members:

Ngahiwi Tomoana (Chair)
Heather Skipworth (Deputy Chair)
George Mackey
Na Raihania
Kerri Nuku
Dr Fiona Cram
Lynlee Aitcheson-Johnson
Trish Giddens
Tatiana Cowan-Greening (Teleconference)
Hine Flood
Ana Apatu

Apologies:

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

Our vision

HEALTHY
HAWKE'S BAY

TE HAUORA O
TE MATAU-Ā-MĀUI

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

Our values

Tauwhiro – delivering high quality care to patients and consumers

Rāranga te tira – working together in partnership across the community

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

Ākina – continuously improving everything we do

PUBLIC MEETING

Item	Section 1 : Routine	Time
1.	Karakia	**9.00am**
2.	Whakawhanaungatanga	
3.	Apologies	
4.	Interests Register	
5.	Minutes of Previous Meeting	
6.	Matters Arising - Review of Actions	
7.	MRB Workplan 2017	
8.	MRB Chair's Report	
9.	Acting General Manager Māori Health Report	
10.	Clinical Council Verbal Update - Kerri Nuku	
	Section 2: Presentation	**9.30am**
11.	Te Ara Whakawaiora - Mental Health (National and local indicators) – Justin Lee / Peta Rowden / Allison Stevenson	20-mins
12.	Health Literacy (Making Health Care Easier to Understand) – Andre Le Geyt / Kate Coley	20-mins
	Section 3: For Discussion	**10.15am**
13.	Te Ara Whakapiri Hawke's Bay (Last Days of Life) – Leigh White	20-mins
14.	Proposal - Request for Alcohol Free Health Awards – Heather Skipworth	20-mins
	Section 4: For Information only (no presenter)	**10.55am**
15.	Ngātahi Vulnerable Children's Workforce Development Programme – briefing paper	5-mins
16.	Ka Aronui Ki Te Kounga Focussed on Quality (draft)	5-mins
17.	Annual Māori Health Plan Q4 Apr-Jun 17 Report and Dashboard	5-mins
18.	MOH Vulnerable Children Definition	5-mins
	Section 5: General Business	**11.40am**
	Karakia Whakamutunga (Closing)	
	Light Lunch	**12.00pm**

Māori Relationship Board Interest Register - 4 July 2017

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	Brother of Waiariki Davis	Perceived Conflict of Interest. Non-Pecuniary interest. Waiariki Davis is employed by HBDHB and is the Health Records Manager.	Will not take part in any decisions in relation to Health Records management. All employment matters in relation to Waiariki Davis are the responsibility of the CEO.	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
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
Tatiana Cowan-Greening	Active	Husband, Parris Greening, Service Manager of Te Kupenga Hauora (TKH)	Contracted health provider of HBDHB	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.03.14
	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussions in relation to the Trust.	The Chair	19.03.14
	Active	Director Te Pou Matakana	Whanau Ora Commissioning Agency	No conflict	The Chair	27.03.17
Kerri Nuku	Active	Kaiwhakahaere of New Zealand Nurses Organisation	Nursing Professional / Industrial Advocate	Will not take part in any discussions relating to industrial issues	The Chair	19.03.14
	Active	Trustee of Maunga HaruruTangitu Trust	Nursing Services - Clinical and non-Clinical issues	Will not take part in any discussions relating to the Trust	The Chair	19.03.14
George Mackey	Active	Wife, Annette Mackey is an employee of Te Timatanga Ararau Trust (a Trust aligned to Iron Maori Limited)	The Trust Holds several contracts with the HBDHB	Will not take part in any discussions relating to the Trust	The Chair	19.03.14
	Active	Wife Annette is a Director and Shareholder of Iron Maori Limited (since 2009)	The company is aligned to a Trust holding contracts with HBDHB	Will not take part in any discussions relating to Iron Maori Limited	The Chair	04.08.16
	Active	Trustee of Te Timatanga Ararau Trust (a Trust aligned to Iron Maori Limited)	The Trust Holds several contracts with the HBDHB	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.06.14
	Active	Director and Shareholder of Iron Maori Limited (since 2009)	The company is aligned to a Trust holding contracts with HBDHB	Will not take part in any discussions or decisions relating to the Contract aligned to Iron Maori Limited).	The Chair	04.08.16
	Active	Employee of Te Puni Kokiri (TPK)	Working with DHB staff and other forums	No conflict	The Chair	19.03.14
Lynlee Aitcheson-Johnson	Active	Chair, Maori Party Heretaunga Branch	Political role	Will not engage in political discussions or debate	The Chair	19.03.14
	Active	Trustee, Kahuranaki Marae		No conflict	The Chair	14.07.16
	Active	Treasurer for Ikaroa Rawhiti Maori Party Electorate		No conflict	The Chair	04.07.17
Na Raihania	Active	Wife employed by Te Taiwhenua o Heretaunga	Manager of administration support services.	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.03.14
	Active	Member of Tairawhiti DHB Maori Relationship Board		Will not take part in any matters that may to any perceived contracts with Tarawhiti	The Chair	19.03.14
	Active	Employeed as a Corrections Officer		No conflict	The Chair	19.03.14
	Active	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
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	Assistant Director Governor, Rotary District 9930		No conflict	The Chair	15.04.15
	Active	Member of the Lotteries Board		No conflict	The Chair	15.04.15
Ana Apatu	Active	CEO of U-Turn Trust (U Turn is a member of Takitimu Ora Whanau Collective)	Relationship and and may be contractural from time to time	No conflict	The Chair	12.08.15
	Active	Chair of Directions	Relationship and contractual	Potential Conflict as this group has a DHB Contract	The Chair	12.08.15

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict (if any)	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Declared
	Active	Chair, Health Promotion Forum (previously Deputy Chair from 12.08.15)	Relationship	No conflict	The Chair	12.08.15 04.08.16
Hine Flood	Active	Member, Health Hawkes Bay Priority Population Committee	Pecuniary interest - Oversight and advise on service delivery to HBH priority populations.	Will not take part in any conflict of interest that may arise or in relation to any contract or financial arrangement with the PPC and HBDHB	The Chair	23.02.17
	Active	Councillor for the Wairoa District Council	Perceived Conflict - advocate for the Wairoa District population and HBDHB covers the whole of the Hawkes Bay region.	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	23.02.17
Dr Fiona Cram	Active	Board Member, Ahuriri District Health Trust	Contribution to the health and wellbeing of Māori in Napier, as per the settlement under WAI692.	Declare and interest and withdraw from any discussions with respect to any contract arrangements between ADHT and HBDHB	The Chair	14.06.17
	Active	Adjunct Research Fellow, Women's Health Research Centre, University of Otago, Wellington	Health research involving data and/or participant recruitment from within HB DHB rohe.	Declare a potential conflict of interest, if research ethics locality assessment requires MRB input.	The Chair	14.06.17

MINUTES OF THE MĀORI RELATIONSHIP BOARD (MRB) MEETING HELD ON WEDNESDAY, 12 JULY 2017, IN TE WAIORA MEETING ROOM, DISTRICT HEALTH BOARD (DHB) ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS COMMENCING AT 9.00AM

Members:	Na Raihania (Proxy Chair) Ngahiwi Tomoana (Chair) Ana Apatu Dr Fiona Cram Hine Flood Kerri Nuku Trish Giddens
Apologies:	George Mackey Heather Skipworth (Deputy Chair) Lynlee Aitcheson-Johnson Tatiana Cowan-Greening Chrissie Hape (Iwi/CYF Partnership Advisor, Ngāti Kahungunu Iwi Incorporated) Dr Kevin Snee (CEO HBDHB) Kevin Atkinson (Chair Hawke's Bay District Health Board) Matiu Eru (Pouahurea, Māori Health HBDHB)
In Attendance:	Graeme Norton (Chair of HB Clinical Council) Helen Francis (Board Member Hawke's Bay District Health Board) Linda Dubbeldam (Manager Innovation & Development, Health Hawke's Bay PHO) Patrick Le Geyt (Acting General Manager, Māori Health HBDHB) Peter Dunkerley (Board Member Hawke's Bay District Health Board) Tracee Te Huia (Executive Director of Strategy & Health Improvement HBDHB) Members of the Māori Health Service Members of the Public
Minute Taker:	Amy Martin (MRB Administration Coordinator, Māori Health HBDHB)

SECTION 1: ROUTINE

1. KARAKIA

Patrick Le Geyt opened the meeting with karakia.

2. WHAKAWHĀNAUNGATANGA

The MRB Chair welcomed everyone to the meeting. Ngahiwi briefed MRB on his recent family trip to Rome and his experience meeting the Pope. He expressed his learnings from the meeting and his visions for what our community needs. 'Kotahitānga ki te rangi, kotahitānga ki te whenua, kotahitānga ki te tangata' and reiterated the value of Māori tikanga, te reo and kaupapa.

3. APOLOGIES

Apologies were received from H Skipworth, T Cowan-Greening, G Mackey, and L Aitcheson-Johnson. N Tomoana advised he was leaving early.

4. INTERESTS REGISTER

No MRB members declared any additional conflict of interest to the register or with today's agenda items.

5. MINUTES OF THE PREVIOUS MEETING

The minutes of the MRB Board meeting held 14 June 2017 were taken as read and confirmed as a correct record, pending the following amendments:

Chair of Consumer Council
Graeme Norton, announced he is stepping down as Chair of Consumer Council HBDHB in August and has been elected onto the Consumer Council NZ.

MRB Hosting the next Te Whiti ki te Uru.
Tatiana resigned from her position coordinating the next Te Whiti ke te Uru. MRB are seeking registrations to replace Tatiana.

Moved: N Raihania
Seconded:
CARRIED

6. MATTERS ARISING FROM THE PREVIOUS MINUTES

The following matter from the June minutes was discussed.

The 'Fluoridation wānanga' action point was queried as to whether the purpose of a workshop at NKII is in the interest of MRB? MRB elaborated on the decision to support the wānanga and await confirmation of the workshop date and time. MRB acknowledge the paper presented by Dr Robin Whyman to MRB in 2016.

- Circulate recent study from Australia on Fluoridation to MRB **ACTION Dr Fiona Cram**
- Email Dr Fiona Cram a copy of Dr Robin Whyman Fluoridation paper presented to MRB in 2016. **ACTION MRB Administration Coordinator**
- Finalise a date for Lynlee Aitcheson-Johnson to host fluoridation workshop at NKII. **ACTION GM Māori Health and Chrissie Hape**

REVIEW OF ACTIONS

The Action and Progress List as at July 2017 was taken as read. The following actions were discussed.

Māori Representative in the Workforce
Total FTE numbers of all ethnicities employed at the DHB was provided. MRB queried the statistical amalgamation of British and Irish ethnicity. **ACTION GM Māori Health** to seek confirmation on the standard ethnicity grouping.

Patient Experience Survey
Ethnicity breakdown of the patient experience survey data was provided. GM Māori Health noted the low Māori response of Adult Inpatient. Action is now complete.

Ngahiwi Tomoana left the meeting at 9.30am.

Health Equity Update 2016 NZ Territorial Authorities Statistics Gap in Years between Māori and non-Māori Life Expectancy by Gender and Region 2012-14
Patrick and Nick had a teleconference with Suzanne Pitama, resulting in no conclusive answer however predominately socio-economic and mainstream factors. Action is now complete.

7. MRB WORKPLAN 2017

The workplan as at July 2017 was taken as read.

8. MRB CHAIR'S REPORT

The Chairs Report for June 2017 was taken as read and the contents noted. The following matter was discussed:

NUKA training

MRB discussed at length the NUKA training and composition of the group of clinicians and management who travelled to Alaska to attend the NUKA training with the South Central Foundation in Anchorage. MRB support this model and acknowledge the learnings from this training will support the drive to change principals for a co design model of care. MRB **recommend** those who attended from HB present to MRB post their presentation at the Leadership Forum on 9th September.

MRB **endorse** a *Special Meeting* be held on 10th August 9am-12pm. **ACTION GM Māori Health** to present a brief summary paper of the NUKA model and identify any benefits for the region of Hawke's Bay.

9. GENERAL MANAGER (GM) MĀORI HEALTH REPORT

The GM Māori Health report for June 2017 was taken as read and the contents noted.

The following matters were discussed and information advised:

Tūruki Online Database Update

The benefits of the Real-time data and tracking of Tūruki and HWNZ scholarship recipients was discussed. The database will contribute towards a more robust system to improve engagement with scholarship recipients. The purpose of Tūruki online is to enable the HBDHB to track students and support them into employment.

It was acknowledge that study techniques are specific to the individual and the individuals, while some prefer online learning, others prefer classroom interaction.

Kerri informed MRB there has been recent research that will be provided to Heads of Nursing Schools. The finding from this research will be distributed to MRB for MRB perusal.
Circulate research paper to MRB. **ACTION Kerri Nuku**

Customer Focused Booking Project - Māori DNA Rate

MRB acknowledge the significant drop in the number of DNAs due to the Customer Focused Booking project, and the new phone and computer system whereby bookers are now only booking appointments after making contact with patient.

10. CLINICAL COUNCIL UPDATE

There was no update presented at this meeting.

SECTION 2: PRESENTATION

11. BUDGET 2017/18

Ashton Kirk (Head of Contracts), was in attendance to present the Budget 2017/18. MRB **noted** the contents of the presentation.

12. BUILDING A DIVERSE WORKFORCE

Kate Coley (Executive Director of People and Quality) and James Graham (Senior Advisor Cultural Competency, Māori Health) were in attendance to present the report on Building a Diverse Workforce and Engaging Effectively with Māori.

Kate Coley opened the presentation with Building a Diverse Workforce providing statistics, providing an overview of the report, highlighting successes and information on the next phase of the Building a Diverse Workforce journey through Engaging Effectively with Māori, Supply, Recruitment and Retention.

MRB **noted** the contents of the report and provided the following feedback:

- MRB **recommend** job descriptions and selection criteria emphasise what Māori consumers value, i.e. relationships, caring, cultural competency etc.
- MRB **recommend** interview mechanisms are flexible enough to give candidates opportunity to demonstrate their values.
- MRB **recommend** the Social Inclusion plan not only support rangatahi / young people with their career pathways and guide them into the paid workforce as employees but also foster social enterprise in order that they become business owners.
- The NetP programme's equity approach has successfully increased Māori workforce.
- MRB requested an additional column in the graph Māori Staff Representation at HBDHB to include statistics of the users of the services. **ACTION Kate Coley**

Kate Coley highlighted the following statistics on Māori applicants applying for roles at the HBDHB:

- 10% of applicants to HBDHB are Māori,
- Over 50% of candidates shortlisted who identified as Māori were hired

It was confirmed to MRB it is the responsibility of hiring managers to ensure there is Māori representation on all interview panels and all panellist have completed Engaging Effectively with Maori training. MRB **recommend** it be a requirement for hiring managers to assign Māori representation on interview panels.

Helen Francis left the meeting at 11.33am.

James Graham (Senior Advisor Cultural Competency, Māori Health) presented the review of the Engaging Effectively with Māori training and the key learnings and the plan going forward for Cultural Competency through Engaging Effectively with Māori training. James Graham advised MRB 100% EMT members have participation in this training. Engaging Effectively with Māori training is mandatory for all new staff.

Circulate Engaging Effectively with Māori presentation to MRB. **ACTION MRB Administrator**

MRB **noted** the contents of the report and was very supportive of the work being undertaken.

13. HE WAKA KAKARAURI

Paul Malan (Strategic Services Manager, Mental Health) and Teracia Smith (Renal Social Worker) were in attendance to present the He Waka Kakarauri Advance Care Planning booklet and were seeking endorsement from MRB for use of this tool in the Kahungunu rohe

MRB **endorsed** He Waka Kakaraui tool and were very supportive of the work being undertaken

SECTION 5: GENERAL BUSINESS

There were no items for General Business.

The meeting was closed by Patrick Le Geyt (Acting GM Māori Health) with Karakia at 12.00pm.

Signed: _____

Chair

Date: _____

Date of next meeting: 9.00am Wednesday 9 August 2017
Te Waiora (Boardroom), HBDHB Corporate Administration Building

MĀORI RELATIONSHIP BOARD
Matters Arising – Review of Actions

Action No	Date Issue first Entered	Action to be Taken	By Whom	Month	Status
1.	12 July 17	**Fluoridation papers** 1.1 Circulate Robin Whyman presentation to Dr Fiona Cram 1.2 Circulate Draft Information Paper: Effects of water fluoridation on dental and other health outcomes – Australian Government National Health and Medical Research Council	Amy Martin Fiona Cram	July July	**COMPLETE** **COMPLETE**
2.	12 July 17	**Māori representatives in the workforce** 2.1 Confirm grouping of ethnicities, i.e. British and Irish. 2.2 Additional column to be inserted into Māori Staff Representation at HBDHB graph to include statistics of the users of the service.	Jim Scott Kate Coley	Aug Aug	**IN PROGRESS** **IN PROGRESS**
3.	12 July17	**MRB Special Meeting** Special meeting to present a brief summary paper of the NUKA model and identify and benefits for the region of Hawke's Bay	Patrick Le Geyt	10 Aug 17	**IN PROGRESS** Scheduled for 10 August 2017 at HBDHB
4.	12 July 17	**Student Report** Circulate research paper to MRB.	Kerri Nuku	TBA	**IN PROGRESS** Kerri will circulate once the paper is available for public distribution.
5.	12 July 17	**Engaging Effectively with Māori presentation** Circulate presentation to MRB	Amy Martin	July	**COMPLETE**
6.	14 June 17	**Ngātahi Workforce Development** Seek Clarification from MOH the definition of Vulnerable Children and Vulnerable Families.	Patrick Le Geyt	July	**August Agenda Item**

Action No	Date Issue first Entered	Action to be Taken	By Whom	Month	Status
7.	10 May 17	**Upgrade plan** Present the upgrade plan of the Tower Block and reconfiguration of Level 2 Corporate Administration Building	Trent Fairey	Oct	**IN PROGRESS** Scheduled to present to MRB on 11 October 2017
8.	10 May 17	**Cultural Competency training restrictions of RMOs** a) Investigate and report back to MRB the current cultural competency training restrictions of RMOs and SMOs	Patrick Le Geyt	June	**IN PROGRESS**
9.	10 May 17	**Health Hawke's Bay Health Literacy Programme** Present to MRB an update of PHO Health Literacy Programme	Andre Le Geyt	August	**August Agenda Item**
10.	12 Apr 17	**Māori representatives in the workforce** A brief update of feedback from exit interview of Māori staff including the position/income level data.	Paul Davies	June	**IN PROGRESS**
11.	8 Feb 17	**Fluoridation** Coordinate an independent workshop/wānanga with MRB to discuss the impacts of Fluoridation on populations and any recommendations to be bought back to a formal MRB meeting.	L Aitcheson-Johnson Patrick Le Geyt / Chrissie Hape	May 2017	**IN PROGRESS** 12/04/17 L Aitcheson-Johnson and N Tomoana to meet and discuss L Aitcheson-Johnson presenting to NKII 12/07/17 Finalise date for this workshop.
12.	14 Sep 17	**MRB hosting the next Te Whiti ki te Uru:** a) Develop the agenda and discussions b) Consider future MRB representation to the Māori Caucus.	MRB	Oct 2017	**IN PROGRESS** 14/06/17 seeking registrations of interest to support Tatiana Cowan-Greening. Hawke's Bay is scheduled to host the TWkTU meeting 2 October 2017.
13.	12 May 16	**Review form and function of MRB and Youth Representative** NKII and MRB are reviewing MRB including the composition and consideration of a Youth Representative.	CEO NKII	Sept 2016	**IN PROGRESS** **NKII Review on HOLD**
14.	12 May 16	**Bariatric Surgery Investigation** Request for an investigation of the evidence to rationalise the increase of surgeries per annum.	Paul Malan	Oct 2016	**DEFERRED** September 2017

MĀORI RELATIONSHIP BOARD

WORKPLAN AUGUST 2017- DEC 2017

NOTE: This workplan is still in draft therefore is subject to change.

Date/ Month 2017	Performance Monitoring and for Information and Discussion	EMT Lead	Strategic / Decision Papers	EMT Lead
9 Aug	Te Ara Whakawaiora: Mental Health and AOD (National and Local Indicators) Annual Maori Health Plan Q4 April-June 17 Quality Accounts Draft	Sharon Mason Tracee Te Huia Kate Coley	Final 2017/18 Annual Plan and Central Region RSP	Tracee Te Huia
6 SEPT	***Hawke's Bay Health Leadership Forum, 8.30-3.00pm, East Pier, Napier***			
SEPT	**NO MEETING FOR MRB IN SEPT – email papers below to MRB for feedback**			
	Quality Accounts Final Te Ara Whakawaiora: Culturally Competent Workforce (Local Indicator) Position on Reducing Alcohol Related Harm – progress Consumer Experience Feedback Q4 Report Te Ara Whakawaiora: Healthy Heathly Weight (National Indicator)	Kate Coley Kate Coley Tracee Te Huia Kate Coley Tracee Te Huia	Orthopaedic Review Phase 3 DRAFT Social Inclusion (to Committees) Implementing the Consumer Engagement Strategy Metabolic (Bariatric) Survery - in the context of a Healthy Weight Strategy for Adults	Andy Phillips Tracee Te Huia Kate Coley Tracee Te Huia
11 Oct	Establishing Health and Social Care Localities Update	Tracee Te Huia		
8 Nov	Te Ara Whakawaiora: Smoking (national indicator) Tobacco Annual Update against Plan Annual Maori Plan (MRB only) Q1 July-Sept 17	Tracee Te Huia Tracee Te Huia Tracee Te Huia	Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-May-Nov18) Recognising Consumer Participation - Policy Amendment - review by EMT	Tracee Te Huia Kate Coley
DEC	**NO MEETING FOR MRB IN DEC - – email papers below to MRB for feedback**			
	Consumer Experience Feedback Quarterly Report Q1 March, Jun, Sept, Dec, Mar18 - incorporating Annual Review Board actionsa	Kate Coley		

HAWKE'S BAY District Health Board Whakawāteatia	**Chair's Report**
	For the attention of: **Māori Relationship Board (MRB)**
Document Owner:	Ngahiwi Tomoana, Chair
Month:	August 2017
Consideration:	For Information

RECOMMENDATION

That the Māori Relationship Board
Note the content of this report.

PURPOSE

The purpose of this report is to update the Māori Relationship Board (MRB) on relevant discussions at the Board meeting held in July 2017 pertaining to Māori health.

INTRODUCTION

For this month, I provide an overview of the Chief Executive Officer's (CEO) report including:

- Ministerial Targets
- System Level Measures
- Building A Diverse Workforce
- Health Literacy

MINISTERIAL TARGETS

For the month of June, Shorter Stays in Emergency Departments showed an improvement and an average of 94 percent for the full 2016/17 year. Elective activity has achieved annual targets; 100.9 percent against the health target, 102.09 percent against Additional Orthopaedic Joints and 102.59 percent against the General Surgery additional plan.

Faster Cancer Treatment continues to improve, with reduction in waiting times for diagnostic intervention, with both internal and external providers. Likewise, there were reductions in waiting times for surgical treatment internally. Partnership with Improvement Advisors has identified a number of opportunities for improvement across pathways with many improvements already actioned. The Faster Cancer Treatment Action Plan has been refreshed following meetings between the CEO and Clinical Leads. Highlighting; one-stop shops for diagnosis and treatment, reduced waiting times for diagnostic tests, improved triaging from clinical teams, design of electronic systems to replace paper processes and agreement of waiting times with external providers.

A pleasing result this quarter for the eight month Immunisation target, meeting the 95 percent target and further resulting in Hawke's Bay ranking second nationally. The national coverage has dropped slightly from 93.2 percent to 91.9 percent.

Raising Healthy Kids significant improvements have resulted in the target being met six months before the Ministry of Health deadline. During June 2017, 95 percent of children identified at a Before School Check as being in the 98th weight percentile, received a referral and support.

There was a lot of pressure in the hospital and the health sector mainly due to excessive illness in the community and amongst health-care staff. Taking into consideration this pressure, the performance against ministerial targets for the quarter is to be commended.

SYSTEM LEVEL MEASURES

The 2016/17 System Level measures for acute hospital bed days, ambulatory sensitive hospitalisations for 0-4 years, amenable mortality and person centred care – roll-out of the primary care patient experience survey, have been achieved to 30 June. Milestones and activity were set in collaboration with Health Hawke's Bay and Primary Care. These results will be included in the August non-financial performance report.

BUILDING A DIVERSE WORKFORCE

Building a Diverse Workforce and Engaging Effectively with Māori was presented, highlighting the progress of the Engaging Effectively with Māori programme. It was stressed the importance of all HBDHB staff completing the Engaging Effectively with Māori training and reiterated that high proportion of patients are Māori. It was further discussed the expectation of mandatory training and how to manage staff, including Drs, to complete this training. To achieve the desired results, this training is deemed just as critical as other forms of competency. Further updates will be provided in September by Kate Coley.

HEALTH LITERACY (MAKING HEALTH CARE EASIER TO UNDERSTAND)

PHO and DHB co-presented a progress update related to health literacy, as per a Board action. The preferred approach is making health easy to understand through information, understanding and action. The overall aim is making health easy to understand, making health easy in everything we do and, ultimately, embedding health literacy into our everyday values and behaviours. We will cease using the language health literacy going forward.

HAWKE'S BAY District Health Board Whakawāteatia	**Acting General Manager Māori Health Report**
	For the attention of: **Māori Relationship Board (MRB)**
Document Owner:	Patrick Le Geyt, Acting General Manager Māori Health
Month:	August 2017
Consideration:	For Information

RECOMMENDATION

That the Māori Relationship Board

Note the content of this report.

PURPOSE

The purpose of this report is to update MRB on implementation progress of the Māori Annual Plan objectives for July 2017.

INTRODUCTION

In this months report contains an update about the following:

- Service Level Measures
- Research Priorities
- Māori Provider Integration Project
- National Sudden Unexpected Death in Infancy Prevention Programme
- General Anaesthetic Pathways
- Oral Health Services and Kōhanga Reo
- Well Child Tamariki Ora – Supporting Oral Health
- Māori Student Placement Pilot
- Health Worforce New Zealand Scholarship Round Closed
- Engaging Effectively with Māori Update
- Whānau Manaaki Model of Care
- Te Reo Māori Course Eastern Institute of Technogy

Service Level Measures

Māori Health has been working with the DHB Planning Team on series of consultation meeting with Action Plan Leads to collect their inputs on the Service Level Measures (SLMs) for 2017/18. The consultations focused on Patient Centred Care General Practice Attendance; Keeping Children out of Hospital; Acute Hospital Bed Days; Prevention and Early Detection; and Using Health Resources Effectively. The meetings were quite successful in generating vital information to improve SLMs to monitor DHB service planning and delivery. All SLMs were met by 30 June.

Research Priorities

A number of consultation meetings with selected key Action Plan Leads which focused on areas of planning and implementation which might benefit from further information through small scale "operations research" were concluded. Three key areas; Oral Health, Mental Health and Child Health – breastfeeding, were identified and tentative questions developed to guide small scale "operations reserach" in the respective areas.

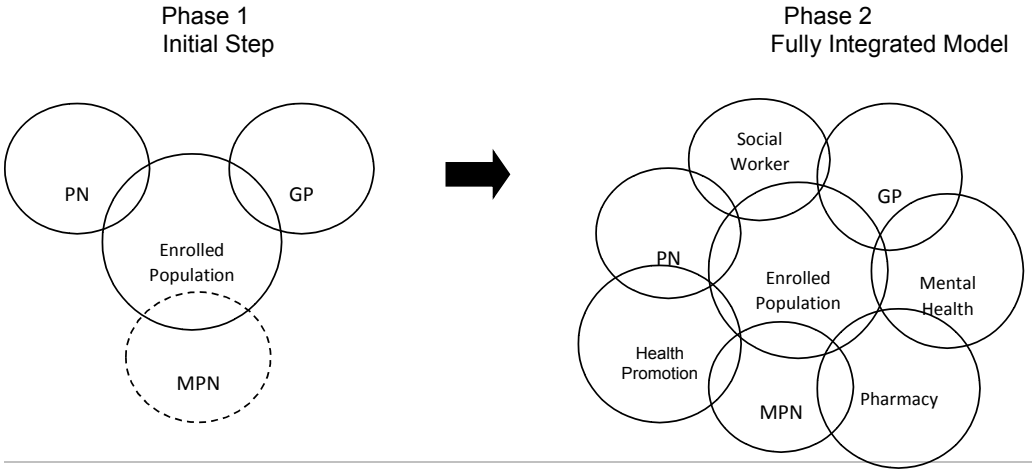
Māori Provider Integration Project

Māori Health, the Primary Care Portfolio Manager and Health Hawke's Bay have begun having initial discussions with Māori providers and GP practices to support provider integration. To date there are nine GP practices from Wairoa to CHB that have shown interest of working in functional partnerships with Māori providers.

The overarching service model proposed would be based on the 'Nuka Model of Care' by developing Integrated Care Teams (ICTs), between Māori providers and GP practices, working across Hawke's Bay, with enrolled populations of whānau. This will also build upon proposed alignment of Allied Health services with primary care.

The project aims to "formalise the informal"; to reorganise and standardise these practices so we were able to provide a better coordinated, safe and efficient service to consumers.

Integrated Care Team Structure



The drivers for change are:

a. Working locally within health and social localities

b. Reducing acute demand through early intervention and prevention

c. A growing client population of high needs with complex chronic conditions

d. Transformation to a model of care conducive to a Whanau Ora approach

e. Improve patient and whānau consumer experience of services. Maximising the patients opportunity to experience a continuous service with consistent relationships. Not having to repeat their story.

f. Best utilisation of multi-disciplinary teams, clinical leadership and professional development

Project success criteria:

1. High trust relationship amongst partners
2. Clear targets for engagement and achievement of a set of shared population health measures
3. Formal governance and operational committees established and operating
4. Regular reporting and service improvements through dashboard and score card reporting
5. Whānau participate in design at the touch points in their health journey
6. Collaboration identified and delivered through action plan
7. Māori provider health services aligned to working within a primary health care arrangement more effectively and efficiently
8. A paradigm shift in service delivery from an individualistic to a holistic whānau approach
9. Service delivery emphasis on engagement and behavioural design with whānau leadership and navigation
10. Contracts configured to support a new model of delivery
11. Current and future workforce needs defined and planned with resources allocated appropriately

National Sudden Unexpected Death (SUDI) in Infancy Prevention Programme

The Ministry of Health has developed a new $5.1m National Sudden Unexpected Death in Infancy (SUDI) Prevention Programme (NSPP) to be implemented from 1st July 2017. It's part of the Government's goal to reduce the toll of SUDI by 86% within eight years. The new NSPP will continue to build on the Ministry's campaign to 'make every sleep a safe sleep' for babies with the aim of working with the wider Government sector to reduce the toll from SUDI. The NSPP includes a national SUDI Prevention Coordination Service and Regional SUDI Prevention Programmes delivered by DHBs and coordinated regionally. Each DHB will have a CFA variation that will agree how they support delivery of the Regional component of the NSPP and will detail reporting requirements.

The national SUDI Prevention Coordination Service will be responsible for providing oversight, monitoring, support, and resources to the Regional SUDI Prevention Coordinators and DHBs to establish and implement their Regional SUDI Prevention programmes.

Once the Regional SUDI Prevention Coordinator is in place, the central region will develop a Regional SUDI Prevention Plan by the end of quarter one 2017/18. Additional guidance and templates outlining what these plans are to include will be provided by the National SUDI Prevention Coordination Service once it is in place, expected from 1st July 2017.

HBDHB stands to gain additional annual funding, and made available to DHBs from 1st October 2017 to 30th June 2020, and based on an estimated high risk population, to enhance the existing Community Safe Sleep Programme and potentially purchase new services locally.

General Anaesthetic Pathways

An investigation of the care pathway for tamariki 0–4 years admitted to hospital for a dental procedure under General Anaesthetic (GA) is underway. These tamariki have had dental decay severe enough that extraction of teeth is required under a GA. In 2016, approximately 65 tamariki required this procedure. A review of the primary-secondary care pathway will help identify barriers, gaps, and areas for improvement in the pathway, and to inform strategies for improving service responsiveness to whānau Māori. This work is also related to ASH 0–4 years dental conditions, and will inform developments in this area.

Oral Health Services and Kōhanga Reo

Māori Health, the Community Oral Health Service, and the local National Kōhanga Reo Trust are working together to explore options to improve access to oral health services for tamariki attending Kōhanga Reo. This is both an exciting and challenging opportunity, and requires us to look at the current service configuration, and a model of care that is appropriate for this context. The initiative is in the very early developmental stages.

Well Child Tamariki Ora – Supporting Oral Health

Māori Health is funding a new initiative with Well Child Tamariki Ora (WCTO) providers to improve access to oral health education and services. This new arrangement involves WCTO taking an increased role in the provision of oral health education and support, and includes:

- Oral health education and advice in the home at core health checks
- Improving access to oral health services for whānau by booking and taking them to their scheduled dental appointments - especially for vulnerable whānau with limited resources
- Building a closer working relationship with the Community Oral Health Service applying a collaborative approach to improve tamariki Māori oral health outcomes.

An oral health training workshop is being held on the 25th August.

Māori Student Placement Pilot

Tūruki have secured funding from Kia Ora Hauora to pilot a Māori student placement programme between HBDHB, Māori providers and tertiary education providers.

The funding will provide an opportunity to assist Tūruki scholarship recipients enrolled in medicine, dental and other health-related programmes to ultimately become employed within the Hawke's Bay health sector. A dedicated resource in the form of a contractor will engage with students, the health care industry and tertiary education providers with a view to promoting opportunities for either targeted placements in Hawke's Bay or work experience opportunities. Engagement with students to date has identified a gap with providing financial assistance and mentoring within the workplace during the course of their study.

The benefits include:

- Increased return on the investment from scholarship recipients returning to Hawke's Bay for employment once they have completed their programme of study
- Better engagement between students and the healthcare industry so that when applications for employment commence, the student is already known to the employer. The risk of employment is therefore minimised due to the relationship that has been formed during the period of study.
- A model for other District Health Boards to roll out once the relationships with tertiary providers in particular have been made and the contributing scholarship programme from various DHBs is duplicated.

The programme will commence in late August 2017.

HWNZ Scholarship Round

The Health Workforce New Zealand (HWNZ) scholarship funding round has been completed for second semester two focusing on entry-level certificate and diploma course related to health. 44 applications were received and 22 were successful within the following areas of study: Hauora Māori, Applied Business and Primary Health Care.

HWNZ have significantly reduced from previous years' allocation. HBDHB have applied to other District Health Boards for any underspend in this area. As a result, Midlands DHB have provided funding which has been allocated to the programme of study with most demand in Hauora Māori. Future applications by HBDHB for HWNZ funding will highlight the need to fund DHBs that consistently achieve scholarship requirements so that future students can be supported to complete entry level qualifications in healthcare.

Engaging Effectively with Māori (EEM)

There have been three mandatory workshops in the last month at the hospital and one in Waipukurau with great, positive feedback that is being utilised to assist in the review and delivery process of EEM. For example, the following feedback provides such highlights:

> *Was helpful to see why or how history has impacted and puts clinical practice into perspective when engaging with Māori ...*
>
> *Makes you think about ways to relate back to clinical area ... essential to my nursing competencies and practising certificate ...*
>
> *Really enjoyed the workshop and became more aware of values, Ngāti Kahungunu background and milestone moments, I would invite anyone who joins the DHB to attend and enjoy the workshop.*

There are three workshops scheduled for August at the DHB, a further workshop scheduled for Wairoa in September and dialogue with the Surgical Directorate has started on the delivery of a workshop for SMOs in late September.

Whānau Manaaki Model of Care.

In July, the Māori Health Operations team implemented 'Whānau Manaaki' a new model of care. The model has been presented to all directorates and internal hospital services. The feedback has been very positive, with reports on how the model is addressing needs and gaps across various directorates. Initial results indicate that the team is performing well above expected outputs and will be reported at the end of Quarter 1 (October 2017).

Regular attendance at the Daily Hospital Operations Meeting has proven very helpful in ensuring that Māori Health Services are in a position to support the hospital wards and patients. In July, due to high numbers of sick staff, and the acuity of patients, Māori Health was able to support the shortfall of available nurses by releasing staff to work in the wards as a Care Advocate. Reports from the Hospital Based Leadership were that staff have been a valued addition to the staff, who has added value to the teams supported.

Te Reo Māori Courses at HBDHB

Semester two commenced on Monday 24th July and was held at Te Awa Hauora Marae (hospital marae) with Eastern Institute of Technology (EIT) facilitating an evening class for Te Reo Māori Level 2 on Tuesdays from 5.00pm-8.00pm with 15 HBDHB staff participating, in addition a total of six staff from a combination of Hastings Health Care, Health Hawke's Bay PHO, Te Kupenga Hauora and Ministry of Social Development have jumped on board with this training. Furthermore, EIT have asked if HBDHB could accommodate up to 10 staff from Taikura Rudolf Steiner School as they did not meet the minimal numbers required to validate a course on Rudolf Steiner campus.

At the end of semester one, 12 from the HBDHB graduated Level 2, one from Te Taiwhenua o Heretaunga, Ministry of Social Development and EIT.

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora – Mental Health**
	For the attention of: **Māori Relationship Board, Clinical and Consumer Councils**
Document Owner:	Sharon Mason – Executive Director Provider Services
Document Author(s):	Justin Lee – Acting Service Director; Simon Shaw – Medical Director; Peta Rowden – Acting Nurse Director
Reviewed by:	Paul Malan – Strategic Service Manager; Health Services Leadership Team and Executive Management Team
Month:	August 2017
Consideration:	For Discussion

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Council:

Note actions being taken to address continuing issues in :

- Rate of Compulsory Treatment Orders for Maori
- Number of children and youth without a discharge plan
- Wait times for non-urgent Mental Health or Addiction Services

OVERVIEW

Te Ara Whakawairoa (TAW) is a report drawn from the Māori Health Plan and is reported on quarterly with champions to ensure improvements are made and sustained.

The Māori Relationship Board identify areas of concern which require action and exception reporting through governance committees and then onto the HBDHB Board.

This report focuses on key actions being taken to improve Mental Health Services for Māori.

UPCOMING REPORTS
The following are the indicators of concern in 2017 / 2018.

Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
Mental Health	Rate of section 29 Compulsory Treatment Orders	81.5%	Sharon Mason	Allison Stevenson	August 2017
	Percentage of clients discharged from Child, Adolescent and Family Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) Services with a transition (discharge) plan	95%	Sharon Mason	Allison Stevenson	August 2017
	PP8 mental health wait times for non-urgent mental health or addiction services seen within three weeks (mental health provider arm), 0 to 19 years	80%	Sharon Mason	Allison Stevenson	August 2017

WHY ARE THESE INDICATORS IMPORTANT?
Use of Section 29, Compulsory Treatment Orders (CTO) is symptomatic of system-wide and socioeconomic issues. Monitoring rates is important to provide data for teams to prepare for clients with CTO and for them to respond appropriately. Māori have 3 – 4 times higher rates of use of Section 29 compared to non-Māori showing that just less than half the consumers on CTO are Māori.

The percentage of clients discharged from Child, Adolescent and Family Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) Services with a transition (discharge) plan is an indicator of integration with primary care. The current data shows improvement needed in the partnership between primary and secondary services.

The proportion of people aged 0 to 19 years requiring non-urgent Mental Health or Addiction Services seen within three weeks, shows that people are not currently receiving services within acceptable timeframes of referral to face-to-face appointment. Where consumers are waiting a long time for appointments this points to services not having been timely and effective in their care.

Inequality in Outcomes in Mental Health Status for Māori
Along with a number of other indicators, this data shows continuing and persistent inequity in quality of care for Maori. This is evidenced by :

- Māori have a high rate of access to Mental Health Services than non-Māori.
- Māori have 3 – 4 times higher rates of use of Section 29 compared to non-Māori on average.

- Estimated twelve month prevalence of schizophrenia for Māori (0.97%) is significantly higher than for non-Māori (0.32%[i]).
- Hospitalisation rate and readmission rate is higher for Māori (17%).

First Indicator : Rate of Section 29 Compulsory Treatment Orders

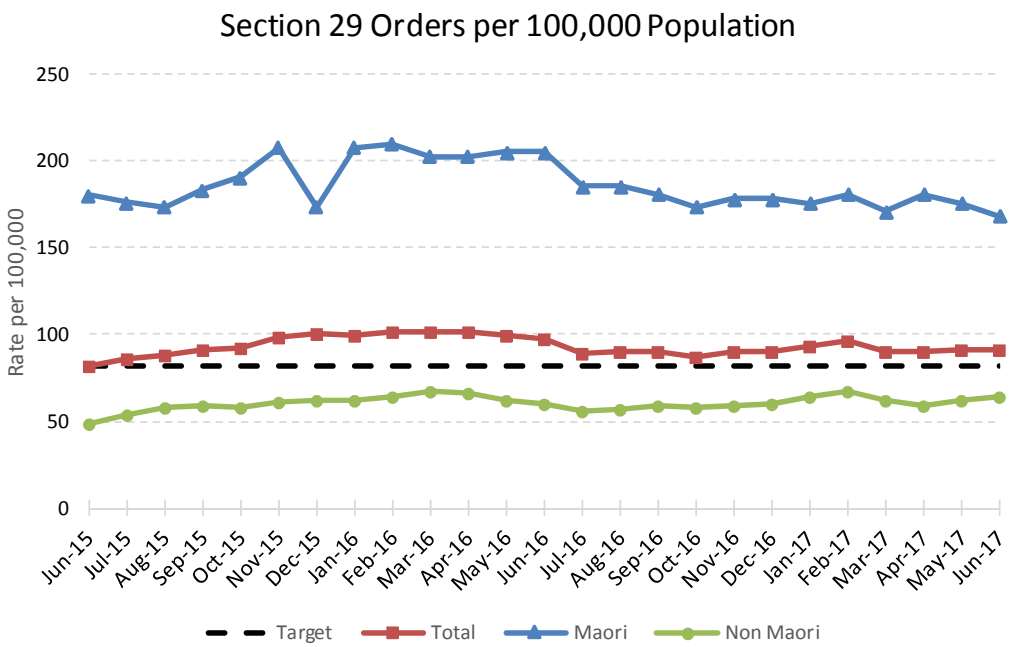
The Office of the Director of Mental Health reports annually on rates of Section 29 use by DHBs. The report comments that Māori have 3 - 4 times higher rates of use of Section 29 compared to non-Māori on average.

Responsiveness requires clear understanding of who is impacted and of the socioeconomic issues that increase vulnerability. Better understanding helps to increase collaboration with external agencies, including cultural and social agencies, so as to provide a more holistic, integrated and comprehensive response.

No target was assigned to DHBs for this indicator through the "DHB Māori Health Plan Guidance". However, the guidance document does mention that DHBs are to "reduce the rate of Māori on the Mental Health Act". The guidance document goes on to state[ii]:

> *New Zealand has very high rates of compulsion under the Mental Health Act, compared with similar jurisdictions. Māori are nearly three times as likely as non-Māori to be treated under a community treatment order which represents a significant disparity. There are regional and local differences, not necessarily related to population mix, which DHBs need to understand and work to reduce. The mental health indicator also supports implementing the priority actions for Māori in Rising to the Challenge, and the Mental Health and Addiction Service Development Plan 2012-2017 including other actions in the plan that relate to addressing disparities or self-management.*

HBDHB Section 29 Orders – June 2016 to June 2017



		Target	Total	Maori	Non-Maori
2016/17	Q1	≤ 81.5	89.7	183.9	57.0
	Q2	≤ 81.5	89.3	176.7	59.0
	Q3	≤ 81.5	93.2	175.9	64.6
	Q4	≤ 81.5	90.7	175.1	61.5

COMMENTS:

In Q4 2016/17 the rate ratio of Maori to non-Maori for compulsory treatment orders was 2.8:1 a reduction from 3.2:1 in Q1. This is trending in the right direction however the 95% Confidence Interval for the rate ratio for Hawke's Bay for the calendar year 2015 were approx. 2.8:1 to 5.7:1

Our current target is to achieve reduction to a sustained rate ratio of 2:1 Maori to non-Maori as this would represent a significant change from the current rate ratios.

Broadly, with regard to the prognosis in treatment of schizophrenia, there are two key factors which impact significantly, including: (a) longer duration of untreated psychosis and (b) higher functional impairment[iii]. Assertive services, especially at initial onset of psychosis, which support functional gain are crucial to generating positive outcomes.

Actions being taken to achieve plan include:

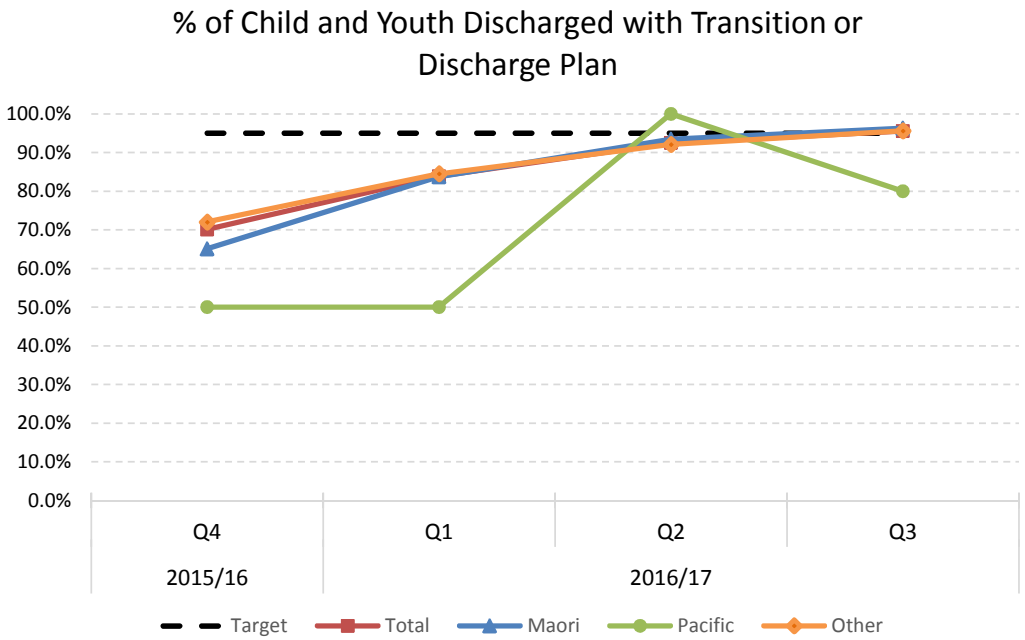
- Home Based Treatment team to provide services closer to home, to prevent mental health conditions worsening and reduce the need for people to be admitted to Nga Rau Rakau when acutely unwell, hence reducing the need for compulsory treatment.
- Provision of Acute Day Service for the community, based in Nga Rau Rakau will be operational in 2017/18, again reducing the need for admission.
- The Clinical Risk Management System is being used to provide expert review of risk management for high risk patients, reducing the need for longer term compulsory treatment.
- Te ara Manapou, the newly founded pregnancy and parenting service for women and whanau with addictions problems who are not engaged with services, will help give children a better start in life and may have impact oncompulsory treatment in the long term
- Extended whanau are increasingly being used in reviews of compulsory treatment, by both community key-worker and psychiatrist. This will enable the whole network around the person to provide alternatives to continuing compulsory treatment orders.
- Targeted treatment pathways have been developed with wider availability of evidence-based therapies, such as Dialectical Behavioural Therapy to treat emotionally unstable personality disorder with associated suicide risk. Trauma-based Cognitive Therapy is being used to treat Post Traumatic Stress Disorder and reduce the severity and duration of some conditions.
- Greater use of longer interval injectable antipsychotic medication will well reduce the need for compulsory treatment associated with refusal to continue necessary treatment and subsequent relapse.

Second Indicator

Percentage of Clients Discharged from CAFS and Youth Alcohol and Other Drug (AOD) Services with a Transition (Discharge) Plan

This indicator is that after three face-to-face meetings with the child and family, a transition or discharge plan must be generated and sent to family and/or referrer.

CAFS is now meeting the KPI on transition planning. Improvement over time has largely been driven by regularly reviewing reporting, and correcting occasions when a discharge plan has not been completed. Our Pacific data shows low referral volumes, meaning not completing of a single transition plan tends affect data significantly.



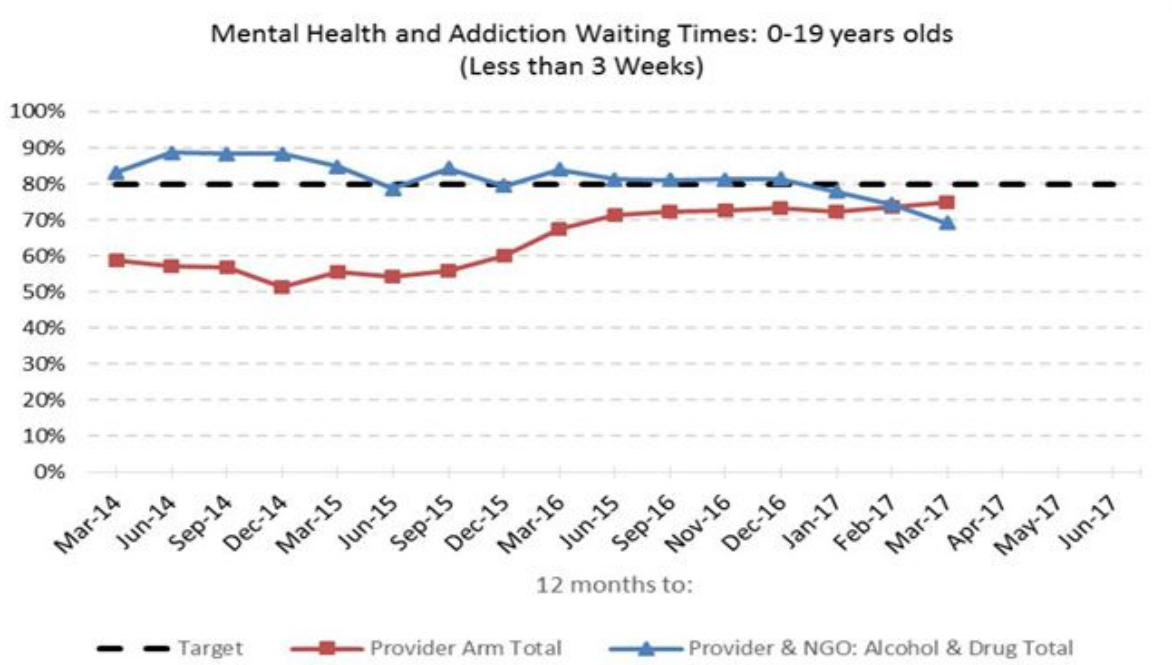
Third Indicator

Mental Health Wait Times for Non-Urgent Mental Health or Addiction Services Seen within Three Weeks (provider arm) 0 – 19 years

This indicator is defined by the time between receiving the referral to the time the child / family are seen face to face by a health practitioner. It should be noted that if there is an acute need, the young person is seen the same day.

Discussion between a number of Child and Adolescent Mental Health providers highlights two significant issues:

- First, some settings have noted a shifting of clinical practice, in that referrals are seen quickly (meeting the KPI) but the subsequent contact is scheduled at a significantly later period. This has led to calls to monitor not just the initial appointment, but also the timeliness of subsequent appointments. Positively, in the Hawkes Bay, subsequent contacts are monitored closely and we are not seeing significant waits between initial contact and subsequent ongoing work.
- Second, the goal of the KPI is largely to provide a measure of service responsiveness. If a family do not attend a planned appointment, then this counts against the KPI. Similarly, family preferences are also considered, which can impact on the KPI (i.e., over school holidays, request is often for later appointments due to travel or other commitments). This encourages our services to be provided in a way that meets whanau needs including in a time and place convenient to them.



Note: the table below reports data to March 2017.

	Mental Health Provider Arm									
	<3 weeks					**<8 weeks**				
12 months to Mar-17	Target	Provider Arm Total	Māori	Pacific	Other	Target	Provider Arm Total	Māori	Pacific	Other
	80.0%	74.8%	78.0%	72.2%	72.6%	95.0%	90.9%	92.8%	88.9%	89.7%

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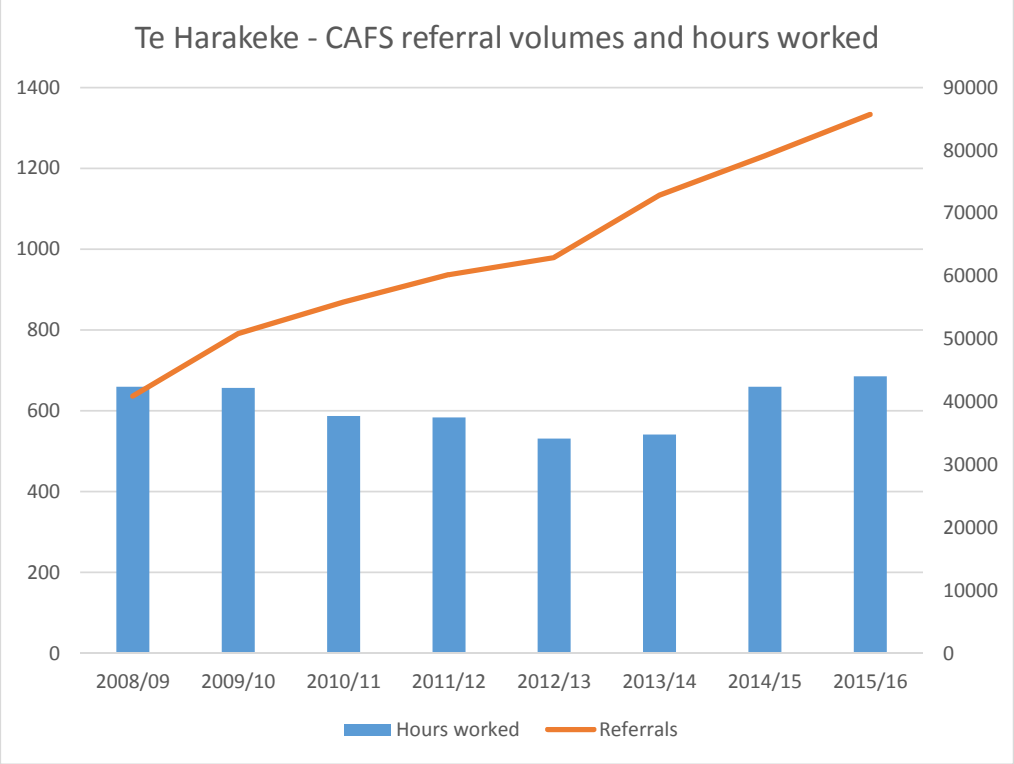
As per the graph above, our youth addictions team (1.8 FTE) has an increase in wait times, and is now now failing to meet the KPI at 10.8% below the target. Analysis indicates drivers for this include: (a) Access issues in nearly ½ cases (clinical review indicates strong follow-up); and (b) issues around data reporting (i.e., family contacts not appearing to trigger meeting the KPI), which CAFS Clinical Manager will resolve urgently with the health information reporting team. The data errors indicate that performance is being underestimated.

Access issues impact on the wait times KPI. Efforts to address this have included:

- Telephone contact with the family is occurring shortly after referral to introduce the service and to ensure the proposed appointment time works for the family.
- Kaetakawaenga support is available to the team. At referral, families who may benefit from support are identified by the Kaetakawaenga, and their role in engagement facilitated.
- CAFS are seeking to engage with young people in settings familiar to the young person (i.e. at schools, at other agencies where the young person or family already have relationships).

Timeliness and responsiveness are crucially affected by the match of capacity to demand. Of note, CAFS referral volumes have significantly increased since 2008, while hours worked by clinicians has remained stable over time (see graph below). Vacancies impact on wait times KPI, and we expect this to be seen in April – June 2017 (during which several vacancies were present).



It is clear that we need to deliver responsive and clinically sound services for children and young people with moderate to severe mental health difficulties.. Delivering such services not only supports meaningful change in the lives of the most vulnerable whanau, but also represent an opportunity for early intervention, with associated social and economic benefits. We need to ensure that our services have the correct capacity to match the needs of ou communities..

CHAMPIONS REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THIS INDICATOR

Compulsory Treatment Orders

An audit of Mental Health and Addiction Services performance on CTO has given us some baseline understanding of the actions required to reduce the numbers of people under CTO. As a result of this we have implemented a new model of care for acute and community services. This includes a shift in focus to a recovery approach that builds resilience for people with low-prevalence conditions and / or high needs and is more responsive to the wider socioeconomic factors that drive the need for intensive mental health treatment. These have enhanced access by integrating hospital and community services, strengthening collaboration with kaupapa services, and developing better primary care responses.

From Annual Plan 2016/ 2017

Short-term outcome		Activity	Monitoring and Reporting
Māori Health Priority	**Reduce the rate of Compulsory Treatment Orders**	Home-based treatment team increases family involvement with planning and crisis intervention by Q4.	**Rate of CTO** in Māori and non-Māori **100% of intensive service staff** trained by Q3 **Number of referrals** to specific services **SI5**: WHĀNAU ORA Key Indicator
		Ongoing daily step up step down with Ngā Rau Rākau, CMH, HBT, EMHS, Wai-O-Rua and TTOH to improve discharge and admission communication.	
		Implement intensive day programme from Q1.	
		Staff education around sensory modulation and trauma informed care to help reduce restrictive models of care.	
		Increase availability of treatment options across community mental health services.	
		Building networks within the community – increased use and referrals to NGOs within the community for follow up; meetings with NGOs and whānau/families to agree on and document plans & outcomes by Q2.	

Transition and Discharge Planning

Every CAFS clinician who has primary responsibility for a case now completes the core transition document. The completed transition plans are communicated to the primary referrer. Regular auditing of exceptions assists in identification of the small number of cases in which transition plans were not completed, and this is corrected.

From Annual Plan 2016/ 2017

Short-term outcome	Activity	Monitoring and Reporting
Improve the follow-up care for those discharged from Child and Adolescent Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) services	Formalise implementation of Transition Planning Checklist as standard practice in Q1. Amend discharge documentation to include standard prompt to primary referrer in Q2. Introduce “error flag” in patient administration system to prompt completion in Q3.	**PP7:** 95% of clients discharged with have a transition (discharge) plan + exception reporting
	Ongoing monthly audit and performance monitoring of compliance with transition plan policy.	

Reducing Waiting Times

A significant amount of procedural and administrative work has been completed this has included establishing prompts with appropriate policies and procedures to ensure proactive management of referrals. This is enhanced with good monitoring of results and attention to the needs of people having difficulty accessing the service.

From Annual Plan 2016/ 2017

Short-term outcome	Activity	Monitoring and Reporting
Improve access to CAFS and Youth AOD Services	Trial an initial phone contact by Choice Clinician and implement as standard practice if successful by Q1.	**PP8:** 80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks this year + narrative report
	Liaise with KPI Forum stakeholders and other DHBs regarding "face-to-face" rule for first contact with children and families by Q2.	
	DNA's and joint appointments – review policy and impact of current practice by Q3. Redesign if necessary.	
	Scoping of potential for alternatives to admission for youth to be developed by Q2, e.g. Home-Based Treatment, and the mechanisms by which this would be sustainable.	

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

From the HBDHB Annual Plan 2017 / 2018[iv], the table below shows the activity that is planned to improve CTO performance.

Mental Health	Improve the quality of mental health services, including reducing the rate of Māori under community treatment orders.	**One team**	1. Monitor Compulsory Treatment Orders (CTOs) by ethnicity and continue with actions which have contributed to a decrease in CTOs for Māori; partnership with police; education of nurses and key workers to support whānau to understand legal issues and the process of CTO courts. 2. Explore written material which is used to explain these processes to whānau in other centres, with a view to using locally, if appropriate.	Q1-4 Q2	PP36: Reduce the rate of Māori on the mental health Act: section 29 community treatment orders relative to other ethnicities.

To support transition planning there are actions that will be progressed in 2017/18
CAFS will

- Continue to audit and improve performance against transition plan KPI
- Introduce 'error flag' or discharge checklist into ECA to prompt completion

.

Actions to improve maintaining waiting for 2017/18 include
CAFS:

- Increase collaboration with NGOs to enhance capability and to reduce demand for secondary services.
- Deliver group therapies in primary care by CAFS clinician, to increase access to evidence-based intervention.

RECOMMENDATIONS FROM TARGET CHAMPION

Further reduction in CTO will be achieved by acting on analysis to ensure the most appropriate use of compulsory treatment. I support the intentions to increase family involvement, integrate services and service providers, and develop staff capability and to build networks.

The intentions in the Annual Plan 2017/18 regarding Compulsory Treatment Orders will deliver ongoing improvement. I will in addition require that the service ensure robust operational performance monitoring of these aspects of service quality to capture the gains.

Transition planning targets are now being met and I will ensure that CAFS undertake regular audit of monitoring to make sure this is maintained.

I will ensure that waiting times in child and adolescent mental health and addictions continue to reduce despite significant increase in demand. As well as continuing to work on improving data quality, and ensuring that services are delivered that are valued by our people I wil ensure ensure that we have the capacity to match demand.

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

Description	Responsible	Timeframe
Home Based Treatment: establish framework for regular review of frequent presenters/clients with CTO history	ACM Home Based TreatmentTeam Manager Community Mental	June 2018
Acute Day Service fully staffed and operational	ACNM Nga Rau Rakau	December 2017

Te Ara Manapou PPS – Service fully staffed and operational	Service Directorship Clinical Team Leader Manager Community Mental Health	July 2018 March 2018
Clinical Risk Management System – review of and focus on CTO	CRMS Committee Service Directorship	September 2017
Develop Process and Response map for acute presesentation under Police MH Partnership strategy	Project Working Group/Quality Improvement Coordinator Service Directorship	March 2018
Actions to improve maintaining waiting for 2017/18 include CAFS: Deliver group therapies in primary care by CAFS clinician Increase collaboration with NGOs to enhance capability and to reduce demand for secondary services.	CAFS Manager Service Directorship	December 2017
Actions to improve Transition Planning completeion include CAFS: Continue to audit and improve performance against transition plan KPI Introduce 'error flag' or discharge checklist into ECA to prompt completion .	CAFS Manager CAFS Manager	Quarterly September 2017

REFERENCES

[i] Kake, Arnold and Ellis. Estimating the prevalence of schizophrenia among New Zealand Māori: a capture-recapture approach. Aust NZ J Psychiatry. 2008 Nov: 42(11):941-9

[ii] http://nsfl.health.govt.nz/dhb-planning-package/201617-planning-package-and-review-plans/mhp-guidance

[iii] Diaz-Caneja, C., Pina-Camacho, L., Rodriguez-Quiroga, A., Fraguas, D., Parellada, M., * Arango, C. (2015). Predictors of outcome in early-onset psychosis: A systemic review. Schizophrenia (2015) March (1): Article number 14005.

[iv] Hawke's Bay District Health Board, Draft Annual Plan 2016/17. HBDHB.

HAWKE'S BAY
District Health Board
Whakawāteatia

12

Health Literacy (Making Health Care Easier to Understand)

OURHEALTH HAWKE'S BAY Whakawateatia	**Te Ara Whakapiri Hawke's Bay**
	For the attention of: **Māori Relationship Board, Clinical and Consumer Council**
Document Owner:	Mark Peterson, CMO Primary Care
Document Author:	Leigh White, LTC Portfolio Manager, Strategic Services
Reviewed by:	Executive Management Team
Month:	August, 2017
Consideration:	For Endorsement

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Council

1. Endorse roll out of Last Days of Life Care Plan and Toolkit
2. Support ongoing work

PURPOSE

The purpose of this document is for EMT to:

- Endorse roll out of HBDHB localised Care Plan and Toolkit for Last Days of Life into:
  - ✓ All HB ARC Facilities (note: we cannot make this compulsory with national corporates however we will encourage facilities to be in line with local development)
  - ✓ All HB Hospital Wards (staged approach)
  - ✓ Excluding Cranford Inpatient Unit (Care Plan has been analysed with components of Palcare).
- Support further work as we progress with roll out (enclosed action/work plan).

EXECUTIVE SUMMARY

An international and national review resulted in the phasing out the Liverpool Care Pathway (LCP), however many service providers providing palliative care report that there is still a requirement for a care planning tool for last days of life. It was noted in HB that tools are being used based on the "old" LCP framework and that these tools are not representative of: individualised care planning, not supported by education, quality review, or audit. In response to this, key stakeholders within Hawke's Bay drafted a localised care plan and toolkit.

In May 2016 HBDHB Executive Management (EMT) and respective Councils were presented with a proposal to review and endorse work as outlined below:

- A proposed proof of concept trial of the HBDHB Last Days of Life Care Plan and toolkit (Draft) in five nominated Aged Residential Care (ARC) Facilities, Cranford Hospice Inpatient Unit and a Medical Ward in HB Hospital.

- An evaluation of the proof of concept to be commissioned and completed by Cranford Hospice. Key to the evaluation was to measure the HBDHB tools against the national guidance document Te Ara Whakapiri and other national tools (Full report enclosed). Key findings were:
  - ✓ Overwhelming support from our trial sites and integrated working group that the HBDHB Care Plan and toolkit be adopted locally into all ARC Facilities and Medical Wards of HB Hospital. Note: we cannot insist ARC Facilities but we can encourage and we are supportive to share our local tools to ARC national bodies.
  - ✓ Feedback suggested some minor changes to the care plan and tool kit. These changes are currently being worked on with key members from the integrated working group and publisher. Note: there are no changes to the local medication prescribing tools that have been in place in General Practice for some years.

RECOMMENDATIONS

- This piece of work has been a truly integrative approach and it cannot go unnoticed of the work of the Integrated Advisory Group (inclusive of GP support), Cranford Hospice, Inpatient Specialist Palliative Care Team and ARC Facilities.
- Committed ongoing support , once endorsed by EMT and respective Councils:
  - ✓ Cranford Hospice will continue to roll out Care Plan and Toolkit to ARC Facilities.
  - ✓ Manager of Specialist Palliative Care Team in-hospital fully supported and has commenced planning to roll out.
  - ✓ LTC Portfolio Manager to seek funding for published tools
  - ✓ Socialise this work through Map of Medicine

SUCCESS FOR US IN HB

- Health records will better reflect a holistic approach to care in the last days of life. This includes evidence of communication and consideration of the individual needs of the person and family/whanau.
- Staff working with the documents will show high level of confidence in planning and providing care.
- A consistent approach to the delivery and management of care will allow for effective evaluation and subsequent improvement to services provided through evaluation. This will be inclusive of the family/ whanau experience.

THIS PIECE OF WORK SUPPORTS TWO SIGNIFICANT DOCUMENTS:

1. Ministry of Health Palliative Care Action Plan: – Priority 3 action (2017): "Implement Healthy Ageing Strategy action: Support the implementation of the Te Ara Whakapiri Principles and guidance for the last days of life".
2. HBDHB Live well, stay well and die well, Palliative care in HB[i]: actions required: "Last Days of Life (Te Ara Whakapiri) pathway is developed and implemented across the region" with an **outcome** of "100% of ARC facilities and hospital wards implementing the Last Days of Life (Te **Ara** Whakapiri) supported by Specialist Palliative Care services".

June 2017: LW

Action planning for roll out of Te Ara Whakapiri (inclusive of Logic Model)

Brief Summary

Last days of life care planning is an integral component of care and management of people in their last hours to days of life. It is imperative that all health professionals are competent to provide care.

The impact of delayed last days of life planning can lead to a number of adverse outcomes:

- continued aggressive, unwanted and/or unwarranted life-sustaining measures instigated
- poor experiences for families where distraught family members are called on at a time of grieving to engage in decisions
- potentially avoidable conflicts between families and the health care team, or within the health care team about the best course of treatment and care for the dying person
- care being delivered in acute settings when better outcomes could be delivered in supported community or home environments
- stress for health professionals balancing their obligation to act in the best interests of the dying person, sometimes differing views amongst treating clinicians and families.

Outcomes:

- improved decision making
- a positive impact on multi-professional team communication and working
- increased confidence of nurses about when to approach medical colleagues to discuss treatment plans
- people being treated with greater dignity and respect – dying well
- greater clarity around preferences and plans about how these can be met.

What will show improvements

Health records will better reflect a holistic approach to care in the last days of life. This includes evidence of communication and consideration of the individual needs of the person and family/whanau.

It is expected that staff working with the document will show high level of confidence in planning and providing care. Having a consistent approach to the delivery and management of care will allow for effective evaluation and subsequent improvement to services provided through evaluation. This will be inclusive of the family/ whanau experience.

The journey thus far

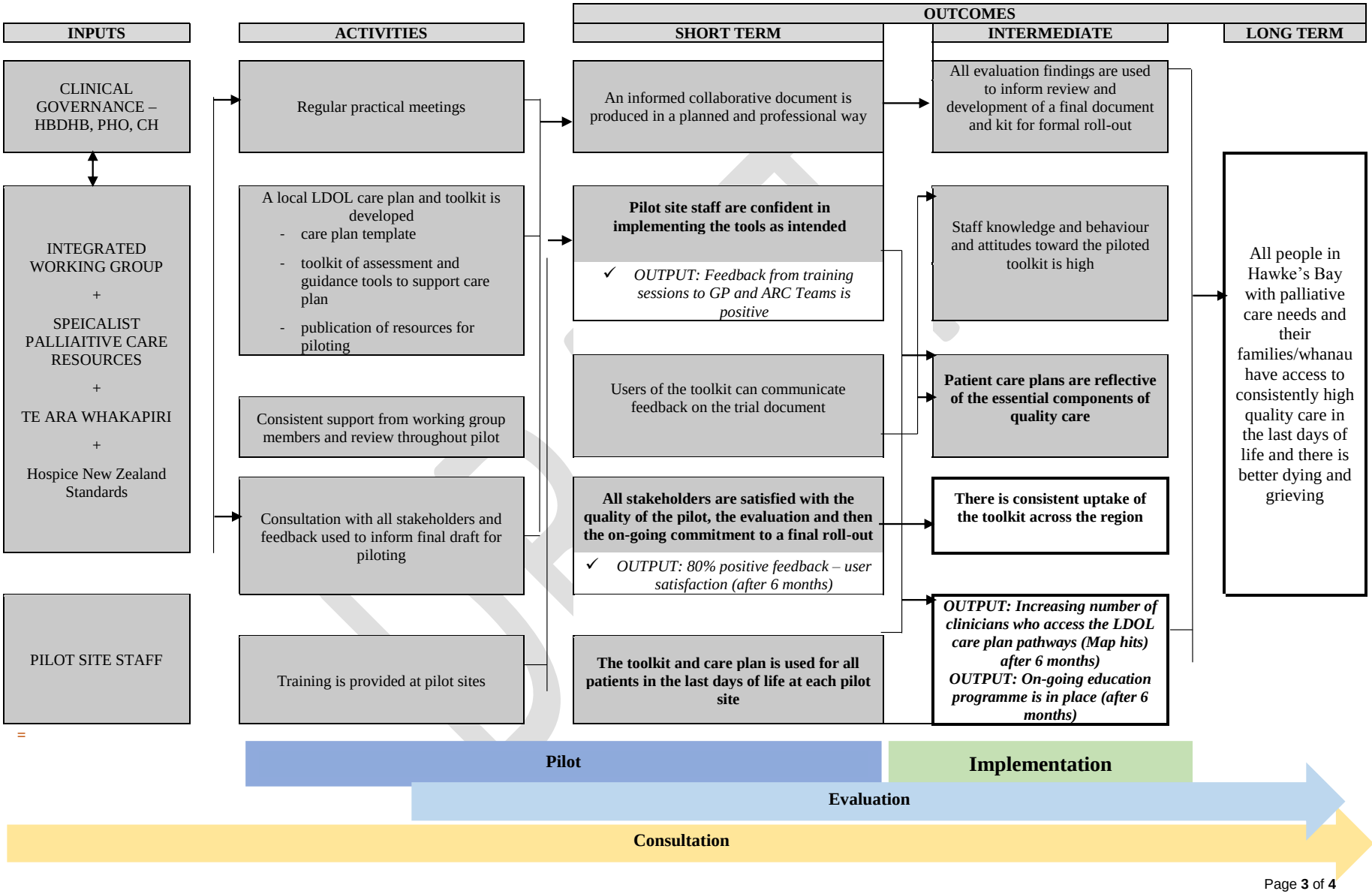
1. HBDHB Integrated Steering group was formed: Key purpose:
   - develop a Care plan and Toolkit unique for HB but aligns with the Te Ara Whakapiri document
   - note: half way through our HB process a decision was made to develop same nationally
2. Pilot the Care plan and Toolkit (enclosed document). GPs were kept informed of Pilot and progress:
   - ARC Facilities Piloted : Mary Doyle, Brittany, Masonic and Atawhai/Gracelands
   - GP support: Dr M. Peterson, Dr P. Henley, Dr L. Whyte and Dr J. Eames
3. Evaluation of the pilot (enclosed document)

Next steps

HBDHB Governance Committees to endorse the work and support implementation of the HBDHB Last Days of Life Care Plan document and toolkit as a replacement for LCP based on Te Ara Whakapiri: Principles and Guidance. The tool has similarities that are already embedded into Palcare the electronic tool used at Cranford Hospice. Note: Medication symptom Management for last days of life algorithms are currently well embedded into general practice and these will not change.

Milestones to date (Work to be done)	Names	To complete by August 2017
Tool and Toolkit		

1	**From Evaluation - make recommendations to change master** Planning for Last Days of Life Care Plan	Sarah Jo	Plan **Do** Done
2	Liaise with Publishing to gain costs for changes	Leigh	**Plan** Do Done
3	Changes Made with Publisher	Leigh	**Plan** Do Done
4	Implement changes into Map of Medicine.	Leigh	**Plan** Do Done
Advisory Committees			
1	Integrated Steering Group • Inform them of outcome and share Evaluation report	Leigh	Plan Do **Done**
2	Provide update to PHO Palliative Care Steering Group/ HB Governance Steering Group	Leigh	Plan Do **Done**
3	LTC Advisory Committee (Present: 15 July 2017) • Endorse roll out	Leigh	Plan **Do** Done
4	EMT (9/08/2017)	Leigh	**Plan** Do Done
5	Clinical Council (9/08/2017)/Consumer Council (10/08/2017)/ Maori relationship Board (9/08/2017)	Leigh	**Plan** Do Done
6	PHO Clinical Advisory groups (PHOLT 4/09/2017, CAG 12/09/2017)	Leigh	**Plan** Do Done
Roll out Planning – ARC by Cranford Hospice			
1	Confirm endorsement (Evaluation)	Leigh	Plan **Do** Done
2	Roll out to ARC – confirm with Cranford	Sarah/Jo	Plan Do **Done**
3	Date of Implementation and Socialisation to all ARC	Sarah/Jo/Leigh	**Plan** Do Done
4	QA audit processes – recommend a year post implementation	Sarah/Jo/Leigh	**Plan** Do Done
Roll out Planning – HB Hospital general wards and Rural Wairoa/Waipuk)			
1	Confirm endorsement – Agree Operational within budget	Leigh/Mandy Anne/Emma	Plan Do **Done**
2	Implementation planning – Meeting 11/07/2017 Operational	Leigh/Mandy Anne	**Plan** Do Done
3	Date of Implementation – Ann to Lead/Resource Nurse in wards/staff meetings/Meetings with CNM/Meeting with Education Department (25/07/2017) to script modules to Ko Awatea	Leigh/Mandy Anne	Plan **Do** Done
4	QA audit processes – recommend a year post implementation	Leigh/Mandy Anne	**Plan** Do Done
5	Rural Wairoa/Waipuk – link with Managers		**Plan** Do Done
Socialisation			
1	Link in with other DHBs – what are they doing? Link: Kate Grundy: Kate.Grundy@cdhb.health.nz, being socialised at Canterbury DHB		Plan Do **Done**
2	Educational workshops for ARC (Presented to ARC Forum 25/07/2017)	Sarah/Jo	Plan Do **Done**
3	Grand Round – Date confirmed 23/08/2017	Emma Mary	Plan Do **Done**
4	Update to Primary care	Leigh	**Plan** Do Done
5	Update Map of Medicine		**Plan** Do Done


INPUTS
ACTIVITIES
OUTCOMES
SHORT TERM
INTERMEDIATE
LONG TERM
CLINICAL GOVERNANCE – HBDHB, PHO, CH
INTEGRATED WORKING GROUP
+
SPEICALIST PALLIAITIVE CARE RESOURCES
+
TE ARA WHAKAPIRI
+
Hospice New Zealand Standards
PILOT SITE STAFF
=
Regular practical meetings
A local LDOL care plan and toolkit is developed
- care plan template
- toolkit of assessment and guidance tools to support care plan
- publication of resources for piloting
Consistent support from working group members and review throughout pilot
Consultation with all stakeholders and feedback used to inform final draft for piloting
Training is provided at pilot sites
An informed collaborative document is produced in a planned and professional way
Pilot site staff are confident in implementing the tools as intended
✓ OUTPUT: Feedback from training sessions to GP and ARC Teams is positive
Users of the toolkit can communicate feedback on the trial document
All stakeholders are satisfied with the quality of the pilot, the evaluation and then the on-going commitment to a final roll-out
✓ OUTPUT: 80% positive feedback – user satisfaction (after 6 months)
The toolkit and care plan is used for all patients in the last days of life at each pilot site
All evaluation findings are used to inform review and development of a final document and kit for formal roll-out
Staff knowledge and behaviour and attitudes toward the piloted toolkit is high
Patient care plans are reflective of the essential components of quality care
There is consistent uptake of the toolkit across the region
OUTPUT: Increasing number of clinicians who access the LDOL care plan pathways (Map hits) after 6 months)
OUTPUT: On-going education programme is in place (after 6 months)
All people in Hawke's Bay with palliative care needs and their families/whanau have access to consistently high quality care in the last days of life and there is better dying and grieving
Pilot
Implementation
Evaluation
Consultation

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Hawke's Bay Last Days of Life Care Plan and Toolkit

Evaluation and Pilot Report April 2017

ABSTRACT

An integrated Hawkes Bay District Health Board Working Group, was given the task of designing, implementing and piloting a care plan and supporting documents for a person's last days of life. This plan and associated documents are based on Te Ara Whakapiri - The Principles and Guidance for the Last Days of Life. This evaluation report has been prepared to outline the findings of the pilot and inform future recommendations of implementation.

ACKNOWLEDGEMENTS

This report has been prepared by Sarah Nichol on behalf of the Cranford Hospice Leadership Team. This report was commissioned to evaluate the pilot trial of the Hawke's Bay Last Days of Life Care Plan and Toolkit implemented into five Aged Residential Care Facilities, Inpatient Unit Cranford and a Medical Ward in Hawke's Bay Hospital.

As the author of this report, I would like to thank all the people who have provided information and feedback for the purpose of this evaluation

Thanks to the members of the Integrated Working Group and to the areas that agreed to pilot these tools:

Integrated working group

- Leigh White (DHB)
- Karen Franklin (Cranford Hospice)
- Sarah Nichol (Cranford Hospice)
- Ann Gray (DHB/Cranford Hospice)
- Joan McAsey (Hastings Health Centre)
- Irene O'Connell (Eversley ARC)
- Jo Loney (Cranford Hospice)
- Sue-Mary Davis (Cranford Hospice)
- Liz Beattie (Masonic)
- Trish Freer (PHO)

Pilot Sites

- Cranford Hospice In-patient Unit
- HBDHB Ward A1
- Brittany House Residential Care
- Mary Doyle Life Care Trust
- Taradale Masonic Resthome
- Atawhai Lifestyle Care
- Gracelands Lifestyle Care

CONTENTS

EXECUTIVE SUMMARY

An integrated service working group consulted, designed, produced and after consultation, a Hawke's Bay "Last Days of Life Care Plan" and "Tools and Resources to Guide the Care of People in Their Last Days of Life" (collectively known as "Toolikit").

The toolkit was based on Te Ara Whakapiri – The Principles and Guidance for the Last Days of Life and are practical tools intended to support equal access to the best quality of care for all people with palliative care need regardless of setting. A key point of difference for the Hawke's Bay version is the inclusion of a planning tool section that involves taking the findings of an initial assessment to develop a plan of care that is individualised to the patient.

This evaluation was commissioned by the Leadership Team at Cranford Hospice, and the Integrated Hawkes Bay District Health Board (HBDHB) working group. The evaluation priorities were limited to short term outcomes, related to feedback on the usability, confidence and satisfaction with the document. The quality of actual care provision was outside the scope of the evaluation, however the level of documented evidence of care was reviewed.

Nursing and some medical staff (N26) that worked with the document during the trial period provided feedback via focus groups, informal written and verbal interview and in writing through communication journals. In addition, care plans (N19) and patient records were reviewed at each site using a consistent tool developed for in the evaluation.

The evaluation showed that the pilot was successful in achieving its short term goals. The above evaluation methods and data sources provided consistent findings and those key standards were:

- The peer review of the patient files showed that **most of the components of the documentation were completed** as instructed therefore providing evidence that the principles of quality care were applied.
- There were **some suggestions for improvement** to the tool which were mostly for user ease, with few that may have implications on patient care if not rectified.
- **Most of the staff that were involved in the use of the tool were supportive of the permanent use of the tool** as part of their organisational policy. This included 100% support for use in ARC settings; while there was a universal view that it was not suitable for continued use in the Cranford Hospice IPU. There was 100% support for its use in the HBDHB Ward that piloted the tool, however this finding should consider that the tool could only be used in one case.
- The pilot successfully achieved its outcomes within set timeframes apart from the unexpected delays in starting in the HDBHB and the resulting small data pool.

"it's straight forward, doesn't need instructions….and it is a refreshing stand-out colour"
'worked well, leaves no ambiguity i.e. who to ring, what to do post passing away……"

The integrated approach of the tools development, the implementation of the pilot and the evaluation have appeared to enhance relationships across services and provides an opportunity for on-going peer review and data benchmarking which has recently been identified as an outcome measure in the Hawke's Bay Regional Palliative Care Strategic Plan – Live Well Stay Well Die Well 2016-2026.

Recommendations

- A regional commitment to the consistent use of the localised version of the careplan and toolkit (presented with this report based on changes identified during evaluation)
- Continued resourcing and full 'roll out' in Aged Residential Care settings
- Cranford Hospice to discontinue use of the paper tool and consider alternatives
- Hawkes Bay District Health Board should consider continued use
- On-going integrated peer review and data analysis should be fostered.

INTRODUCTION

Background

An international and national review in 2013 resulted in the phasing out the Liverpool Care Pathway (LCP) , however many service providers providing palliative care reported that there is still a requirement for a care planning tool for last days of life. It was noted in HB that tools were being used based on the "old" LCP framework and that these tools are not representative of: individualised care planning, not supported by education, quality review, or audit. In response to this, key stakeholders within Hawke's Bay drafted a localised care plan and toolkit. In May 2016 HBDHB Executive Management (EMT) and respective clinical councils were presented with a proposal to review and consequently endorsed ongoing work as outlined below:

- A proposed pilot to trial the HBDHB Last Days of Life Care Plan and Toolkit (Draft) in five nominated Aged Residential Care (ARC) Facilities, Cranford Hospice Inpatient Unit and a Medical Ward in HB Hospital
- An evaluation review of the pilot was commissioned and to be completed by Cranford Hospice. Key to the evaluation was to measure the HBDHB tools against the national guidance document Te Ara Whakapiri and other national tools.

What are we wanting to achieve with the Pilot? (Appendix 1: Logic Model)

- That the HBDHB Last Days of Life Care Plan and Toolkit assists in achieving all the components of care outlined in Te Ara Whakapiri. Note: Outside this scope of evaluation is investigating the quality of care provision and the direct impact on service users was not evaluated.
- Gain learnings from providers and suggestions for improvement

Description of Pilot

This Pilot was trialled in Cranford Hospice In-patient Unit, HB Hospital Ward A1, Britany House, Mary Doyle Life Care Trust, Taradale Masonic, Atawhai Lifestyle Care and Graceland Lifestyle Care.

The pilot was undertaken by Cranford Hospice, with a key focus on providing education to the workforces on the purpose and the "how to" use the tool. In ARC support in practice was overseen by the Cranford Hospice ARC Liaison Nurses and in HB Hospital support was provided from Clinical Nurse Specialist.

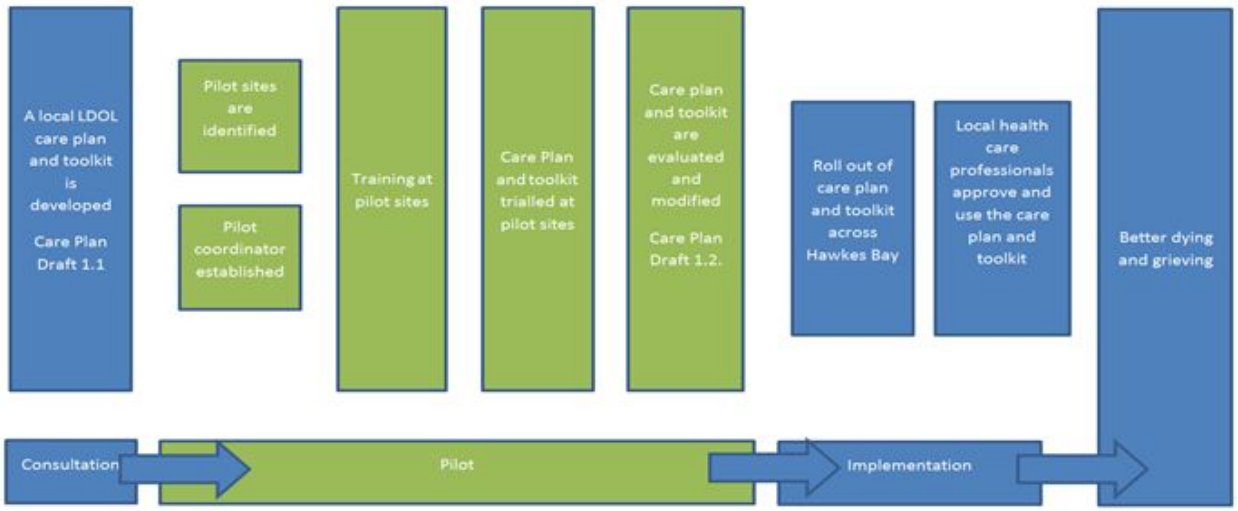


Figure 1: Demonstrates the pilot processes phases of: sites identified, co-ordinator established, training at sites and evaluation. (FROM ORIGINAL PILOT PLAN)

EVALUATION APPROACH

This evaluation was completed as part of the predetermined pilot plan, August 2016 (figure 1). Ultimately, the evaluation seeks to answer the questions:

Evaluation Question 1. How successfully did the pilot achieve its' outcomes?
Evaluation Question 2. How ready is the LDOL Care Plan and Toolkit for final roll-out?

During the project and evaluation planning stage, a logic model was developed (refer to Appendix 1) to illustrate the key project pilot activities and the intended outcomes This model was developed based on the HBDHB and PHO communication documents authored by Leigh White and; the Pilot and Draft Evaluation Plan developed by C. Dempers in August 2016. NOTE: Outputs included on the model link to the Map of Medicine LDOL Pathway Evaluation Plan outputs.

The pilot and evaluation schedule was effected by an unexpectedly low number of deaths in some sites and the medical strike and staffing issues at the HBDHB. Key short term outcomes from the logic model (highlighted in pink) were selected as priorities based on the need for useful data to inform further developments and roll out, and that is most practical to evaluate (Appendix 1). Table 1 shows the evaluation priorities and the methods for obtaining related evidence.

Table 1. Success definition table (criteria) – outlines the priorities for the evaluation

Priority	Criteria (what will a successful outcome look like?)	Sources of data	Methods
➢ Measure whether the care plan does indeed promote achieving the aims of the national guidance document Te Ara Whakapiri.	The care plan assists in achieving all the components of care outlined in Te Ara Whakapiri	Patient notes	Data analysis Documentation review
➢ Gather suggestions for improvement of the care plan and toolkit from the pilot users.	Site specific and generic suggestions for improvement are captured	Staff at pilot sites ARC Link Nurses	Interview
➢ Gauge support for the care plan and toolkit before roll-out.	Support for the care plan and tool kit is gauged		

Peer audit of patient files was completed by two to three members of the evaluation team using a pre-determined audit tool based upon the components of care outlined in Te Ara Whakapiri (see Appendix 2). Results were analysed as internal audits are using basic descriptive methods looking for trends.

Focus group discussions were facilitated using a discussion guide (see Appendix 2). The discussions at each site were minuted by an objective observer. The observer and facilitator met after each session to establish and record themes and key points from each focus group. The quality of actual care provision was outside the scope of the evaluation, however the level of documented evidence available was reviewed.

Criteria for success (Table 1) were defined by the evaluation team based on a predetermined merit rating rubric of Poor - Moderate - Good - Excellent and methods for obtaining evidence were aimed at measuring the level success – see table 2 below.

Evaluation Findings

Pilot sites were provided an opportunity to contribute to the evaluation via focus groups (Appendix 2), by informal written, verbal interviews and in writing through communication journals. A total of twenty-six nursing and medical staff that had worked with the documents during the pilot period provided feedback (figure 2). In addition,

nineteen care plans and patient records were reviewed at each site* using an audit tool specifically developed for the evaluation (Appendix 2). Note: during the trial period in the HB Hospital medical ward one person died, for this reason, the data related to the completion of the document was focused on the feedback from staff.

Table 2. Standards for determining merit (rubric) – conclusion (SHORE, 2015)

Rating	Explanation
Excellent	Peer audit of patient files shows almost all of components are achieved. There are very few suggestions for improvement of tool. All are in support of the care plan and toolkit.
Good	**Peer audit of patient files show most of components are achieved:** - completed documents provided evidence of the application of the principles of Te Ara Whakapiri. **Most are in support of the care plan and toolkit:** - 100% support for use in ARC settings - universal view that it was not suitable for continued use in the Cranford Hospice IPU. - 100% support for its use in the HBDHB Ward that piloted the tool (however this finding should consider that the tool could only be used in one case). - those involved in the pilot appeared engaged and committed to actively and critically use the care plan and toolkit in practice - care plan and toolkit enhanced their ability to plan care for patients in the last days of life **There are some suggestions for improvement of tool (user ease).** - Almost all the suggested improvements to the tool were repeated by multiple parties and the issues associated with the problems were also confirmed during the review of notes e.g. sections that were unclear were also often not completed fully. - feedback relating directly to the template and toolkit are detailed in Appendix 3. The use of this feedback will contribute to a continued sense of ownership for those using the tool and has the potential to greatly improve the quality of the document.
Moderate	Peer audit of patient files show at least half of the components are achieved. There is a significant amount of suggestions for improvement of tool. At least half are in support of the care pan and toolkit.
Poor	Peer audit show less than half the components are achieved. There is a significant amount of suggestions for improvement of tool. Few people are in support of the care plan and toolkit.

Focus groups were established and discussions were facilitated using a discussion guide (Appendix 2). A total of 14 ARC Nurses, 6 Cranford Hospice Nurses, 3 secondary care nurses and 2 medical staff and 1 GP participated in face to face feedback sessions or provided written feedback.

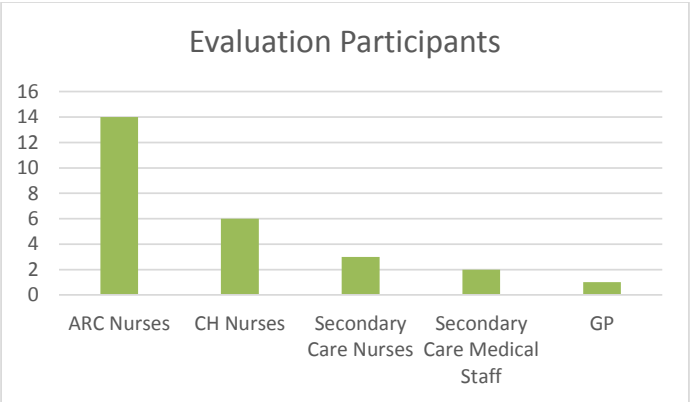


Figure 2: Illustrates breakdown of evaluation participant sources

The discussions were documented and later, themes and key points from each focus group were agreed by the three working groups members present at each session. Each site was also provided a communication journal to provide feedback and these were collected and collated.

*Current staff from Brittany House did not participate in the focus groups. The Clinical Lead in place at Brittany House during the pilot moved to another participating facility and provided feedback.

Evaluation Question 1: How successfully did the pilot achieve its' outcomes?

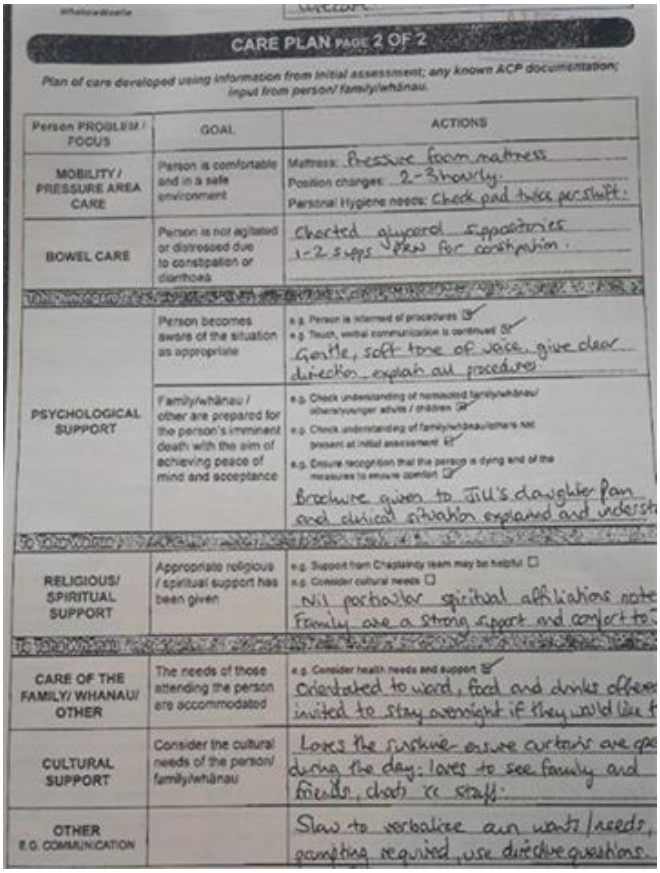
→ There was 100% support for its ongoing use in the ARC and HBDHB

"It's more manageable than the LCP was"
"gives us hints for what to look for in a palliative patient"
"it keeps focus and prompts when you are busy"
"GPs are on board because you can fax their part to them"
"it's straight forward, doesn't need instructions….and it is a refreshing stand-out colour"

→ There was universal view from Cranford Hospice nursing staff NOT to continue using the tool in the IPU setting.

"PalCare care plans make more sense for us and we do them well"
"It doesn't really make sense to move to paper notes at that stage"
"I can see how it was be very useful in the ARC setting, but not here"

→ Completed care plans were most often of a high quality and illustrated a clear understanding and application of the principles of Te Ara Whakapiri. Example below (figure 3) highlights the individualised care component unique to the Hawkes Bay toolkit.



CARE PLAN PAGE 2 OF 2

Plan of care developed using information from initial assessment; any known ACP documentation; input from person/ family/whānau.

Person PROBLEM / FOCUS	GOAL	ACTIONS
MOBILITY / PRESSURE AREA CARE	Person is comfortable and in a safe environment	Mattress: Pressure foam mattress Position changes: 2-3 hourly. Personal Hygiene needs: Check pad twice per shift.
BOWEL CARE	Person is not agitated or distressed due to constipation or diarrhoea	Charted glycerol suppositories 1-2 stat PRN for constipation.
PSYCHOLOGICAL SUPPORT	Person becomes aware of the situation as appropriate	e.g. Person is informed of procedures ☑ e.g. Touch, verbal communication is continued ☑ Gentle, soft tone of voice, give clear direction, explain all procedures
	Family/whānau / other are prepared for the person's imminent death with the aim of achieving peace of mind and acceptance	e.g. Check understanding of normalized family/whānau/ others/younger adults / children ☑ e.g. Check understanding of family/whānau/others not present at initial assessment ☑ e.g. Ensure recognition that the person is dying and of the measures to ensure comfort ☑ Brochure given to Jill's daughter Pam and clinical situation explained and understo
RELIGIOUS/ SPIRITUAL SUPPORT	Appropriate religious / spiritual support has been given	e.g. Support from Chaplaincy team may be helpful ☐ e.g. Consider cultural needs ☐ Nil particular spiritual affiliations note Family are a strong support and comfort to
CARE OF THE FAMILY/ WHANAU/ OTHER	The needs of those attending the person are accommodated	e.g. Consider health needs and support ☑ Orientated to ward, food and drinks offered invited to stay overnight if they would like t
CULTURAL SUPPORT	Consider the cultural needs of the person/ family/whānau	Loves the routine ensure curtains are ope during the day: loves to see family and friends, chats re staff.
OTHER E.G. COMMUNICATION		Slow to verbalise own wants/needs, prompting required, use directive questions.

Figure 3. Example completed page from care planning section showing individualised care

Evaluation Question 2: How ready is the LDOL Care Plan and Toolkit for final roll-out

→ Since the completion of the pilot period ARC sites have continued to use the tool and report a general satisfaction that it meets their needs and fills the 'gap' left by the removal of the LCP.

→ The key criticisms of the LCP have been addressed with the Hawke's Bay version, including supporting individualisation and other principles outlined in Te Ara Whakapiri (figure 2)

→ There are changes required in response to feedback which will require resourcing to make the alterations and produce a final version.

→ After each focus group and site visit, the evaluation team debriefed and concurred that there appeared to be a sense of ownership and engagement from staff using the HBDHB document and the evaluation process provided a positive inter-organisational communication opportunity.

→ Feedback from HBDHB staff was generally supportive of its use in that setting, while also feeding back some challenges and suggestions (improvements included in appendix 3)

Lead physician: *"most of the paperwork was easy, but…"*
House surgeon and Registrar: *"straightforward, easy to follow, but…."*
'*worked well, leaves no ambiguity i.e. who to ring, what to do post passing away……"*
"*found it really good to use……was easy to use and went in a logical manner.*

→ There were several suggestions for improvements for the tool, however few were 'significant' and all of which are outlined Appendix 3 from staff at all sites.

CONCLUSIONS

The HB Localised LDOL Care plan and toolkit was developed and trialled successfully per the predetermined plan with only minor delays resulting from uncontrollable factors. The evaluation process showed evidence of a commitment from participants in the trial to engaging in the use of the tool and in the critical analyses of its application. The feedback from participants can be used to directly improve the usability and impact of the tool on care planning for people at the end of life.

The review of the Liverpool Care Pathway found that "generic protocols are not regarded as the right approach to caring for dying people; care should be individualised and reflect the needs and preferences of the dying person and those who are important to them". The Hawke's Bay Localised version includes a care planning section which other versions do not. This evaluation highlighted the value of this added component.

Participants of the pilot expressed universal support for the full roll out of the document across the region in a variety of settings, excluding those that primarily use electronic health records as this was found to be an inefficient way of documenting care.

Due to the engagement of staff that worked with the document and the apparent positive relationship building aspect of this pilot, it is predicted that the modification and roll out of the localised version would be received well and further enhance integration in palliative care across settings

This piece of work supports two significant documents:

a. Ministry of Health Palliative Care Action Plan: – Priority 3 action (2017): "*Implement Healthy Ageing Strategy action: Support the implementation of the Te Ara Whakapiri Principles and guidance for the last days of life"*.
b. HBDHB Live well, stay well and die well, Palliative care in HB[i]: actions required: *"Last Days of Life (Te Ara Whakapiri) pathway is developed and implemented across the region"* with an outcome

of "*100% of ARC facilities and hospital wards have implemented the Last Days of Life (Te Ara Whakapiri) supported by Specialist Palliative Care services".*

RECOMMENDATIONS

The evaluation concluded with HB Last Days of Life Integrated Working Group being reconvened to consider findings and contribute to the development of the following recommendations:

1. During the evaluation (April 2017), a National Toolkit was produced by the Ministry of Health Working Group. The Integrated Working Group considered the new national tool and based on this evaluation, **recommend making the proposed changes the localised version and** making a commitment to rolling out this version. This is due to the inclusion of a planning tool section that involves taking the findings of an initial assessment to develop a plan of care that is individualised to the patient and the sense of ownership that the contribution to its development has resulted in.
2. ARC settings should continue to **resource the permanent use** of a LDOL care plan and toolkit due to the universal support from staff who have or are using it and the evidence of high quality care planning that the tool supports.
3. Cranford Hospice IPU should continue to review the quality of care planning using PalCare alongside the standards outlined in Te Ara Whakapiri **without the use of the paper tool**. Staff should be supported to remain familiar with the toolkit to support and champion its use in other settings. The concept of using the toolkit in the community setting should remain on agenda for consideration.
4. Only one patient died during the very short trial period in the HBDHB ward, for this reason, the data related to the completion of the document was focused on the feedback from staff. The HB Hospital should continue to resource the rollout of the LDOL toolkit across appropriate Hospital wards **if the feedback in this evaluation** is considered sufficient.
5. **On-going peer review and data analysis** should be planned to make use of the valuable information that can be obtained and shared as experienced in this evaluation. This may be useful in informing education and resourcing needs.
6. Commitment by participants to engage in the trial and implement. **Participants need to be commended** for their obvious commitment to the pilot and engagement in the feedback. This resulted in excellent and relevant feedback that will be easily applied to make improvements to the document and supporting education content.
7. The toolkit to be reviewed in 2 years by relevant stakeholders.

REFERENCES

i. Palliative Care Council. (2015*). Te Ara Whakapiri – Principles and guidance or the last days of life*. Palliative Care Council: New Zealand

ii. Last Days of Life Care Plan, Integrated HB DHB Working Group, 2016.

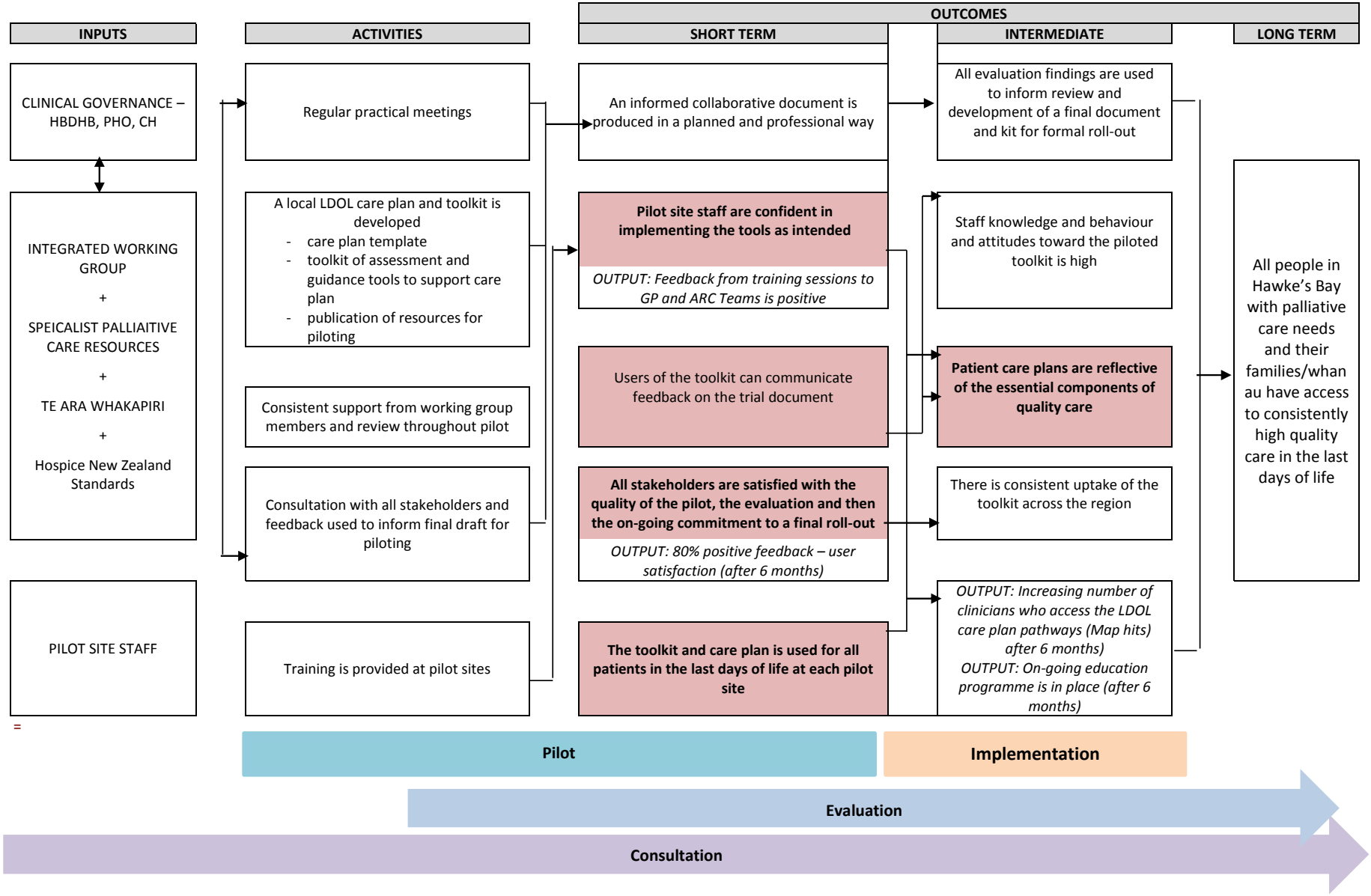
iii. Tools and resources to guide the care of people in their last days of life, Integrated HB DHB Working Group, 2016.

iv. SHORE & Whariki Research Centre. (2013). *Evaluation Workbook.* Massey University. School of Public Health

v. Ministry of Health Te Ara Whakapiri: http://www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life

vi. HBDHB. (2017) Live well, Stay well, Die well - Palliative Care in Hawke's Bay 2016-2026

HAWKE'S BAY LAST DAYS OF LIFE CARE PLANNING TOOLKIT PROJECT PLAN 2017 – LOGIC MODEL **APPENDIX 1**



Cranford Hospice - April 2017

EVALUATION TOOLS APPENDIX 2

Evaluation of the Pilot: Last Days of Life Care Plan and Toolkit – AUDIT TOOL			
Audit tool (based on pg. 44-48 Te Ara Whakapiri) was developed specifically for peer audit of patient records – Summarised for this report.			
Audit criteria	**No evidence**	**Evidence found**	**Unsure**
Has it been recognised that this person is / is at risk of entering the last days of life?			
Has a lead health practitioner been identified?			
Has the family been informed of how to contact this person?			
Physical needs are assessed and documented in care plan			
Family is consulted in developing the individualised care plan			
Review of, and anticipatory prescribing for core LDOL symptoms			
The person is aware of their changing condition?			
Consideration of food and fluids			
Consideration of ICD			
Persons preferences for EOL are assessed			
Communication barriers are identified and addressed if applicable			
Family is aware of changing condition			
Cultural needs are discussed and addressed			
Info about the facilities is provided to family			
Spiritual needs of person and family are identified and addressed			
There is ongoing assessment of the person's care			
Changing spiritual needs are discussed and addressed			
Death is verified and communicated to all services involved			
Family is informed of death.			
Info given to family about what to do next			
Family bereavement needs are assessed.			
Info given to family about support available			
Environment offers private space to meet needs of family			
The audit initially required a score to be assigned to each question. The evaluation team decided that this data was difficult to complete and did not add to the description of care plan application. It was not possible to access evidence of prescribing due to the use of electronic prescribing			

FOCUS GROUP DISCUSSION GUIDE

- Each pilot site will be offered the opportunity to have a focus group facilitated by the Cranford Hospice ARC Liaison Nurse Team on location at a time and date that is mutually agreed.
- The payment of staff to attend, and which staff members attend, will be at the discretion of the ARC Facility Manager. There is no budget in this evaluation to provide that funding.
- An invitation explaining the intention of the group will be made available for individual participant recruitment as identified.
- Tone is intended to be fun and promote open self-disclosure of feedback and experience related specifically to the Last Days of Life Care Pathway.
- The session will be structured as follows, but flexible enough to allow facilitator to use judgement and moderate as necessary:

Facilitators: Jo Loney and Sue Mary Davis Assistant (notes): Sarah Nichol

The following questions will be asked one at a time:

Opening question: What has your experience of the care plan and the toolkit been?
Introductory question: What are some of the benefits of the care plan and toolkit?
Introductory question: Can you give examples where the tool has worked well?
Transition question: Can you give examples of challenges you have experienced using the care plan and toolkit?
Key question: What would you like to see changed with the care plan and toolkit?
Key question: Is there anything else you would like to say about the care plan and toolkit?
Ending question: Are you supportive of the care plan and toolkit?
Thank you and negotiate to agree on the best way to share with the group the evaluation report and recommendations. Jo, Sue Mary and Sarah to debrief after the session and to identify factors that stood out – notes made.

Krueger, Richard A. and Mary Anne Casey (2000). Focus Groups: A Practical Guide for Applied Research. 3rd Edition. Thousand Oaks, CA: Sage Publications.

This measurement was evaluated against the national guidance document Te Ara Whakapiri.

→ The principles of care for people in their last days of life (pg. 17, Te Ara Whakapiri)

→ The minimum components of service delivery required for quality care (pg. 44-48, Te Ara Whakapiri

Findings from Aged Residential Care Facilities (ARC)

A peer review of patient files was completed by Cranford Hospice Quality Coordinator and both ARC Liaison Nurses using a pre-determined audit tool based upon the components of care outlined in Te Ara Whakapiri (pg. 44-48). Each pilot site provided access to patient LDOL care plan notes and between 2 and 4 notes were randomly selected for review. A total of 18 notes from ARC settings were reviewed and some key themes were identified. Detailed findings are recorded:

→ Reviewers were unable to assess evidence of anticipatory prescribing in relation to LDOL and the toolkit as it had not been anticipated that the pilot sites use electronic prescribing. Verbal feedback suggested that this was not an area of concern and that generally prescribers are pre-emptively charting medication for symptoms common in the last days of life (sometimes with prompting from the assessing nurse). The initiation of the care plan was at times a prompt for this discussion.

→ Many of the care plan examples had sections on cultural and spiritual needs left blank, and did not include evidence of any related conversation or assessment.

→ The final page relating to after death actions was inconsistently used, which was predicted, due to each facility having their own checklists. Staff believed that the LDOL tool was of added use (alongside existing forms), but some work is required to ensure it is most effective.

→ The progress notes remained thorough and staff did not revert to "Variance Reporting" which is the intention of the tool as it reduces the amount of documentation required.

→ Reviewers did not investigate the number of residents that died without the use of the toolkit.

→ Some clarity is required about whether a nurse can start the care plan without the approval of the GP.

→ There was a clear commitment from nursing staff to use the care plan to its fullest capacity – see example figure 3

Findings from Hawkes Bay Hospital

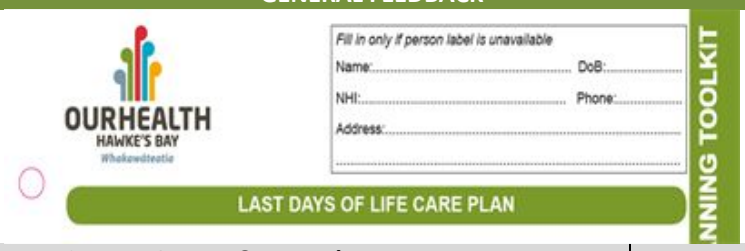
Only one patient died during the very short trial period in the HBDHB ward. For this reason, the data related to the completion of the document was focused on the feedback from staff:

- Medical Staff both indicated that "could have been helpful to have an area to put in a diagnostic summary to date at commencement of the care plan. I felt a little uncomfortable that if anybody needed to see the patient for new symptoms or whatever that would have had to refer back to the main file to get an idea of what the clinical problems were" "it would have been helpful to have a box on the front with diagnosis or the course that led the patient to the LDOL care plan"
- "A challenge is the length (for some who don't like to document things.)" …. "Initially thought it was quite a large document and found it a bit daunting"
- "Liked the resources attached to it and thought the card of how to talk to people and the prompts were really useful especially for younger nurses and new graduates……."
- "Spent some time going through the resource stuff and there were lots there to be used".
- "Liked being able to see all the things to monitor i.e., secretions and the variants on the same page"….. "Helped to see the trend of what was happening."
- "Also, felt some sort of summary in the front about the patient. On the ward, we put the old notes away. If we needed to know anything about them, we would have to go through the old notes which are often put in a different place. Not a big history just bullet points about how they got to the point they are at. Can't be too much otherwise the doctors won't want to fill it out"

Findings from Cranford Hospice IPU

- During the trial period in the IPU (10 October to 31 December 2016) there were 22 deaths. In 12 of those cases the LDOL care plan document and toolkit was implemented. While there were 3 obviously sudden deaths, this does illustrate that staff did not perceive the care plan as adding value to the care they provided, consistent with verbal feedback.
- Where the LDOL tool was used, the level of completion of the document was variable and in almost all cases the patient's electronic notes continued either as an overlap or in one or other location. A reminder that electronic notes should be discontinued during the trial, however the practice continued. The associated risks with having notes in different locations outweighed the benefits of using the paper tool and the Cranford Hospice Clinical Governance Team elected to urgently remove the tool from use as soon as this was identified as part of the evaluation.

COLLATED DATA SPECIFIC TO CARE PLAN

GENERAL FEEDBACK	
	
ARC Focus Groups & Journals	**Notes Review**
• "More manageable than LCP" • "Straight forward – a good thing" • "Gave us hints for what to look for in a palliative patient" • The colour is great – it is a refreshing colour. • Can this decision be made by and RN? At times the care plan was initiated by nurses at times with the doctor coming later and other times the LDOL section is faxed to the doctor to complete. • It doesn't overlap with other forms. It is "not repetitive – great prompts and even if we have the information somewhere else, it is a good way to check the most important things" • Easy to use – don't need instruction • "great, very positive about it" • "it keeps focus and prompts you when you are busy" • "GP's are more on-board with this because you can fax it to them" • "Does the Doctor NEED to be informed?" • "The name LDOL makes so much more sense than the LCP as it actually says what it is" • Reasons for the tool not being used where could have included: • Communication with GP • Difficult family • Disagreement with GP that the person is LDOL • APPEARS that there continues to be people giving the whole document to the family. • "It works well because the assessments page has all the information about the person.	• Patient labels were often not used and instead nurse handwritten details in its place. Is this because their labels are too big or something? Must be time-consuming. • "A few missed opportunities" to initiating the care plan – "waiting for the OK"
CRANFORD HOSPICE IPU Focus Groups & Journal	**Notes Review**
• Moving to paper notes feels like "a backward step" for many staff. Other negative consequences of using paper notes mentioned included: • Difficulty for FST to access/track down paper notes e.g. communicating with NASC	• Multiple deaths did not apply the LDOL pathway e.g. 10/22 (3 were sudden deaths).

Cranford Hospice - April 2017

OVERALL FINDINGS – CARE PLAN AND TOOLKIT **APPENDIX 3**

- Handwritten notes are harder to read, especially for those staff with English as a second language
- It is "time consuming"
- Bereavement follow up is not as easy to access the notes on how the death was etc.
- Most staff reported preferring the care planning system on PalCare and believe adequate information is held on the electronic notes.
- "a picture builds on PalCare over the course of time and moving to paper notes interferes with that"
- "it is not as easy to track medication changes e.g. doses etc."
- Acknowledged that there has been an improvement in the quality of information on PalCare since audit 12-24 months ago, with the use of a care plan issue template. *Routine audits still show some inconsistency with that however and still room to improve.*
- General feeling that the LDOL care plan is "less personable than PalCare allows"
- Universal support for this being useful in a non-specialist setting.
- No person providing feedback supported the continued use of the tool in the IPU
- Some support for a one page checklist however.
- "Where does this go on PalCare?" "it is cumbersome and clumsy"

- When LDOL pathway was used, PalCare notes also continued in detail – in both places and referring to each other.
- Not all care plans were completed. Medical staff completed other sections.
- Progress notes remained thorough and multidisciplinary. Pharmacist only wrote in PalCare.

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WARD STAFF FEEDBACK TO HPCT CNS	Notes Review
• 'worked well, leaves no ambiguity i.e. who to ring, what to do post passing away. A challenge is the length (for some who don't like to document things.)' • 'Worked well. Benefits are specifically asking about the symptoms we need to look at. A challenge was not sure about starting it- otherwise it's easy to use.' • (The nurse who completed the initial assessment): "found it really good to use. Initially thought it was quite a large document and found it a bit daunting. • Took a couple of attempts to fill it out as struggled to find the time. Felt there was nothing to change as it was more an unfamiliarity with the document and that with more use it would get better. • Was easy to use and went in a logical manner. • Liked the resources attached to it and thought the card of how to talk to people and the prompts were useful especially for younger nurses and new graduates. • Spent some time going through the resource stuff and there were lots there to be used. • We would have to go through the old notes which are often put in a different place. Not a big history just bullet points about how they got to the point they are at. Can't be too much otherwise the doctors won't want to fill it out.	• Generally, well completed

FRONT PAGE – DECISION TREE

ARC Focus Groups	Notes Review
• No mention of this page in any of the focus groups or journal entries	• Unclear if should be completed or just used as a guidance flowchart. • At times ticked – others not.

OVERALL FINDINGS – CARE PLAN AND TOOLKIT — APPENDIX 3

CRANFORD HOSPICE IPU FOCUS GROUPS	Notes Review
• Some discussion regarding prognostication e.g. Patients admitted for terminal cares and then later discharged	

HBDHB WARD STAFF FEEDBACK TO HPCT CNS	Notes Review
• From the medics (lead physician): 'most of the paperwork was easy but could have been helpful to have an area to put in a diagnostic summary to date at commencement of the care plan. I felt a little uncomfortable that if anybody needed to see the patient for new symptoms or whatever that would have had to refer to the main file to get an idea of what the clinical problems were. Otherwise seemed good.' • House surgeon and Registrar: 'straightforward, easy to follow. Main feedback was that it would have been helpful to have a box on the front with diagnosis or the course that led the patient to the LDOL care plan.' • Also, felt some sort of summary in the front about the patient. On the ward, we put the old notes away. If we needed to know anything about them.	

NOMINATING LEAD PROVIDERS PAGE


LEAD HEALTH PRACTITIONER/S

Doctor: Page contacts (HBDHB):

If GP - See Page 3 for Contact Details

Nurse Practitioner:

Work number: After hours number:

Primary Nurse:

THIS PLAN SHOULD BE REASSESSED EVERY THREE DAYS

Date of Life Care Plan commencement: Signed:

Reassessment date: Reassessment time: Signed:

Reassessment date: Reassessment time: Signed:

Reassessment date: Reassessment time: Signed:

2 of 13

CRANFORD HOSPICE FOCUS GROUPS	Notes Review
• CH IPU staff reported that the Lead Health Practitioner concept did not apply in the IPU and by nominating a primary nurse, this was a barrier to other nurses changing the care plan if needed	• Often empty

SAMPLE SIGNATURE PAGE


PLANNING CARE

OURHEALTH HAWKE'S BAY

Fill in only if person label is unavailable

Name: DoB:

NHI: Phone:

Address:

ALL PERSONNEL COMPLETING THE LAST DAY OF LIFE - *CARE PLAN* - PLEASE SIGN BELOW

You should also have an understood the 'Health Care Professional' leaflet

Name (print)	Full Signature	Initials	Professional Title	Date

ARC FOCUS GROUPS	Notes Review
• Several people mentioned the need for this page to be page 1 or 2 instead of page 6. • CH IPU staff reported that the Lead Health Practitioner concept did not apply in the IPU and by nominating a primary nurse, this was a barrier to other nurses changing the care plan if needed	• Appeared to be completed well • Often empty

MEDICAL OFFICER SECTION

OVERALL FINDINGS – CARE PLAN AND TOOLKIT **APPENDIX 3**

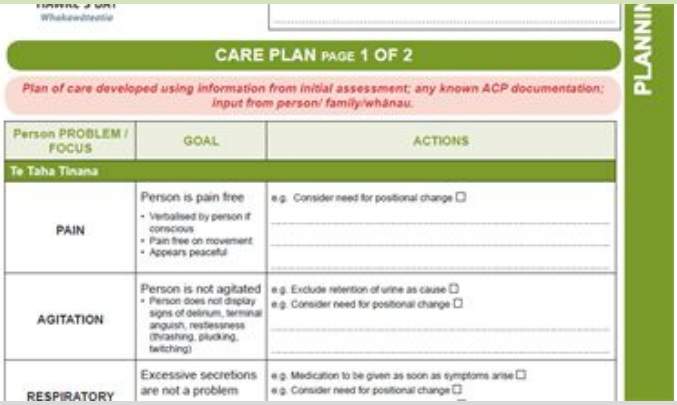

MUST BE COMPLETED BY MEDICAL PRACTITIONER

- Active acute medical treatment is no longer in the person's best interest ☐ Yes ☐ No Date: Signature:
- Non-essential medications discontinued and current medications reviewed ☐ Yes ☐ No Date: Signature:
- PRN subcutaneous anticipatory medications charted ☐ Yes ☐ No Date: Signature:
  See Symptom Management Algorithms
- Inappropriate interventions discontinued e.g blood tests, routine observations, blood glucose monitoring, oxygen therapy ☐ Yes ☐ No Date: Signature:
- The need for artificial hydration/nutrition has been discussed ☐ Yes ☐ No Date: Signature:
- Not for Resuscitation status recorded ☐ Yes ☐ No Date: Signature:
- Implantable Cardioverter Defibrillator (ICD) is deactivated ☐ Yes ☐ No Date: Signature:
- Organ donation considered and information given to person/family ☐ Yes ☐ No Date: Signature:
  See Tissue Donation brochure

Individual/Specific Requests

ARC FOCUS GROUPS	Notes Review
• "GP section is not always being used" GP sometimes goes back to the usual medical progress notes. • GP reported being very pleased that the medical area is condensed compared to the LCP. • There are too many initial and date sections – it is not necessary. • Need contact number for pacing radiographer. • Need N/A option for ICD and organ donation section	• At times N/A handwritten. • At times 'no' has been ticked – unclear if this is due to interpretation of the question or not. E.g. no regarding hydration – appeared the doctor was say not necessary, when question is "was this considered/discussed" • Where no was ticked – there is not a prompt to tell the doctor to write explanation in the progress notes.
CRANFORD HOSPICE FOCUS GROUPS	**Notes Review**
• Should say "Yes, No or NA" • "Is pacemaker present" e.g. this does not need to be deactivated. • "any other implantable device"	• Doctor handwritten N/A in some instances

CAREPLAN SECTION


CARE PLAN PAGE 1 OF 2

Plan of care developed using information from initial assessment; any known ACP documentation; input from person/ family/whānau.

PLANNI

Person PROBLEM / FOCUS	GOAL	ACTIONS
Te Taha Tinana		
PAIN	Person is pain free • Verbalised by person if conscious • Pain free on movement • Appears peaceful	e.g. Consider need for positional change ☐
AGITATION	Person is not agitated • Person does not display signs of delirium, terminal anguish, restlessness (thrashing, plucking, twitching)	e.g. Exclude retention of urine as cause ☐ e.g. Consider need for positional change ☐
RESPIRATORY	Excessive secretions are not a problem	e.g. Medication to be given as soon as symptoms arise ☐ e.g. Consider need for positional change ☐

ARC FOCUS GROUPS	Notes Review
• Several people commented that the size of the ACTIONS boxes are too small • Suggestion that the "Actions" column should be named "interventions" • Suggestion that the examples in the action column don't say "e.g."	• Some care plans had symptoms or assessment details rather than actions in the column. • Some repeated the examples rather than just ticking them. • No place to indicate if family involved in the development of the care plan. • NO SECTION FOR FOOD AND FLUID • Difficult to add specific things like e.g. continue with insulin
Cranford Hospice IPU	**Notes Review**
• Not enough ability to document skin integrity e.g. wound care • "no ability to express care delivered other than progress notes"	• As above in ARC, with less detail at times

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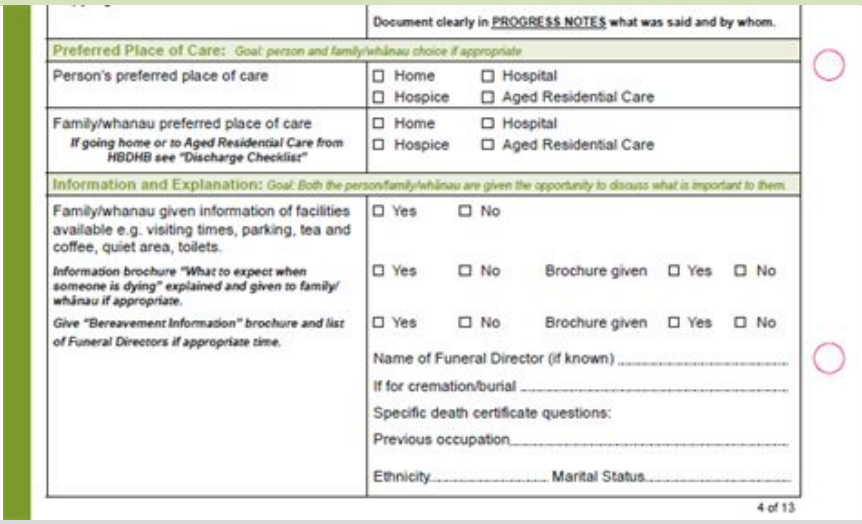
OVERALL FINDINGS – CARE PLAN AND TOOLKIT **APPENDIX 3**

FUNERAL DIRECTOR SECTION



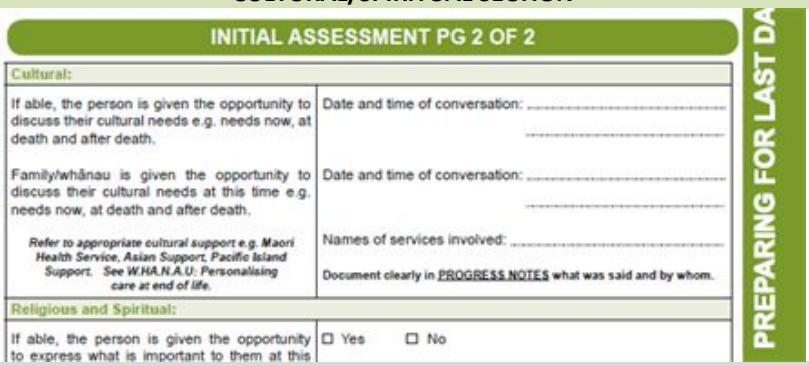
	Document clearly in PROGRES$ NOTES what was said and by whom.
Preferred Place of Care: *Goal: person and family/whānau choice if appropriate*	
Person's preferred place of care	☐ Home ☐ Hospital ☐ Hospice ☐ Aged Residential Care
Family/whanau preferred place of care *If going home or to Aged Residential Care from HBDHB see "Discharge Checklist"*	☐ Home ☐ Hospital ☐ Hospice ☐ Aged Residential Care
Information and Explanation: *Goal: Both the person/family/whānau are given the opportunity to discuss what is important to them.*	
Family/whanau given information of facilities available e.g. visiting times, parking, tea and coffee, quiet area, toilets.	☐ Yes ☐ No
Information brochure "What to expect when someone is dying" explained and given to family/ whānau if appropriate.	☐ Yes ☐ No Brochure given ☐ Yes ☐ No
Give "Bereavement Information" brochure and list of Funeral Directors if appropriate time.	☐ Yes ☐ No Brochure given ☐ Yes ☐ No
	Name of Funeral Director (if known) .....
	If for cremation/burial .....
	Specific death certificate questions:
	Previous occupation.....
	Ethnicity..... Marital Status.....

4 of 13

ARC FOCUS GROUPS	Notes Review
• One family "when I went to ask, all family members looking at me like what I am asking as their dad still alive, however the next day family told me that it given a chance for the family to discuss if and make a decision"	• Often not completed – left empty.

Cranford Hospice IPU	Notes Review
• "Lots of people don't want to talk about these things at a very stressful time and so it gets left blank".	

CULTURAL/SPIRITUAL SECTION



INITIAL ASSESSMENT PG 2 OF 2

PREPARING FOR LAST DA

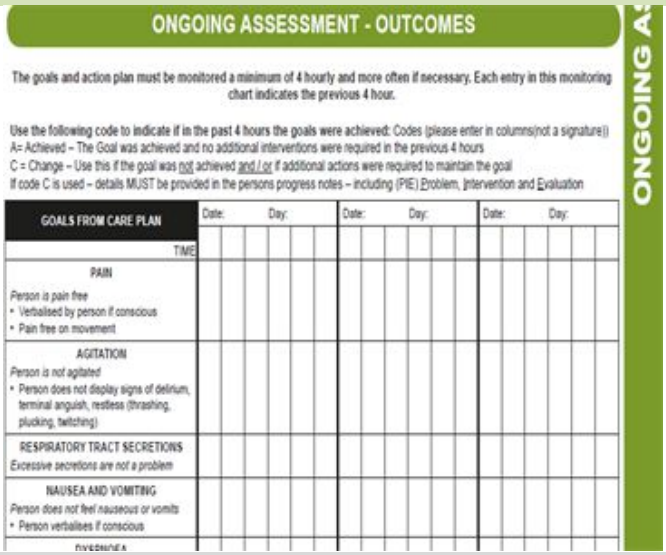
Cultural:	
If able, the person is given the opportunity to discuss their cultural needs e.g. needs now, at death and after death.	Date and time of conversation: ....
Family/whānau is given the opportunity to discuss their cultural needs at this time e.g. needs now, at death and after death.	Date and time of conversation: ....
Refer to appropriate cultural support e.g. Maori Health Service, Asian Support, Pacific Island Support. See W.HA.N.A.U: Personalising care at end of life.	Names of services involved: ..... Document clearly in PROGRES$ NOTES what was said and by whom.
Religious and Spiritual:	
If able, the person is given the opportunity to express what is important to them at this	☐ Yes ☐ No

ARC FOCUS GROUPS	Notes Review
• Some staff mentioned difficulty in knowing what to ask of the family or patient. • Some said they felt that they have this information obtained over a long period and therefore is hard to decide what is most relevant.	• Incomplete in many notes.

Cranford Hospice IPU	Notes Review
• The HOPE tool is much better	• Empty in most cases. • In one case the doctor completed the whole tool, but asterixed (#) this section for the nurse to complete

OVERALL FINDINGS – CARE PLAN AND TOOLKIT **APPENDIX 3**

ON-GOING ASSESSMENT SECTION


ONGOING ASSESSMENT - OUTCOMES

The goals and action plan must be monitored a minimum of 4 hourly and more often if necessary. Each entry in this monitoring chart indicates the previous 4 hour.

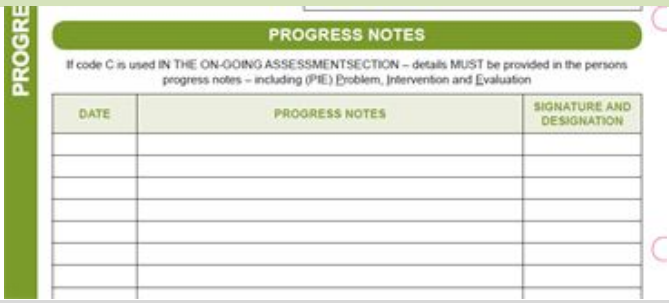
Use the following code to indicate if in the past 4 hours the goals were achieved: Codes (please enter in columns(not a signature))
A= Achieved – The Goal was achieved and no additional interventions were required in the previous 4 hours
C = Change – Use this if the goal was not achieved and / or if additional actions were required to maintain the goal
If code C is used – details MUST be provided in the persons progress notes – including (PIE) Problem, Intervention and Evaluation

GOALS FROM CARE PLAN	Date: Day:	Date: Day:	Date: Day:
TIME			
PAIN *Person is pain free* • Verbalised by person if conscious • Pain free on movement			
AGITATION *Person is not agitated* • Person does not display signs of delirium, terminal anguish, restless (thrashing, plucking, twitching)			
RESPIRATORY TRACT SECRETIONS *Excessive secretions are not a problem*			
NAUSEA AND VOMITING *Person does not feel nauseous or vomits* • Person verbalises if conscious			

ONGOING A

ARC FOCUS GROUPS	Notes Review
• Suggestion that there should be one page for each day instead of putting 3 days on one page. • Some mentioned confusion about the number columns in each day. Some say that they • HCA's are not able to assess these things. • HCA's are not often involved heavily. • "Why aren't there times like there was with the LCP"	• At times, not all columns were used
CRANFORD HOSPICE IPU FOCUS GROUPS	**Notes Review**
• Not always easy to document on the right day. What about times?	
HBDHB WARD STAFF FEEDBACK TO HPCT CNS	**Notes Review**
• Liked being able to see all the things to monitor i.e., secretions and the variants on the same page. • Helped to see the trend of what was happening.	

PROGRESS NOTES


PROGRESS NOTES

If code C is used IN THE ON-GOING ASSESSMENTSECTION – details MUST be provided in the persons progress notes – including (PIE) Problem, Intervention and Evaluation

DATE	PROGRESS NOTES	SIGNATURE AND DESIGNATION

PROGRE

ARC Focus Groups & Journals	Notes Review
• Most did, but some didn't seem aware that these notes were intended to be multidisciplinary. • Doctors at times reverted to usual medical progress notes despite the use of the sticker stating stop – now LDOL care plan. • Request that stickers be green also. • Need extra copies of progress notes with no page numbers	• Most did not use the code 'c' with issue and then the details of intervention as suggested. • Progress notes were very detailed. Almost all completed progress notes as they would normal notes e.g. not restricted to variances only. E.g. "no pain, no sob"
Cranford Hospice IPU	**Cranford Hospice IPU**
• Page numbers issue noted • Pages not always dated, which is an issue if they get out of order • Discomfort with variance based notes as this doesn't feel consistent with "if it is documented, it didn't happen"	• Notes recorded in both places • Patient labels not always put on all pages • Detailed notes showing achieved and changes in total – e.g. not variance based notes as intended

OVERALL FINDINGS – CARE PLAN AND TOOLKIT APPENDIX 3

FINAL OFFICES PAGE

ARC Focus Groups	Notes Review
• Some confusion over the term verification vs certification of death. • Need to add pharmacy to the list. • Everyone denied that they felt that this form overlapped with other forms in the organisation. Some organisations have a separate form, others not. • Discussed identification of bereavement support needs etc. and what follow up is possible.	• Verification of death is being completed, despite official meaning of the term. • Community providers section not very relevant

Cranford Hospice IPU	Notes Review
• Cremation / burial information should be on this page • Cremation forms require information about any surgery in the last 12 months, including the name of the surgeon • Needs part about coroner's case • Some felt that an "after death checklist was absent"?	

OURHEALTH HAWKE'S BAY

INSTRUCTIONS

This toolkit is an integrated care pathway that can be used across all settings, including the home, aged residential care, hospital and hospice

The term “last days of life” defines the period of time in which a person has been assessed and diagnosed as dying by a multi-disciplinary team and that death is expected within hours or days.

The goals of care are optimal symptom management and support for the person/family/whānau. The person should be assessed and a care plan developed in line with the person (if able), family/whānau wishes and needs

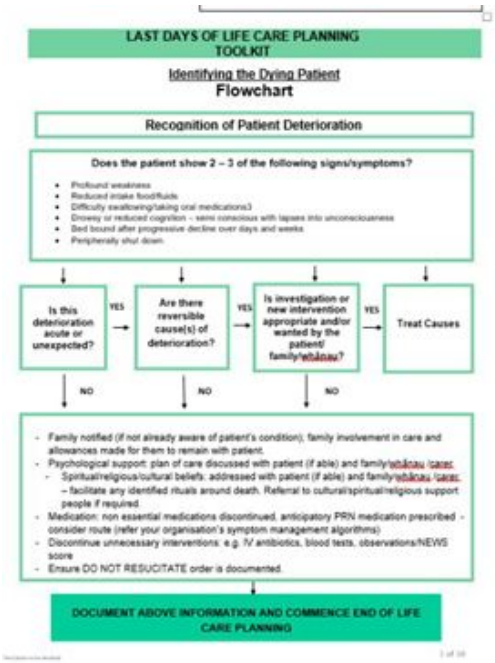
Criteria for the use of the care plan

A health practitioner undertakes assessments when recognising a person may be entering their last days of life, planning priorities of care and continually assessing care needs. Any changes in condition act as a prompt to ensure conversations occur with the person and with their family/ whānau.

Instructions for use

Document is organised in three parts and must link with the person’s clinical records. It is imperative to clearly communicate all decisions leading to a change in care, and document these conversations. This plan does not replace the need for accurate documentation in the persons’ clinical records (progress notes).

Preparing for last days of life:	Baseline assessment to identify priorities of care
Planning for care:	Person centred priorities of care
Ongoing assessment:	Regular assessments *(recommend 4 hourly or more often if required)* of the persons condition to ensure that changes are addressed in a timely manner.



References:
Ministry of Health (2015) Te Area Whakapiri Principles and Guidelines for the Last Days of Life. Wellington. Ministry of Health
International Collaborative for Best Car for the Dying Person www.mcpcil.org.uk
Ministry of Health. (2017). http://www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life

PLANNING CARE

OURHEALTH HAWKE'S BAY

First Name: _____ Gender: _____

Surname: _____

AFFIX PATIENT LABEL HERE

Date of Birth:_____ NHI#: _____

Ward/Clinic: Consultant:

ALL PERSONNAL COMPLETING THE LAST DAYS OF LIFE – CARE PLAN – PLEASE SIGN BELOW

You should also have and understood the 'Health care Professional' leaflet

Name (print)	Full Signature	Initials	Professional Title	Date

Lead health practitioner/s (this is the person's GP, hospital specialist or Nurse Practitioner)

Doctor: …… Pager contacts: (HBDHB) ……

If GP – See Page 3 for Contact Details

Nurse Practitioner: …… Work number: ……After hours number: ……

Medical Assessment section completed ☐ Date:: …… Time: ……

This plan should be reassessed every three days

Reassessment date: _____Reassessment time: _____Signed_____

Reassessment date: _____Reassessment time: _____Signed_____

Reassessment date: _____Reassessment time: _____Signed_____

Discontinued date:…… Time:……

Reasons why this care plan was discontinued by MDT…….....

…….

OURHEALTH HAWKE'S BAY

Patient name:
NHI:
DOB:

CONTACTS PAGE

KEY SERVICE PROVIDERS:	
Name of General Practitioner Notified of change in person's condition □ Yes □ No In what circumstances do they want to be contacted? If unavailable, who should be contacted?	**1st contact:** Name:…… Telephone :……Mobile…… At any time □ Not at night time □ **2nd contact:** Name:…… Telephone……Mobile ……
Community Providers are notified of 'Last Days of Life" if applicable	Cranford Hospice □ Yes □ No □ N/A District Nurses □ Yes □ No □ N/A NASC Agency □ Yes □ No □ N/A Home Support Agency □ Yes □ No □ N/A Other □ Yes □ No □ N/A …… ……
FAMILY / WHĀNAU:	
If the person's condition changes, who should be contacted first? If the person's condition changes, when should they be contacted?	**1st Contact:** Name:…… Relationship…… Telephone Number:…… Mobile Number…… At any time □ Not at night time □ Staying overnight □
If the first contact is unavailable, who should be contacted? When to contact Next of Kin if different from above	**2nd Contact:** Name:…… Relationship…….. Telephone Number:…….. Mobile Number…….. At any time □ Not at night time □ Staying overnight □ Name:…… Relationship…… Telephone Number:……
Advance Care Plan: *Goal: Both the person/family/whānau are given the opportunity to discuss what is important to them*	
Does the person have an existing Advance Care Plan?	□ No □ Yes Located…… **Transfer any key actions to the care plan**
Does the person have an existing Directive?	□ No □ Yes Located……
Does the person have nominated Enduring Power of Attorney (EPOA) for Health? Has the EPOA been activated? Copy sighted? **Document clearly in PROGRESS NOTES what was said and by whom.**	□ Yes □ No Name……Relationship…… Contact Number…… □ Yes □ No □ No □ Yes □ No □ No

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OURHEALTH HAWKE'S BAY

First Name: _____
Surname: _____
Gender: _____
AFFIX PATIENT LABEL HERE
Date of Birth:_____ NHI#: _____
Ward/Clinic: Consultant:

INITIAL ASSESSMENT – FAXABLE SHEET

Physical (Te Taha Tinana):

TO BE COMPLETED BY A SENIOR NURSE OR MEDICAL OFFICER

Diagnosis

Relevant medical history or □ refer to full patient records

Baseline information: Is the person:

□ Conscious □ Semiconscious □ Unconscious
□ Fully alert □ Confused □ Delirious

In pain	□ Yes	□ No	Dyspnoeic	□ Yes	□ No
Agitated	□ Yes	□ No	Experiencing respiratory tract secretions	□ Yes	□ No
Nauseated	□ Yes	□ No	Skin integrity	□ Yes	□ No
Vomiting	□ Yes	□ No	Risk of falling	□ Yes	□ No
Continent (bladder)	□ Yes	□ No	Experiencing order symptoms (e.g. oedema, itch, jerks)	□ Yes	□ No
Catheterised	□ Yes	□ No			
Continent (bowels)	□ Yes	□ No			
Constipated	□ Yes	□ No			

Does the patient show 2 – 3 of the following signs/symptoms?

Tick those that apply

□ Profound weakness
□ Reduced intake food/fluids
□ Difficulty swallowing/taking oral medications
□ Drowsy or reduced cognition – semi conscious with lapses into unconsciousness
□ Bed bound after progressive decline over days or weeks
□ Peripherally shut down (cold hands and feet)
□ Near death awareness (stories, visitations, travel)

□ **I believe this person is entering the last days of life**

Name:…… Signature:…… Date:……

SECTION TO BE COMPLETED BY MEDICAL OR NURSE PRACTITIONER

□ Active acute medical treatment is no longer in the person's best interest
□ Non-essential medications discontinued and current medications reviewed
□ PRN subcutaneous anticipatory medications charted (***See symptom Management algorithms)***
□ The need for artificial hydration/nutrition has been discussed
□ Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) is recorded
□ Inappropriate interventions discontinued e.g. blood tests, routine observations, blood glucose monitoring, oxygen therapy.

Implantable Cardioverter Defibrillator (ICD) (Cardiac Services – contact: 878 8109 ext. 6603)
□ N/A □ Deactivated Date:……_____

Organ donation considered and information given to person/family ***see Tissue Donation brochure***
□ Yes □ N/A

Is the coroner likely to be involved?
□ Yes □ No

Specific requests or exceptions to the above checklist:

Nurse to transfer any key actions to the care plan

Doctor Name…….. Date…….. Time……

Signature……..

OURHEALTH HAWKE'S BAY

Patient name:
NHI:
DOB:

INITIAL ASSESSMENT Pg. 2 of 3

Awareness and Mental Health (Te Taha Hinengaro)

Recognition of Dying: *Goal: Both the person/family/whānau have awareness and understanding of the diagnosis*

The person is aware they are dying? ***See guidelines on "Identifying the dying patient"***	□ Yes □ No □ Unconscious
Is the family/whānau aware their family member is dying? ***See guidelines on "Breaking Bad News" and "W.H.A.N.A.U" tool***	□ Yes □ No □ NA **Document clearly in PROGRESS NOTES what was said and by whom.**

Preferred Place of Care: *Goal: person and family/whānau choice if appropriate*

Person's preferred place of care	□ Home □ Hospital □ Hospice □ Aged Residential Care □ No preference
Family/whanau preferred place of care ***If going home or to Aged Residential Care from HBDHB see "Discharge Checklist"***	□ Home □ Hospital □ Hospice □ Aged Residential Care □ No preference

Extended family health (Te Taha Whānau) Goal: *Both the person/family/whānau are given the opportunity to discuss what is important to them.*

Family/whanau given information of facilities available e.g. visiting times, parking, tea and coffee, quiet area, toilets.	□ Yes □ No
Information brochure "What to expect when someone is dying" explained and given to family/whānau if appropriate.	Brochure given □ Yes □ No
Give "Bereavement Information" brochure and list of Funeral Directors if appropriate time.	Brochure given □ Yes □ No

Religious and Spiritual: (Te Taha Wairua)

Which ethnic group or groups does the person identify with…… You can gain important information at this time, for example, someone's iwi or other cultural affiliations. ***Refer to appropriate cultural support e.g. Maori Health Service, Asian Support, Pacific Island Support. See W.HA.N.A.U: Personalising care at end of life.***	Date and time of conversation…… Name of services involved…… **Transfer any key actions to the care plan** **Document clearly in PROGRESS NOTES what was said and by whom.**
If able, the person is given the opportunity to express what is important to them at this time e.g. wishes, feelings, faith, beliefs, values (needs now, at death and after death)	□ Yes □ No □ No needs expressed Date and time of conversation…… **Transfer any key information to the care plan**
The family/whānau is given the opportunity to express what is important to them at this time eg. wishes, feelings, faith, beliefs, values (needs now, at death and after death)	□ Yes □ No □ No needs expressed Date and time of conversation…… **Transfer any key actions to the care plan**
Religious tradition identified Person's minister/priest/spiritual advisor/tohunga (Maori spiritual advisor) Support of facility spiritual advisor / Chaplin Support of facility cultural support or Maori Health Service ***Refer to Chaplain Service or contact patient's preferred support person if required. See Spiritual care assessment tool based on FICA approach.***	□ No □ Yes please specify:…….. Name:…… Phone:…….. □ Yes □ No □ Yes □ No **Transfer any key actions to the care plan**

Nurse Name…….. Date…….. Time…….

Signature……..

13

Patient name: NHI: DOB:

INITIAL ASSESSMENT – CARE AFTER DEATH

It may be appropriate to complete some of this section before the person's death	
Accomodation and involvement: Has private space been made available for the family/whanau? Provisions are made to ensure family/whanau are able to participate in after-death care if they wish to be involved	 □ Yes □ No □ N/A □ Yes □ No □ N/A
Funeral plans: Is the person to be buried or cremated? Named of funeral director **If no funeral director – use Transfer of Body form and follow guidelines** Are valuables to be left on/with the person/tupapaku?	 □ Buried □ Cremated Service_____ □ Yes □ No Details_____
Bereavement Support: Does the family/whanau appear to be significantly distressed before, during or after the death? Was there evidence of conflict that remained unresolved within the family/whanau? **Consider using the Te Ara Whakapiri Bereavement Risk Assessment Tool**	

Care after death

Person has died	Date/Times/signature……
People in attendance at time of death	……
Person has been verified dead	Date/Time/signature……
Person certified (Medical)	Date/Time/Signature……
Discussed as appropriate with family/whānau procedures following death, e.g. funeral arrangement, viewing of the body/tūpāpaku	□ Yes □ No
Bereavement support has been discussed ***See Organisation Policy on Care at death and after death***	□ Yes □ No

Care after death – Checklist (also see organisation documentation as required)

Notify Next of Kin	□ Yes	□ No	
Notify Attending Doctor	□ Yes	□ No	
Clinical records complete	□ Yes	□ No	
Ensure body correctly identifiable	□ Yes	□ No	
Sign off Release of Body form (if applicable)	□ Yes	□ No	□ NA
WINZ notified/form printed (if applicable)	□ Yes	□ No	□ NA
Ministry of Health (MoH) notification/form printed (Death only)	□ Yes	□ No	□ NA
Options HB notified (if applicable)	□ Yes	□ No	□ NA

Community Providers are notified of Death (if applicable)	Cranford Hospice	□ Yes	□ No	□ N/A
	District Nurses	□ Yes	□ No	□ N/A
	NASC Agency	□ Yes	□ No	□ N/A
	Home Support Agency	□ Yes	□ No	□ N/A
	Other	□ Yes	□ No	□ N/A
	……			

Nurse Name…….. Date…….. Time…….

Signature……..

OURHEALTH HAWKE'S BAY

Patient name:
NHI:
DoB:

CARE PLAN pg 1 of 2

Plan of care developed using information from initial assessment; any known ACP documentation; input from patient/ family/whānau.

PATIENT PROBLEM / FOCUS	GOAL	ACTIONS What should be done to achieve the goal for this particular person?
PAIN	Patient is pain free • Verbalised by patient if conscious • Pain free on movement • Appears peaceful	Consider need for positional change ☐ _____ _____ _____
AGITATION	Patient is not agitated • Patient does not display signs of delirium, terminal anguish, restlessness (thrashing, plucking, twitching)	Exclude retention of urine as cause ☐ Consider need for positional change ☐ _____ _____ _____
RESPIRATORY TRACT SECRETIONS	Excessive secretions are not a problem	Medication to be given as soon as symptoms arise ☐ Consider need for positional change ☐ Symptom discussed with family/other ☐ _____ _____
NAUSEA AND VOMITING	Patient does not feel nauseous or vomits • Patient verbalises if conscious	_____ _____ _____
DYSPNOEA	Breathlessness is not distressing for patient • Patient verbalises if conscious	Consider need for positional change ☐ Consider existing oxygen therapy ☐
OTHER SYMPTOM (E.G. ITCH, HYPER/ HYOPGLYCEMIA)	_____	_____ _____
MOUTH CARE	Mouth is moist and clean • See mouth care guidelines	Ensure mouth is kept moist ☐ Family/whānau/other involved in care given ☐ _____ _____
BOWEL CARE	Patient is not agitated or distressed due to constipation or diarrhoea	_____ _____ _____
MICTURITION DIFFICULTIES	Patient is comfortable	Observe for distress due to urinary retention ☐ Urinary catheter or pads, if general weakness creates incontinence ☐ _____ _____ _____
FOOD/FLUIDS	Oral intake is maintained for as long as person wishes	Minimum of daily reassessment of intake methods ☐

13

Patient name: NHI: DoB:

CARE PLAN pg 2 of 2

Plan of care developed using information from initial assessment; any known ACP documentation; input from patient/ family/whānau.

PATIENT PROBLEM / FOCUS	GOAL	ACTIONS What should be done to achieve the goal for this particular person?
MEDICATION	All medication is given safely and accurately	If syringe driver in progress check rate and site ☐ _____ _____
MOBILITY / PRESSURE AREA CARE	Patient is comfortable and in a safe environment. Family/whanau are given opportunity to assist with personal cares	Mattress _____ Position changes: _____ Personal Hygiene needs:_____ _____
PSYCHOLOGICAL / INSIGHT SUPPORT	Patient becomes aware of the situation as appropriate	Patient is informed of procedures ☐ Touch, verbal communication is continued ☐ _____ _____ _____
	Family/whānau / other are prepared for the patient's imminent death with the aim of achieving peace of mind and acceptance	Check understanding of nominated family/whānau/others/younger adults / children ☐ Check understanding of family/whānau/others not present at initial assessment ☐ Ensure recognition that the patient is dying and of the measures to ensure comfort ☐ _____ _____ _____
RELIGIOUS / SPIRITUAL SUPPORT	Appropriate religious / spiritual support has been given	Support from Chaplaincy team may be helpful ☐ Consider cultural needs ☐ _____ _____
CARE OF THE FAMILY /WHANAU /OTHER	The needs of those attending the patient are accommodated	Consider health needs and support ☐ _____ _____
CULTURAL SUPPORT	Consider the cultural needs of the patient/ family/whānau	_____ _____ _____
OTHER **E.G. COMMUNICATION**		

Health Professional Name:

Signature: **Date:**

Please turn over for on-going assessment / outcome monitoring chart

OURHEALTH HAWKE'S BAY

Patient name:
NHI:
DoB:

ONGOING ASSESSMENT - OUTCOMES

The goals and action plan must be monitored a minimum of 4 hourly and more often if necessary. Each entry in this monitoring chart indicates the previous 4 hour.

Use the following code to indicate if in the past 4 hours the goals were achieved:
Codes (please enter in columns)

A= Achieved
The Goal was achieved and no additional interventions were required in the previous 4 hours

C = Change
Use this if the goal was not achieved and / or if additional actions were required to maintain the goal
If code C is used – details MUST be provided on the interventions sheet

GOALS FROM CARE PLAN	Date	/ /						/ /					
	Time												
Pain *Patient is pain free* • verbalised by patient if conscious • pain free on movement													
Agitation *Patient is not agitated* • patient does not display signs of delirium, terminal anguish, restless (thrashing, plucking, twitching)													
Respiratory tract secretions *Excessive secretions are not a problem*													
Nausea and vomiting *Patient does not feel nauseous or vomits* • patient verbalises if conscious													
Dyspnoea *Breathlessness is not distressing for the patient* *• verbalised by patient if conscious*													
Other symptoms (e.g. oedema, itch)													
Mouth care *Mouth is moist and clean* • see mouth care guidelines													
Micturition difficulties *Patient is comfortable*													
Medication *All medication is given safely and accurately*													
Nurse initials each set of entries													
		AM		**PM**		**N**		**AM**		**PM**		**N**	
Mobility / pressure area care *Patient is comfortable and in a safe environment*													
Bowel care *Patient is not agitated or distressed due to constipation or diarrhoea*													
Psychological / insight support *Patient becomes aware of the situation as appropriate*													
Family/whanau/other are prepared for the patient's imminent death with the aim of achieving peace of mind and acceptance													
Religious / spiritual support *Appropriate religious / spiritual support has been given*													
Care of the family /whanau/other *The needs of those attending the patient are accommodated*													
Cultural support *Consider the cultural needs of the patient/ family/whānau*													
Other e.g. communication													
Nurse initials each set of entries													

13

ONGOING ASSESSMENT

Patient name:
NHI:
DoB:

PROGRESS NOTES

If code C is used IN THE ON-GOING ASSESSMENTSECTION – details MUST be provided in the patients progress notes – including (PIE) Problem, Intervention and Evaluation

DATE	PROGRESS NOTES	SIGNATURE AND DESIGNATION

Patient name:
NHI:
DoB:

INTERVENTIONS REQUIRED SHEET

What occurred?		Interventions taken		Was intervention effective?		If no, what further interventions was taken?	Initials
				Yes	No		
Date:	Time:	Date:	Time:				
Date:	Time:	Date:	Time:				
Date:	Time:	Date:	Time:				
Date:	Time:	Date:	Time:				
Date:	Time:	Date:	Time:				
Date:	Time:	Date:	Time:				
Date:	Time:	Date:	Time:				

13

TOOLS AND RESOURCES TO GUIDE THE CARE OF PEOPLE IN THEIR LAST DAYS OF LIFE

Additional tools

to assist with decision making and providing information to ensure the physical (tinana), psychological (hinengaro), spiritual (wairua) and family (wairua) wellbeing for all people is upheld.

Tool:	Where to access
1. Identifying the dying patient – flowchart	Information Pack In hospital: Via Nettie Map of medicine – Node: ?
2. Symptom Management Algorithms Hawkes Bay Algorithms	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine – Node: ?
3. Hospital Discharge Checklist	In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine – Node: ?
4. W.H.Ā.N.A.U: personalising care	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine – Node: ?
5. Spiritual care assessment tool (FICA)	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine – Node: ?
6. Breaking bad news flow chart (SPIKES)	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine – Node: ?
7. List of cultural support (Be aware of organisations own resources)	??
Brochures available:	**Where to access**
What to expect when someone is dying -information for family/ whānau	For supplies of brochure contact : ?? Cranford Hospice Telephone 06 8787047
Tissue Donation – information for patients and family/ whānau	For supplies of brochure contact: Donor Co-Ordinator Organ Donation of New Zealand Ph 09 6300935
What to do after death, grief and bereavement support – practical information for family/ whānau	For supplies of brochure contact: Funeral Directors Association of NZ (Inc) P O Box 10888 Wellington 6143 Email: info@fdanz.org.nz Website: www.funeralsnewzealand co.nz

Breaking Bad News Flowchart

Preparation

Check the person's notes to assess what has already been discussed *(don't assume prior discussions have been remembered or understood)*
Check who should be present e.g. family, other health professionals
Set time aside with no distractions e.g. pager, mobile phone
Set the scene and ensure privacy

↓

What does the patient know?

It would help me to know what you understand about your illness, how did it all start, what is happening now? "I am afraid it looks more serious than we had hoped"
(this is about gaining the person's level of understanding and engagement, ACP and EPOA)

↓

Is more information wanted?

"Would you like me to give you more details about your illness?"

↓

Give an alert!.... and…….pause!

"I am afraid that it looks more serious than we hoped"

↓

Allow patient to refuse information at this time

"It must be difficult to accept this?" *(Determine how much they want to know at this time)*

↓

Give Explanation (if requested)

A narrative of events may be helpful

↓

Elicit and listen to any concerns

"What are the main things that you are worried about*?" (Reassure that support is paramount)*

↓

Summarise and plan

"Your main concerns at the moment seem to be…."

↓

Offer availability and support

Offer follow up discussion, e.g. social work referral, church minister, chaplain, cultural support services

↓

Communicate with Multidisciplinary Team and Document

Clearly document conversation in clinical notes and who was present at this discussion

Adaption of SPIKES*

S	**SETTING** up the discussion	• read notes/test results • check who should be present ; involve significant others; is a translator needed? • arrange privacy; think of tissues/water • set time aside with no distractions e.g.pager • mentally prepare self how news will be shared and how to respond to reaction • sit down and make a connection with person/family/whanau
P	Assessing the **PERCEPTION** of condition/seriousness	• use open ended questions to gather how person perceives the situation e.g. What have you been told so far? • listen to their level of comprehension, accept denial but do not confront at this stage; this can correct any misinformation and tailor breaking news to what they already understand
I	**INVITATION** from person to give information	• how much do they want to know "Are you the sort of person who likes to know everything?" • accept the person's rights not to know -"Would you like me to give you all the information or sketch out what has happened and spend more time discussing the treatment plan?"
K	**KNOWLEDGE**: giving facts and information to person	• warning the person that bad news is coming lessens the shock and can facilitate information processing "I'm sorry to tell you that…" "The results are not as good as we hoped" • use language intelligible to person; use diagrams if helpful • consider their emotional state • give information in small chunks; avoid jargon and acronyms • Avoid excessive bluntness and avoid "There is nothing more we can do" as this maybe inconsistent with their own goals such as good pain relief and control
E	**EXPLORE** emotions and empathize	• observe and identify emotions expressed by person "You appear sad" "I can see how upsetting this is for you" • what strategies/mechanisms have they used in the past to deal with bad news? • do they have a particular outlook on life/cultural/spirituality that helps • who are the important people in their life
S	**STRATEGY & SUMMARY**	• draw up plan with person "Your appointment to see Mrs Brown the oncologist is on…" "You are going to contact the funeral director…" • consider immediate plans – what are you doing next; who will you tell/how will you tell them; how will they cope? • have person repeat key points to ensure that they have understanding • does anything need to be clarified or any other questions? • by understanding person's goals, hope can be fostered to help them accomplish their goals • offer other professional support e.g. Chaplain, cultural support, social work referral, funeral director • document/communicate discussion/plan with other professionals that need to know • close the meeting

- Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. Oncologist 2000;5(4):302-311.
- Kayleigh Steel, Michael Kennedy, Sean Prendergast, Christina Newton, Andrew MacGillivray and Aileen D'Arcy www.physio-pedia.com/File:SPIKES_Table.jpg

OURHEALTH HAWKE'S BAY

First Name: _____ **Gender:** _____

Surname: _____

AFFIX PATIENT LABEL HERE

Date of Birth:_____ **NHI#:** _____

Ward/Clinic: **Consultant:**

DISCHARGE CHECKLIST FOR A PERSON IN THEIR LAST DAYS OF LIFE

CHECKLIST	YES	NO	N/A	Signed	Date	Comment
Does the person have a preferred place of care						
Person/family are aware of prognosis						
Person's main nominated contact supports decision for discharge						
Not for Resuscitation complete						
Ambulance booked – aware of Not for Resuscitation						
GP or nominated other aware of discharge and arrangements made for GP to visit.						
Hospice is aware of discharge						
District Nurse updated of care needs and discharge date and time (inclusive of Rural/CHB and Wairoa)						
Aged Residential Care updated of care needs and discharge date and time						
Assessment completed by Needs Assessment Co-Ordination Agency (Options HB) and individual care package in place						
Other MDT members aware e.g. social worker, OT, physio						
Current medication assessed and non essential medication discontinued						
Discharge medication/s ordered: **Appropriate subcutaneous AND anticipatory medication prescribed and faxed to pharmacy.**						
If person is being discharged with a continuous infusion pump. Complete appropriate Discharge Checklist.						
Person/family understand the discharge medication						
Equipment delivered/planned e.g. electric bed, mattress,						
Oxygen arranged if applicable.						
Circle of Support has been completed and documented who is the first point of contact.						

W.H.A.N.A.U: Personalising Care At End-Of-Life

Source: Batten et al (2014)

This has been designed as a prompt card providing potential conversation starter questions to guide conversations about end of life. The background image of Te Whare Tapa Whā (Durie 1985) reminds of the need for a holistic approach to care and W.H.A.N.A.U. guides conversations to ensure that care for people can be personalised.

Spiritual Care Assessment Tool Based on FICA Approach

Source: Puchalski and Larson (1998)

Background

The FICA Spiritual History Tool was developed by Dr Puchalski and a group of primary care physicians to help physicians and other healthcare professionals address spiritual issues with patients. Spiritual histories are taken as part of the regular history during an annual exam or new patient visit, but can also be taken as part of follow-up visits, as appropriate. The FICA tool serves as a guide for conversations in the clinical setting.

Suggested questions

These should be adapted to suit each person and revisited as patient circumstances change.

Faith	What things do you believe in that give meaning/value to your life? **and/or:** Do you consider yourself spiritual or religious? **and/or:** **and/or:** What is your faith or belief?
Importance	In what ways are they important to your life? **and/or:** What influences do they have on how you take care of yourself?
Influence	**and/or:** How are your beliefs/values influencing your behaviour during your illness? **and/or:** In what ways do your beliefs/values help you in regaining your health/wellbeing?
Community	Is there a person or group of people who you love or who are very important to you? **and/or:** How is this supportive to you? **and/or:** Do you belong to a religious/cultural community?
Address	Is there anything we can do to help you while you are with us? **and/or:** Would it help to talk to someone about these issues?

An example of a spiritual assessment in a non-religious person

F Naturalist

I Feels at one with nature. Each morning she sits on her patio looking out over the trees in the woods and feels 'centered and with purpose"

C Close friends who share her values

A After discussion about belief, she will try to meditate, focusing on nature, on a daily basis to increase her peacefulness

You can refer to the faith leader or Chaplaincy Department at any time, but some specific situations may include:

- When one's own belief system prohibits involvement in the spiritual/religious/cultural care of the patient
- When spiritual or religious/cultural issues seem particularly significant in the patient's suffering
- When spiritual or religious/cultural beliefs or values seem to be particularly helpful or supportive for the patient
- When spiritual or religious/cultural beliefs or values seem to be particularly unhelpful for the patient
- When addressing the spiritual or religious/cultural needs of a patient exceeds your comfort level
- When specific community spiritual or religious/cultural resources are needed
- When you suspect spiritual or religious/cultural issues which the patient denies
- When the patient or family have specific religious needs e.g. Confession, Holy Communion, Sacrament of the Sick, needs a prayer mat or private space to pray, sacred texts, etc
- When the patient's family seem to be experiencing spiritual/emotional pain or trauma
- When members of staff seem to be in need of support.

HAWKE'S BAY District Health Board Whakawāteatia	**Request for Alcohol Free Health Awards**
	For the attention of: **Māori Relationship Board**
Document Owner: Document Author:	Tracee TeHuia, ED Strategic Services Heather Skipworth, Deputy Chair MRB
Reviewed by:	N/a
Month:	August
Consideration:	Discussion

RECOMMENDATION

That the Māori Relationship Board

Recommend this proposal to the Board to make the Hawke's Bay Health Awards an alcohol-free event.

BACKGROUND

> *How appropriate is it to serve alcohol (a health-harming substance) at an event that celebrates health?*

In consideration of the increasing rates of alcohol related harm in the Hawke's Bay community,[1] it is important that the Hawke's Bay District Health Board (DHB) demonstrate leadership by insisting on alcohol-free environments for staff, visitors and the general public.

In 2016, Hawke's Bay DHB adopted a Position Statement around alcohol with the vision of *"…healthy communities, family and whanau living free from alcohol related harm and inequity".* In adopting this position, the DHB have affirmed that alcohol is a priority health and equity issue in Hawke's Bay. This position statement also makes clear that "...the widespread promotion of and accessibility to alcohol has a significant role to play in people's drinking behaviour."

In addition, the draft Hawke's Bay DHB Alcohol Harm Reduction Strategy 2017-2022 is set to be presented to the Board for approval in September 2017 and, once approved, will reinforce the Health Board's responsibility as a leader in reducing alcohol related harm in the region.

As such, we believe that making alcohol freely available at the upcoming Hawke's Bay Health Awards normalises alcohol use in a health setting and is incompatible with the DHB's commitment to reducing alcohol related harm.

[1] 1 in every 4 adults in Hawke's Bay is a hazardous drinker and Hawkes Bay has higher rates of hazardous drinking that the rest of the country.

Leadership has already been demonstrated in this area. Ngāti Kahungunu Iwi Incorporated have, since 2014, shown that an alcohol-free stance is both possible and effective. All iwi events—for example, Annual Sports Awards and Waitangi Day celebrations—are alcohol-free and remain popular and well-attended. Their stance has been applauded and received much positive media interest.

It is recommended that the Hawke's Bay District Health Board follow this progressive response and demonstrate to the community and to the wider health sector that protecting our most vulnerable communities from alcohol related harm[2] by reducing availability and denormalising alcohol use requires meaningful reflection on our own practices and leadership by example.

It is our belief that the time is right for the Hawke's Bay District Health Board to become a credible role model and commit to being an alcohol-free organisation.

Attached as appendix one is the Hawke's Bay District Health Board Alcohol Harm Reduction Strategy 2017-2022 providing background and discussion that went to the Executive Management Team in June 2017.

[2] This includes injury, violence, and exclusion from society, foetal alcohol spectrum disorder, cancer and chronic conditions.

Appendix One

Tackling Alcohol Harm in Hawke's Bay

DRAFT

Hawke's Bay District Health Board
Alcohol Harm Reduction Strategy

2017-2022

Prepared by: Jessica O'Sullivan for Hawke's Bay District Health Board
Peer Reviewed by: Dr Rachel Eyre, Hawke's Bay District Health Board

Contents

1. Executive Summary

In Hawke's Bay, one in every four adults is a "hazardous drinker"[1]. Hawke's Bay also has higher rates of hazardous drinking than the rest of the country and our hazardous drinking rates are increasing over time.

There is no doubt that we are at the beginning of a long journey to change our national drinking culture and, ultimately, reduce alcohol related harm and inequity in our community. We know that the levers which hold the greatest promise (and evidence base) for effecting change (such as price control, drinking age, accessibility and sponsorship/advertising) are largely outside of Hawke's Bay DHB's control.

We also know that the harm caused by alcohol is significant, and, over time, will place an increasing burden on the health system through injury, violence, foetal alcohol spectrum disorder, cancer and chronic conditions, to name a few. So regardless of progress at a national level, we need to identify what can be done locally, and make a start.

In 2016, Hawke's Bay DHB adopted a Position Statement around alcohol, with the vision of *"Healthy communities, family and whānau living free from alcohol-related harm and inequity".* In adopting this Position, Hawke's Bay DHB drew an important line in the sand, acknowledging that alcohol is a priority health and equity issue for Hawke's Bay.

This Alcohol Harm Reduction Strategy has been developed for, and by, the DHB and health sector in Hawke's Bay, but the strategies and actions identified reach far beyond the control of the health sector. Partnerships across sectors and throughout our community to reduce alcohol harm are essential.

Given the sheer size, scale and complexity of the task at hand, it is simply not possible to do everything that needs to be done at once and it is critical that the DHB prioritises carefully, particularly where additional resources are required. There is a significant amount of work which is already part of "business as usual" (such as licensing work) and this should continue. In terms of new investment, the following three areas of focus have been identified as priorities for the next five years:

- **Health services**
- **Young people**
- **Unborn babies**

Each of these focus areas require further engagement and planning. For young people and unborn babies, broader inter-sectoral approaches will be necessary and strategies will need to consider the contexts of, and influences on, the target populations. In the case of unborn babies (to prevent foetal alcohol spectrum disorder), this might include the role of whānau and community in supporting pregnant women not to drink and in the case of young people, the influence of parent/whānau role modelling and the school environment.

Planning in each of these areas must achieve the right balance of universal (i.e, whole of population) and targeted approaches to ensure that we achieve the vision of reducing alcohol-related harm and inequity in our community. DHB and health sector leadership, together with Māori and Pasifika leadership, will be integral to achieving this.

[1] This means they are likely to be harming their own health or causing harm to others through their behaviour.

2. Background

1.1 The journey this far

Work to elevate alcohol harm as a health sector priority has been underway for a number of years now, and the development of this Strategy signals an important milestone in this journey. A timeline of activity leading up to this point is set out in Appendix 1 and the most recent activity is discussed below.

In November 2016, Hawke's Bay DHB adopted a Position Statement around alcohol, with the vision of *"Healthy communities, family and whānau living free from alcohol-related harm and inequity".*

In May and June of 2017, a number of key health sector stakeholders were engaged in discussions around potential areas of focus and service gaps. On 5th July, a workshop was held with health sector stakeholders at which there was strong support for the strategic framework set out in this Strategy (Appendix 2), and some useful discussions around the proposed priority focus areas.

1.2 Why do we need to take alcohol-related harm seriously?

Despite its wide social acceptability and "normalisation" in New Zealand society, alcohol is no ordinary commodity. Alcohol is a toxin, an intoxicant, and an addictive pyschotropic drug. It has been classifed as a Group 1 carcinogen (carcinogenic to humans) by the World Health Organisation, alongside substances such as asbestos and formaldehyde.

It is also the drug that causes most harm to the most people in New Zealand.

Every year around 600-800 New Zealanders die from alcohol-related causes and the harm caused by alcohol is estimated to cost an overall $6.5 billion per year.

In Hawke's Bay, based on hospital bed days alone, alcohol-related harm is conservatively estimated to cost $3 million per year (2014-15).

1.3 What does alcohol-related harm look like in Hawke's Bay?

One in every four adults in Hawke's Bay is a "hazardous drinker". This means they are likely to be harming their own health or causing harm to others through their behaviour.

The Hawke's Bay population as a whole is drinking more hazardously than New Zealand with hazardous drinking rates in this region 60% higher than nationally. Moreover, hazardous drinking rates appear to be increasing over time.

Significant inequities also exist, with higher rates of hazardous drinking by Māori compared with non-Māori, and higher hospitalisation rates for alcohol-related conditions for Māori and for women.

The age group with the highest rates of hazardous drinking is 15-24 years where, in Hawke's Bay, 41% of this age group are drinking hazardously.

In a recent community survey in Hawke's Bay, two-thirds of respondents said that alcohol has a negative impact in their community.

1.4 What works to reduce alcohol related harm?

The strongest measures for reducing alcohol-related harm are at the national policy level and involve increasing price, reducing availability (e.g. limiting exposure, hours and outlet density), increasing the drinking age and reducing advertising and sponsorship.

Locally, the opportunity exists for communities to have more say to reduce availability through the Local Alcohol Policy (LAP) process and Sale and Supply of Alcohol Act (2012) licensing decisions, but to date there has been limited success in this regard both locally and nationally.

Screening and brief intervention[2] approaches, for example in the hospital (ED), primary care, maternity and in settings which can achieve wider community reach is a proven cost-effective and effective strategy to reduce alcohol-related harm.

The next 'best buys' at a DHB level include a range of community-level interventions that aim to delay drinking in young people, reduce harm to Māori, Pasifika and pregnant women and seek to reduce availability (limiting both demand and supply). In the absence of a 'single fix', evidence suggests that clustering interventions can make a difference.

3. Strategic Framework Overview

The strategic framework in Appendix 2 has been developed to guide future DHB and health system action and investment around alcohol over the next five years. This framework is closely aligned to the National Drug Framework and has been endorsed by a wide range of sector stakeholders.

The overall goal is *"Healthy communities, family and whānau living free from alcohol-related harm and inequity".* To achieve this goal, four key outcomes have been identified:

- Delayed uptake of drinking by young people;
- Reduced hazardous drinking across the whole Hawke's Bay population;
- Reduced hazardous drinking within priority populations (Māori, Pasifika, young people and pregnant women); and
- Reduced illness, injuries and deaths from alcohol.

The key objectives required to achieve these outcomes can be divided into three areas:

- Reducing **demand** for alcohol by addressing the underlying drivers of alcohol use, and influencing societal attitudes towards alcohol (i.e. our drinking culture);
- Influencing the **supply** of alcohol, by addressing the availability of alcohol and the exposure to alcohol in our everyday lives;
- Providing appropriate, accessible and timely **services** for those who need help with their drinking.

The strategic framework then identifies a range of strategies and approaches required to achieve these objectives, including raising community awareness and de-normalising drinking, strengthening our impact on licensing decisions, incorporating alcohol screening and brief intervention into normal clinical routine by health professionals in general (i.e. not limited to the addiction sector), and addressing service gaps and barriers to ensure timely and appropriate treatment services.

Given the sheer size, scale and complexity of the task at hand, it is simply not possible to do everything that needs to be done at once and it is critical that the DHB prioritises carefully, particularly where additional resources may be needed. The strategic framework therefore identifies three priority focus areas where stakeholders believe the greatest gains can be made over the next five years:

- Health services;
- Young people; and
- Unborn babies.

In the case of young people and unborn babies, strategies need to take into account the broader context of the target group. For example, the role of whānau and community in supporting pregnant women not to drink, and the role of parents/whānau and the school environment in young people's decisions around drinking.

[2] Brief intervention is a short, purposeful, non confrontational, personalised conversation with a person about an issue related to alcohol, tobacco, other drug use and/or gambling (i.e. any or all of these) (Matua Raki, 2012)

Planning in each of these areas must achieve the right balance of universal (i.e. whole of population) and targeted approaches to ensure that we achieve the vision of reducing alcohol-related harm and inequity in our community. Leadership (in its many forms, discussed in section 4.2 below) will be integral to achieving this, and with the exception of work to develop health services, success in all areas will require inter-sectoral partnerships.

4. Building Blocks

There is no doubt that we are at the beginning of a very long journey to reduce alcohol related harm and inequity in our community. Therefore, the initial focus must be on constructing the "building blocks" needed to support the long term, transformational change which lies ahead.

1.5 Governance and delivery structures

A system-wide approach will be necessary to tackle alcohol harm and as such, this Strategy will require a high level of 'ownership' and accountability. At this stage, it is envisaged that the DHB's Clinical Council would be well placed for this role with a possible second "tier" of governance in the form of an alcohol harm reduction steering group with representation across the health system.

The operational steering and delivery structure remains a "work in progress" with responsibility for internally focused DHB work allocated to the Executive Director Provider Services (also to the Executive Director Primary Care once they start) and responsibility for externally focussed work (i.e. with communities and other sectors) allocated to the Executive Director for Strategic Health Improvement.

Given the wider, inter-sectoral nature of the priority focus areas around young people and unborn babies, there is likely to be an important role for a governance structure outside of the DHB (for example, the Intersector Forum).

Next steps:
- Confirm Clinical Council as governance body for DHB work to reduce alcohol harm;
- Executive Director Provider Services, Executive Director Primary Care and Executive Director Strategic Health Improvement to agree coordinated steering and delivery structure of internally and externally focussed work.

1.6 Leadership

Leadership is an essential building block for change and, in the case of alcohol, will come in a number of different forms, including:
- DHB Board and Executive Management leadership;
- Clinical and health service leadership;
- Māori and Pasifika leadership;
- Inter-sectoral leadership; and
- Community leadership - community leaders and champions, schools, workplaces etc.

Examples of leadership include Ngāti Kahungunu Iwi Inc's alcohol free policy for all whānau events, and the recent example of the MAC rugby club in Flaxmere becoming alcohol-free.

Next steps:
- Review Hawke's Bay DHB's Alcohol Policy (including the provision of alcohol at the Health Awards);
- Identify ways to communicate health sector leadership to the community;
- Advocate at a national level for stronger policy levers to reduce alcohol related harm.

1.7 Inter-sectoral action

The provision of health services is the only area within the proposed programme of action which lies entirely within the control of the DHB and health sector. Success in all other areas will require partnerships with non-health sector stakeholders. Influencing youth drinking, in particular, will require broad engagement across our community including with schools, training institutions, social sector partners, NGOs and many more.

Next steps:

- Advocate in inter-sector forums to establish alcohol harm reduction as a priority for joint action and for role modelling by agencies, Councils and the DHB through, for example, alcohol policies and alcohol-free events;
- Work with the education sector to advance a whole of school approach to alcohol, including alcohol-free fundraising events (with a target of zero alcohol special license applications being received from schools for fundraising where minors are present).

1.8 Performance and measurement framework

Over the first 12 months of this Strategy, the four key outcomes set out in the strategic framework will need to be "unpacked" into a comprehensive system-wide outcomes framework which includes short, medium and long term measures and targets, including in each of the priority focus areas, to enable progress to be tracked and reported.

The outcomes framework will draw on the set of alcohol harm reduction indicators being prepared for DHBs by Massey University and will include the new mandatory Emergency Department data (commencing from July 2017) which will help Hawke's Bay DHB to monitor the extent of alcohol related harm, the burden on the health system and the effectiveness of any interventions.

Next steps:

- Identify and assign responsibility for the development of a performance and measurement framework for alcohol harm;
- Performance framework to include system level measures as well as population level health outcomes.

5. Priority Focus Area – Health Services

The strongest lever this DHB holds to reduce alcohol related harm lies in the health workforce itself. Not only are people working in health in a position to advise and influence the patients and clients they work with, they are also the largest single workforce in Hawke's Bay – in itself, a captive audience for building community awareness around hazardous drinking.

With clear evidence now available around the harms caused by hazardous drinking and the benefits of screening and brief intervention, a conversation about alcohol can – and should – become part of routine clinical practice.

There are a number of barriers that need to be overcome in order for screening and brief intervention to become part of the normal clinical routine, perhaps the most important of which is that health professionals need to have the skills (and therefore the confidence) to have an effective conversation about alcohol.

Opportunities also exist to build alcohol into the wider "healthy lifestyle" context and associated programmes.

Next steps:
- Convene a steering group and project planning group to develop an action plan focussed on building the systems and workforce capacity and capability required to implement alcohol screening and brief intervention.

6. Priority Focus Area – Young People

Remaining alcohol free throughout childhood and into adolescence is important to ensure a healthy start to life. There is now clear evidence that early uptake of alcohol is a strong predictor for ongoing problems in adult life, including alcohol and substance dependence. It is encouraging that (according to national survey data) more young people are choosing not to drink alcohol and when they do drink, they are drinking at less harmful levels.

Strategies to reduce and delay youth drinking include:
- Reducing the exposure of young people to alcohol promotion and sponsored events;
- Addressing the drivers of youth drinking;
- Delivering clear, consistent and positive messaging;
- De-normalising alcohol and providing opportunities for "fun" without alcohol;
- Whole of school approaches;
- A health workforce skilled in "youth friendly" approaches to identify alcohol issues and intervene early;
- Appropriate counselling and treatment services.

Parents and whānau have an important role to play in reducing youth drinking, through role modelling and having the skills to guide their young person through the risk taking years. A focus on youth also provides a less confrontational way of encouraging the adult population to think about their own drinking.

The need to engage young people in education, training and employment has been identified as a key goal of the Hawke's Bay Social Inclusion Strategy and addressing youth drinking has an important role to play in achieving this goal.

Next steps:
- Identify appropriate governance body (Executive Director, Strategic Health Improvement);
- Convene a project planning group to develop an action plan around youth drinking with broad cross-sector representation and strong youth leadership and participation.

7. Priority Focus Area - Unborn Babies

Hawke's Bay DHB has made good progress over recent years in recognising Foetal Alcohol Spectrum Disorder (FASD) and taking action to address FASD within its clinical services. There is strong leadership and mobilisation around FASD and the next step is to focus on prevention and early intervention.

There are still myths and misconceptions about drinking during pregnancy (both at a community level and within the health workforce itself) which need to be addressed as a matter of urgency through the development of consistent messages, supported by:

- Environments and communities which support women to abstain from drinking during pregnancy;

- Whānau and community support mechanisms;
- Primary prevention approaches within schools;
- Screening and brief interventions (midwifery and general practice);
- Clear referral pathways for women in need of support.

The message that there is no safe amount of alcohol which can be consumed in pregnancy must take into account that, most often, women don't drink alone and are influenced by those around them. Strategies to prevent FASD must avoid making drinking during pregnancy the sole responsibility of the pregnant woman, but rather employ community development approaches to create an environment and support system in which pregnant women are supported not to drink.

Next steps:
- Identify appropriate governance body (Executive Director, Strategic Health Improvement);
- Convene a project planning group to develop a FASD prevention plan;
- DHB Population Health Team to lead this work.

8. Treatment Services

As community awareness grows, and as the clinical workforce begins to build screening and brief intervention into its normal clinical routine, we can expect an increased demand for treatment services. Some gaps are already known, for example services for young people, pregnant women, and adults with moderate levels of hazardous drinking and more may emerge over time.

Without appropriate treatment services in place, strategies to implement screening and brief intervention, to reduce youth drinking and to support pregnant women to abstain during pregnancy will fail. This is because health professionals need to be confident that when they identify problem drinking beyond their ability to manage that they can refer. It is therefore critical that an assessment of treatment services is incorporated into the planning for all priority focus areas.

Next steps:
- Governance body to ensure appropriate input from treatment services across all priority focus areas.

9. Communications and Messaging

Communications and messaging have a critical role to play in implementing this Strategy. Across all three priority focus areas, key messages need to be agreed and communicated consistently across the whole community. An overarching communications and media plan will need to be developed to support each of the priority focus areas, to create more visibility around the role of licensing in addressing alcohol harm and to elevate "alcohol" into the consciousness of our community.

Next steps:
- Ensure communications expertise is included in all action planning around priority focus areas;
- Develop overarching communications plan to support Strategy implementation;
- Work with Iwi and hauora providers to ensure culturally appropriate messaging that is strengths based and encompasses a broad hauora approach.

10. Business as Usual

There is a lot of work around alcohol which forms part of the DHB's "business as usual" and this should continue, such as licensing and regulatory work and health promotion activity around key events and host responsibility. Some new work is planned, including a project to help mobilise communities to get involved in licensing policy and decision making processes.

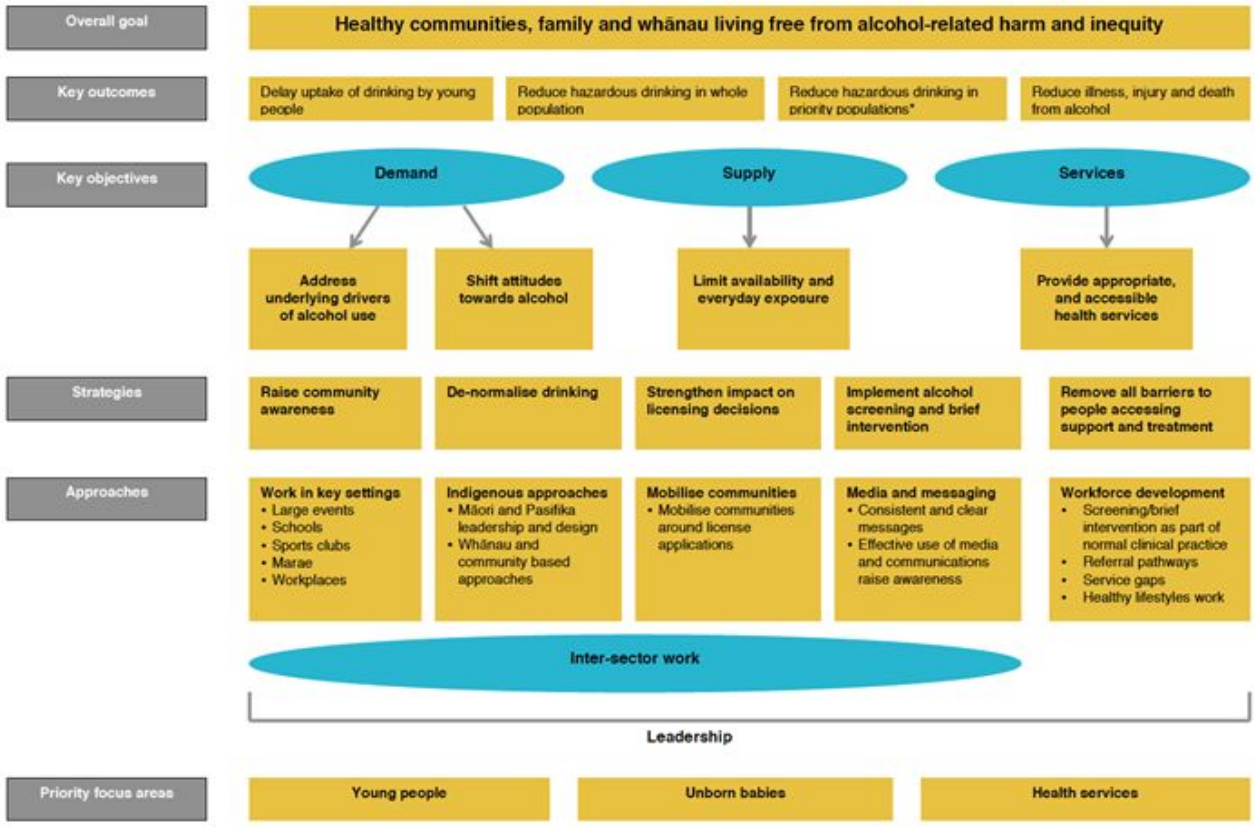
Next steps:

- Undertake project to increase community participation in licensing decisions;
- Continue to work proactively with large event organisers to denormalise drinking and reduce harm;
- Participate in the development of Wairoa's Local Alcohol Policy to ensure it is responsive to community needs;
- Support community initiatives around alcohol (including for example Safer Communities projects and the social supply project in Wairoa).

Appendix 1: Timeline of activity leading into the development of this Strategy

Activity	Date
"First" DHB alcohol strategy planning workshop with key DHB alcohol stakeholders (subsequently referred to as 'Alcohol Advisory Group')	4 Feb 2016
Second meeting of Alcohol Advisory Group	21 March 2016
Production of video clip to support Position Statement https://vimeo.com/174437689	April-June 2016
Dr Paul Quigley presents to DHB Grand Round about screening and brief intervention in the Wellington Emergency Department	May 2016
Prof Jennie Connor & Doug Selman visit to Hawke's Bay around causal relationship between Alcohol and Cancer	Aug 2016
Presentations to DHB Committees (two rounds) including Issues/Discussion paper followed by Draft Position Paper	June-Sept 2016
Foetal Alcohol Awareness day awareness raising by HBDHB	Sept 2016
DHB Board adopts Position Statement	Nov 2016
Alcohol Advisory Group re-convened to oversee stakeholder engagement process and strategy development	2 May 2017
Stakeholder engagement process	May/June 2017
Alcohol Advisory Group meeting to review results of stakeholder engagement process	7 June 2017
Stakeholder workshop – stakeholder engagement results and draft strategic framework presented	5 July 2017
Strategy to DHB Committees and Board for approval	July/Sept-2017

Appendix 2: Strategic Framework



* Priority populations: Young people, Māori, Pasifika, Pregnant women

HAWKE'S BAY District Health Board Whakawāteatia	**Ngātahi Vulnerable Children's Workforce Development Programme - briefing paper**
	For the attention of: **HSLT, EMT, MRB, Board**
Document Owner: Document Author(s):	Tracee Te Huia ED Strategy and Health Improvement, Senior Responsible Owner Dr Russell Wills, Project Sponsor
Reviewed by:	Tracee Te Huia
Month:	August 2017
Consideration:	For Information

15

RECOMMENDATION

That you

Note the contents of this report.

OVERVIEW

Ngātahi is a large, cross-sector, workforce development programme for the vulnerable children's workforce, funded jointly by HBDHB, MSD and the Lloyd Morrison Foundation. Dr Russell Wills is project sponsor and Bernice Gabriel (CAFS senior psychologist on secondment) is the project manager. The project currently includes 24 health, education and social sector agencies and services in Hawke's Bay and around 450 staff. Government and NGO, kaupapa Māori and mainstream services are involved.

BACKGROUND

Tamariki of parents with mental illness, addictions, and in violent relationships ("vulnerable children") are at high risk of poor health, education and social outcomes. Māori are highly over-represented among these families/whānau.

Recognising this, Government has embarked on a programme to reform the way these families and whānau are supported, including changes to legislation and accountabilities of Ministry Chief Executives, Child, Youth and Family evolved to Oranga Tamariki, implementation of multi-agency Children's Teams in ten sites, additional funding and changes to expectations and monitoring of all agencies with a part to play in supporting such families.

The workforce serving such families sometimes lacks the skills to identify these families, assess both strengths and risks, formulate an assessment, design and implement a support plan with families and work collaboratively with the agencies involved. It is widely accepted that these skills are necessary but some essential skills may not be taught at undergraduate level and may be weak or missing in some professionals working with vulnerable children and families.

Government's structural changes are essential but will not achieve what is hoped for if the skills required within the workforce are not strengthened. For these reasons the Ministry of Social

Development Children's Action Plan Directorate began a programme of work to develop a *Vulnerable Children's Core Competency Framework*, in partnership with sector leaders from education, health and social services. The framework was extended by Child, Youth and Family (now Oranga Tamariki). It is still in development but sufficiently well-developed to trial in one region (HB).

The Ngātahi project aims to map the skills and learning needs of health, education and social service professionals in Hawke's Bay working with vulnerable children and families, and design, implement and evaluate a development plan for the workforce over three years.

Because the majority of whānau served by the vulnerable children's workforce are Māori, correct tikanga is essential for this programme. Principles such as aroha, tika and pono, rangatiratanga, whakamanawa and kaitiakitanga, cultural competence and cultural safety will be fundamental to the programme. We have agreed to take a *tuakana-teina* (elder sibling/leader - younger sibling/ learner) approach. This allows services and practitioners to take roles, rather than be judged or graded. Most servies have something to offer as a leader and I have asked all services to share staff to teach and resources that will support practice change, such as job descriptions, appraisal forms and teaching packages. I believe most teaching needs at Foundation level should be met within the resources of local services. This saves money but also strengthens relationships, fostering collaborative practice. Services leaders are supportive of this approach.

Progress to date
Bernice Gabriel was appointed in early March as project manager. Bernice is a clinically credible leader, widely respected in the sector, and founded the Fostering Security programme for caregivers of children in CYF care, in partnership with CYF (now Oranga Tamariki).

The first phase of the project was to socialise the concept, seek support and advice from managers and service leaders, gain agreement on the framework and map staff competencies against it. A hui on 4th May brought together leaders of 25 health, education and social sector agencies representing around 450 staff. Leaders agreed on descriptions of each competency and the tiers of competency required by each sector.

We have made several visits to services and there is unanimous support to date. Bernice continues to visit services, particularly to socialise the programme with staff, finalise with leaders the competencies they expect of their staff, support leaders in their competency mapping with staff, and identify who the leaders (tuakana) are.

We expect all competency mapping to be complete (including data entry) by the end of September. This will allow us to plan the training schedule for 2018 including agreeing programme content, teachers (tuakana) and trainees (teina), venues and logistics. The Child, Adolescent and Family Service (CAFS) are slightly ahead of the rest of other agencies, having completed competency mapping and begun approaching training providers. We hope to begin their training programme this year, which will involve specialist trainers from outside Hawke's Bay.

Research and evaluation
Prof Kay Morris Matthews of EIT has been contracted to provide the evaluation of this phase of the project. Kay and her team have begun interviews with CAFS staff on their experience of competency mapping and will extend this to other agencies shortly. The evaluation will demonstrate whether or not competencies improve, if this leads to practice change, and if this leads to improved outcomes. An early paper describing the project is expected.

Next steps
The end product of the first year of the project will be a business case for the development programme in 2018 and 2019.

FINANCIAL IMPLICATIONS OR OTHER KEY ISSUES AS REQUIRED

A business case for staff development in 2018 and 2019 will be prepared following analysis of the competency mapping. This is an entirely voluntary process. We do not yet know what competencies will be prioritised by sector leaders or how much resource (staff time and back fill, tuakana time) they will be able to contribute. The business case will be written in December when these are known.

ATTACHMENTS:

Ngatahi Terms of Reference

Competency Framework

List of services involved

Agencies/Services Participating in the Ngātahi Project

1 HBDHB – Child Development Service (CDS)
2 HBDHB - Child, Adolescent & Family Service (CAFS)
3 HBDHB – Family Violence & Child Protection Programme
4 HBDHB – NASC
5 HBDHB - Public Health Nurses
6 HBDHB – Te Ara Manapou (Parenting & Pregnancy Service)
7 Te Kupenga Hauora
8 Roopu a Iwi
9 NZ Police
10 Youth Horizons
11 Ministry of Education
12 Birthright HB Child & Family Care
13 Napier Family Centre
14 Ikaroa Rangatahi
15 Ministry for Vulnerable Children Oranga Tamariki (Napier)
16 Awhina Whanau Services
17 Open Home Foundation
18 Resource Teachers- Learning & Behaviour (RTLB)
19 Ministry for Vulnerable Children Oranga Tamariki (Hastings)
20 Directions Youth Health Service
21 Dove Hawkes Bay
22 Family Works
23 Te Taiwhenua o Heretaunga (Mental Health, Tamariki Ora, Family Start)
24 Plunket

Agencies still to reply with dates for visit to discuss mapping:

25 Choices

HAWKE'S BAY District Health Board

Terms of Reference

Project Details

Project Name	Ngātahi Vulnerable Children's Workforce Development
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Project Sponsor	Dr Russell Wills
Project Manager	Bernice Gabriel
Authors:	Dr. Russell Wills and Bernice Gabriel
Reviewed By:	Kate Rawstron

Authorisation

This document authorises the project manager to undertake the delivery of this project. There can be no changes to this document without Project Sponsor sign off of any amendments. This is a formal written process utilising the HBDHB project templates and procedures for change control.

Tracee Te Huia

Senior Responsible Owner **Date**

Dr Russell Wills

Project Sponsor **Date**

Bernice Gabriel

Project Manager **Date**

Kate Rawstron

Project Management Office Manager **Date**

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1. BACKGROUND

Tamariki of parents with mental illness, addictions, and in violent relationships ("vulnerable children") are at high risk of poor health, education and social outcomes. Māori are highly over-represented among these families/whānau. Recognising this, Government has embarked on a programme to reform the way these families are supported, including changes to legislation and accountabilities of Ministry Chief Executives, reform of Child, Youth and Family, implementation of multi-agency Children's Teams in ten sites, additional funding and changes to expectations and monitoring of all agencies with a part to play in supporting such families.

The workforce serving such families lack many of the skills to identify these families, assess both strengths and risks, formulate an assessment, design and implement a support plan with families and work collaboratively with the agencies involved. It is widely accepted that these skills are necessary. But often some essential skills are not taught at undergraduate level and are weak or missing in many professionals working with vulnerable children and families.

Government's structural changes are essential but will not achieve what is anticipated if the skills required within the workforce are not strengthened. It is for these reasons the Ministry of Social Development Children's Action Plan Directorate began a programme of work to develop a Vulnerable Children's Core Competency Framework, in partnership with sector leaders from education, health and social services. The framework is still in development but sufficiently well-developed to trial in Hawke's Bay.

The Ngātahi Project is a multi-agency, collaborative project to assess the skills and learning needs of health, education and social service professionals in Hawke's Bay and will leverage the Vulnerable Children's Core Competency Framework. Agencies working with vulnerable children and families will be invited to actively collaborate in designing, implementing and evaluating a development plan for the workforce over three years. In Hawke's Bay, the project involves the Ministry of Social Development (MSD), Ministry of Vulnerable Children Oranga Tamariki (MVCOT), Hawke's Bay District Health Board (HBDHB), Ministry of Education (MoE) Hawke's Bay, The Lloyd Morrison Foundation, Eastern Institute of Technology (EIT) and local services involved in caring for vulnerable children and their families.
All aspects of this project – values, goals, scope, methodology, benefits and measures - will be discussed and agreed with policy decision-makers, funders, local executives, operational leaders and other key stakeholders before the project begins.

Because the majority of whānau served by the vulnerable children's workforce are Māori, correct tikanga is essential for this programme. Principles such as aroha, tika and pono, rangatiratanga, whakamanawa and kaitiakitanga, cultural competence and cultural safety will be fundamental to the programme. A hui was held on Monday 7th November 2016 including members of the Maori Relationship Board and Consumer Council, facilitated by staff of the Hawke's Bay District Health Board Maori. The values and principles outlined below were highlighted as important in underpinning the Ngātahi Project.

Values and Principles

What should be the key foundational Values and Principles of the workforce development programme? *(Facilitator Laurie Te Nahu)*

1. Must be located within the strengths of the Whānau collective.
2. The health, wellbeing and safety of the child is paramount, however, must be considered within the needs of the Whānau.
3. Facilitation skills must coordinate best practice and include enhancing the mana of the Whānau over-all.

4. The intention of facilitating best practice should empower and enable the whole Whānau to participate in finding solutions.
5. The concept of Kaitiakitanga implies a Duty to Act and Care for people.
6. Key aspects of whanaungatanga (Family roles and responsibilities include accountability for the care of the child (ren).
7. A wholistic approach (able to deal with a range of variables/diversities identified through the facilitation process.
8. Honesty (the ability to have the courage to make a stand, and, or go the extra mile in working through difficult situations).
9. Kanohi Ki te Kanohi (the ability to face the difficulties head on in sometimes complex situations).
10. Tika/Pono (remain truthful and righteous particularly working with stretched Whānau dynamics).
11. Hui (full and active participation in decision-making is important).
12. Wānanga (as a place to impart knowledge, skills, and experience in order to gain competency).

Key Note: A key principle should involve the concept of Rangatiratanga: key aspects for the application of the above elements could be encapsulated in; displaying the qualities of a Rangatira including integrity, generosity, bravery, humility, respect, commitment to the Whānau/community, using facts and honest information, as well as legends and stories to make a case, relay a message, or explain things in a way which binds people together, i.e. facilitating rather than commanding.

2. PROJECT GOAL

The aim of this project is to design, implement and evaluate a development and training programme for the vulnerable children's workforce across the health, education and social service sectors in Hawke's Bay.

This project will **identify and address the gaps in knowledge and skills of the vulnerable children's workforce** in Hawke's Bay in order to work effectively with families and improve outcomes, particularly for tamariki and rangatahi Māori and their whanau. We will benchmark skills against the Children's Action Plan Core Competency Framework and relevant registration bodies via performance development review with each clinician in the vulnerable children's workforce in Hawke's Bay, and aggregate the results up to each service, each sector and as a region. We will then design, deliver and evaluate a training programme to address the skills gaps identified, and assess the impact on outcomes for children and families.

We also aim to **improve relationships and develop a shared language and culture** of "how we do things around here". We will achieve this by:

- Agreeing core values up front – an early goal of the project
- Including relevant stakeholders early, e.g., some unions may wish to be involved
- Joint local governance to model the expected collaborative practice from local leaders and ensure high engagement in the project
- Sharing resources (facilities, people) wherever possible
- Valuing local expertise, e.g., using local trainers wherever possible
- Joint training across services, e.g., practitioners from multiple agencies in one locality attending training together.

3. PROJECT SCOPE

Presently, the sector working with vulnerable children and young people in the Hawke's Bay includes:

- Child, Youth and Family (CYF)
- HBDHB Child, Adolescent and Family Service (CAFS), Child Development Service, Paediatrics, Public Health Nurses, DHB-employed midwives and social workers
- Te Taiwhenua O Heretaunga well child/ tamariki ora team, Family Start, Hinengaro (mental health and addictions) service
- Te Kupenga Hauora Family Start Napier
- Plunket
- NGOs (e.g., Birthright Hawke's Bay, Napier Family Centre, Family Works, Youth Directions, DOVE Hawke's Bay, Women's Refuges)
- Ministry of Education Special Education
- Resource Teaches Learning and Behaviour
- Primary Health providers (e.g. GP practices)
- Lead Maternity Carers

There are multiple (>12), smaller kaupapa Maori and faith-based health and social service NGOs in Hawke's Bay who may also wish to be involved.

We estimate around 250 staff have working with vulnerable families as the core, or a major part of their workload. Participation in this programme is voluntary for all agencies and therefore an individual agency will need to commit to all aspects of the process from engagement, sharing of skills and knowledge, through to being part of the evaluation process.

Participating agencies will be identified and the first wave (i.e. first year) of agencies will be agreed as part of the initial project activity. Followings waves of agency participants (e.g. in Years 2 and 3) will need to be agreed towards the end of Year 1 however it is the intention of this project to enrol and train as many of the c250 identified workforce as possible during the 3 year period.

Inclusions

No.	Objectives	Deliverables
1.	Map the strengths and gaps in the knowledge and skills of the vulnerable children's workforce in Hawke's Bay: • Assess competencies of all Year 1 agreed vulnerable children's workforce practitioners against the Core Competency Framework • Aggregate competency development needs by agency and regionally • Following waves in Years 2 & 3 to be determined at the end of Year 1	• Core competency mapping for each participating agency • Create an integrated Core Competency Map / Competency Database • Formalised performance plan (e.g. PDR) completed per workforce practitioner
2.	Design and deliver a training and development plan to address identified knowledge and skills gaps (as per the Core Competency Framework mapping)	• Workforce development programme -consisting of individual modules (CAFS)

	• Child Adolescent and Family Service (CAFS) Year 1	• Training plan - CAFS (i.e. trainers, supervision etc) • Workforce Development Plan for Years 2 & 3
3.	Design and implement an Evaluation Framework to assess the outcomes, impact and effectiveness of the workforce development training programme	• Evaluation Framework (tools & processes)
4.	To improve relationships and develop a shared language and culture of "how we do things around here" across agencies working with vulnerable children and families in Hawke's Bay	• Enduring/ BAU Governance Structure • Enduring/ BAU Workforce development programme (including evaluation framework)

Exclusions:

- Practitioners not in the workforce listed above, e.g., other education, health and social service personnel
- Discipline-specific skills / competencies not contained in the Core Competency Framework
- Core training of new workforce practitioners specific to their agency
- Practitioners from outside the HBDHB area

4. BENEFITS

Successful implementation of this project is expected to result in the following high level benefits:

Project Benefits

No.	Benefit	Measure (KPI)
1.	Agreed core competency framework for disciplines across sectors	Framework in use by agency workforce
2.	More connected vulnerable children's workforce across Hawke's Bay	Joint training schedules across the sector and qualitative interviews with participants. Example measures include: • % programmes attended by staff from >1 agency • Self-report from practitioners, e.g., collaborative practice measure • Self-report by managers/ practice leaders of collaborative practice • Direct observation by evaluators, e.g., of FVIARS, Strengthening Families, MCWCP, IWS •

3.	Vulnerable children workforce across sectors in Hawke's Bay change and improve knowledge and behaviour in identified core competencies • Practitioner skills increased across the Ministry for Vulnerable Children Oranga Tamariki domains specifically; prevention, early intervention, carer support (3 of 5 workstreams identified)	Year 1: Baseline measures across sectors – as defined by the core competency framework Years 2 & 3: targeted improvements, to be agreed as part of the performance plans Example measures include: • Courses delivered by type and number of attendees • Self-report (before/after) on completing course • New, evidence-based programmes delivered with fidelity, number of attendees, number (%) completing courses • Manager/ practice leader report that delivering content to standard after agreed time • Direct client feedback, e.g., Marama online tool, fidelity tools for client feedback • Direct observation by evaluators • Confidence level of staff to assess
4.	Improved outcomes for caregiver and related improved outcomes for children in care	• Caregivers report improved skills, confidence, relationships with foster children (measures TBA) • Unplanned changes in (failures of) placement fall
5.	Benefits to vulnerable children and their families over time	Outcomes seen beyond the life of the project/longer term benefits – longer term measures to be considered as part of the evaluation activity

Benefits Evaluation
Benefits will be demonstrated by an independent evaluation by expert programme evaluators led by Professor Kay Morris-Matthews of the Eastern Institute of Technology. Benefits will be aligned to the indicated Government's work streams for Oranga Tamariki (prevention, intensive intervention, and caregiver support) and family violence and sexual violence work streams.

The focus of this evaluation in year one is the skills mapping processes and early stage implementation of the workforce development programme within Child, Adolescent and Family Services (CAFS) at the HBDHB and across the wider Hawke's Bay vulnerable children's workforce in two related but separate evaluations:

- **Part A** is an evaluation of the implementation of a workforce development programme in CAFS. A skills mapping process is in progress, core and specialist skills that are clinician specific are being identified and training plans for each clinician planned. That is, the CAFS workforce development programme is one step ahead of that of the wider vulnerable children's workforce.

- **Part B** is an evaluation of the wider vulnerable children's workforce core competency skills mapping, training plan and development programme in year one.

The primary research question for both evaluation parts is "*What differences does a skills mapping development programme make for clinicians and front-line professionals who work with vulnerable children and adolescents?* (What do we know so far that leads to practice change and improved outcomes for children and adolescents?) *"*.
A mixed method approach will be used with both quantitative and qualitative data gathered to support.

Potential Longer-Term Benefits
Hawke's Bay would be the first region to undertake workforce development across the vulnerable children's workforce at this scale so we have agreed to undertake the programme in partnership with the Ministry of Social Development and share the lessons we learn with all relevant ministries and other regions. The original proposal has been discussed with and is supported by leaders in MSD, HBDHB, Special Education and NGO social services in HB working with vulnerable children, who have a well-established history of collaborative working.[1],[2] We believe that this project could become a template for development of the vulnerable children's workforce nationally.

5. STRATEGIC ALIGNMENT

This project strategically aligns as follows:

Strategy Area	Alignment
Better Public Services	The Ngātahi Project is consistent with the aim for government agencies working together and with communities to come up with innovative ways to deliver better public services.
Ministry of Health Strategy	multiple, see also guidance to DHBs for this year's annual plan "identify and address barriers to access to children in the care of Oranga Tamariki
HBDHB Transform & Sustain strategy	**This project supports Whole of Public Sector Delivery, and the multi-agency key intention by establishing a cross-agency programme for workforce development.**
Oranga Tamariki, Expert Advisory Panel final report	The Ngātahi Project supports the new "single point of accountability" model which focuses on five core services: prevention, intensive intervention, care support services, transition support and a youth justice service aimed at preventing offending and reoffending.
Social Inclusion Strategy	It is consistent with government's vision of fairness, opportunity and security for all New Zealanders.
Ngati Kahungunu strategic plan 2016-2017	It supports the Te Ara Toiora o Ngāti Kahungunu - Kahungunu Wellbeing Strategy which focuses on interventions and activities for a strong, vibrant, healthy whānau & hapū – te hau o te mauri, te hau o te ōrā.

[1] Wills R, Morris Matthews K, Hedley C, Freer P, Morris M. Improving school readiness with the Before School Check: early experience in Hawke's Bay. *NZMJ* 2010; 123: 47-58
[2] Wills R, Ritchie M, Wilson M. Improving detection and quality of assessment of child abuse and partner abuse is achievable with a formal organisational change approach. *J Paed Child Health* 2008;44: 92-98

6. ASSUMPTIONS

- Policy environment and Government priorities - vulnerable children will continue to be a Government priority, Ministers will commit resource and require ongoing collaboration of agencies for vulnerable children
- Relationships and buy-in will continue from:
  - Ministries
  - Local executives
  - Practice leaders and agency managers
  - Practitioners
  - Families, whanau, rangatahi and tamariki
  - Other stakeholders, e.g., trades unions, registration and disciplinary bodies
- Funding and resources will be available from MoE, MSD, HBDHB and philanthropic sources for years 2 and 3

7. INTERDEPENDENCIES

No hard dependencies have been identified at this point however the project will need to be aware of the following in the event a new dependency (or constraint) develops:

- Policy priorities: vulnerable children, family violence, sexual violence
- Local agency priorities, e.g.:
  - HBDHB strategic plan, Transform and Sustain, health and social care networks
  - MSD and Oranga Tamariki, e.g., establishment of new agency, development of funding strategy and local collaborations
  - MOE strategy, e.g., how this project facilitated MOE strategies such as improved ECE enrolment and NCEA L2 achievement
  - NGOs' strategic plans
- Other funders' priorities, e.g., Lloyd Morrison Foundation.

8. DELIVERY APPROACH

This project will leverage the MSD-led intersectoral Core Competency Framework to assess and develop the vulnerable children's workforce capability in Hawke's Bay. The need for training modules will be met through a combination of existing resources from the participating agencies, purchase of new modules not already available locally and some purpose-built training developed utilising regional skills and expertise.

The project has an expected duration of 3 years, but will be planned and delivered in waves with the project scope re-evaluated and agreed at year-end 'stage-gates' for the following year. CAFS will be the main focus of the first year of the project, as the leader of mental health care for children and young people in Hawke's Bay, and will be used to test and refine the programme for further rollout in Years 2&3.
This project can only be successful if done in a staged and collaborative way - done with, rather than to families and whanau, practitioners, services, local and national chief executives and other senior managers, funders and policy makers.

The project will utilise the HDBHB Project Management methodology based on PRINCE2 principles.

<u>Multi-Agency Governance Approach</u>
While there are many effective inter-agency groups in HB, we believe the **High and Complex Needs Local Steering Group (HCN LSG),** which includes leaders from key organisations

within the vulnerable children's sector, would be the ideal local operational governance group for this project in Hawke's Bay. We recommend that governance of the current project be a partnership between the HCN LSG and the Service Director of the HBDHB Mental Health and Addiction Service, Allison Stevenson. Consumer involvement in governance would be sought.

9. COMMUNICATION MANAGEMENT

A communications plan for the project has been developed and includes:

- Key communication points/schedule
- Communications methods (newsletter, direct email, face-to-face meetings with project steering group.

Due to the number of interested parties and stakeholders, and multi-agency focus, support will be sought from the HBDHB Communications Team for communications for the project.

10. REPORTING AND ISSUES ESCALATION

Reporting will be as follows.

- Project Manager will report monthly to the Project Sponsor and Project Management Office using the HBDHB monthly reporting template
- The Project Manager and/or Project Sponsor will report monthly to the Project Steering Group
- The Project Sponsor and/or SRO will providing reporting to the Bilateral Partnership Group.

Risks and issues will be reported to the same groups as indicated above.

11. QUALITY STANDARDS

Consistent with:

- HBDHB Project Management Standards are used to support project delivery
- Best Practice Communication and Engagement approach in engagement with stakeholders including: agendas / minutes etc.
- Information solutions comply with IS infrastructure and development strategy in HB
- Marketing information re hours of service etc. are of a professional standard and align with national messaging etc.

12. PROJECT TIMELINE

High Level Milestones	Date of Completion
Year 1 - Wider Vulnerable Children's Workforce • Face-to-face engagement with key stakeholders to ascertain participation in and commitment to project • Socialise and agree core competencies and tiers of competencies, mapped with key client issues and needs	 April 2017 May 2017 - early engagers, and June 2017 for all participating agencies

High Level Milestones	**Date of Completion**
• Staff performance appraisals indicating current and preferred level of competence submitted to Project Manager • Training and practice change plan developed for individual agencies and across sectors <u>Year 2</u> • Begin implementing training and practice change plan	September 2017 October & November 2017 February 2018
<u>Year 1- Child, Adolescent & Family Service</u> • Socialise and agree core competencies and tiers of competencies, mapped with key client issues and needs • Staff performance appraisals against core competency framework completed and training and practice change plan developed • Initial training programmes implemented • Plan for second wave of training for year 2 developed <u>Year 2</u> • Begin implementing training and practice change plan	May 2017 June 2017 August to November 2017 November/December 2017 February 2018
<u>Year 3 - TBC</u>	TBC
<u>Benefits evaluation/Research</u> • Benefits evaluation framework completed • Baseline data collected • Evaluations alongside training implementation plan • Report completed	 May 2017 June 2017 August to November 2017 January 2018
<u>Project Management Milestones</u> • Business Case / Resource application to deliver the training and practice change plan in Year 2 • Business Case / Resource application to deliver the training and practice change plan in Year 3	 Dec 2017 Dec 2018

13. FINANCIALS

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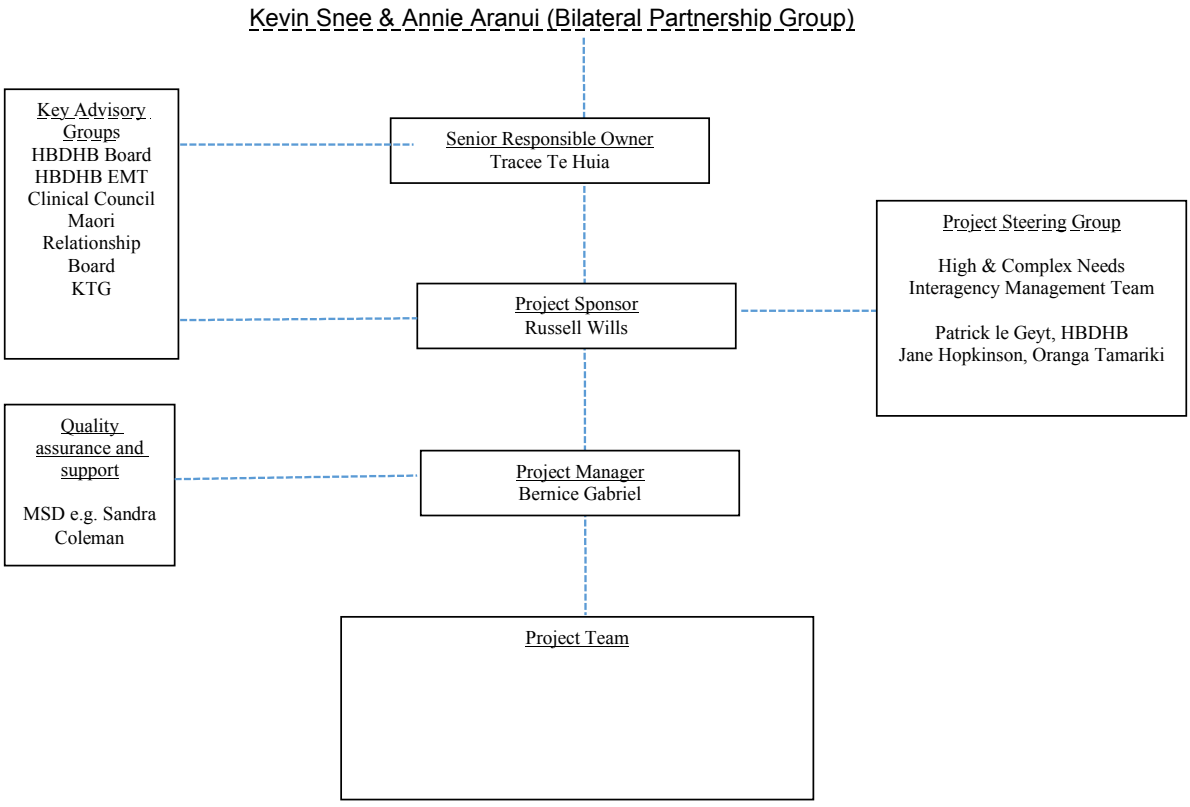
Other project requirements will be met out of baseline budget.
Funding for subsequent years will be secured through the business case completed at the end of Year 1 (and 2).

14. Project Management Team Structure



See Appendix 1 for project role descriptions.

15. RISK MANAGEMENT

The purpose of the risk management system is to:

- Effectively and efficiently manage project risk in order that project deliverables may be met within planned schedule, budget and quality requirements.
- Ensure Lessons learned are captured for use in future project activities

The HBDHB Project Support Office guide to Risk Management will be used to capture risk management for this project. Relevant mitigation activities will be included in the project plan.

15

Preliminary Risk Analysis:

Risk: Failure to:	Likelihood Hi/Med/Lo	Impact Hi/Med/Lo	Planned Response
Fail to engage / get buy-in from Bilateral Partnership Group	Low	High	Early discussion with likely executives Align project goals with ministers' and organisational goals
Engage skilled evaluator in timely fashion	Low	High	Shoulder tap skilled local academic early
Maintain relationships with MSD	Low	High	Early and ongoing communications with key stakeholders
Maintain relationships with LMF funder	Low	High	Early and ongoing communications
Maintain relationships with ley HBDHB stakeholders	Low	High	Early and ongoing communications
Engage key local practice leaders and managers	Med	High	Early and ongoing communications
Provide data in timely fashion	Med	High	Engagement of executive leads in governance group
Share data with practitioners in ways that engage them and avoid stigmatisation, leading to disengagement	High	High	Steering group's advice to be sought on how best to communicate data that demonstrated poor outcomes

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Appendix 1: Project Role Descriptions

Bilateral Partnership Group
Provides *executive leadership*

- Local executive leaders of MSD and HBDHB
- Champions for the project
- Ensures the project is integrated into sector-wide strategies, e.g., the Hawke's Bay Regional Economic Development Strategy and Social Inclusion Strategy
- Ensures the project is integrated into organisational strategies and plans, e.g., HBDHB Transform and Sustain
- Strategic guidance, advice and removal of road-blocks
- Final decision maker Go / No Go decisions at key points and deliverables acceptance
- Available for key meetings to ensure the project momentum.

Project Steering Group (High and Complex Needs Interagency Management Group including Patrick le Geyt, HBDHB and Jane Hopkinson, Oranga Tamariki)
Provides *leadership for practice change*

- Operational champions for the project with leaders and frontline staff of involved organisations
- Provides regular up-dates and review of the status of the project
- Supports the Project Sponsor and Project Manager to manage major project issues and risks
- Contributes to decisions on acceptance of project deliverables and Go / No Go decisions at key points
- Escalates risks and issues as appropriate
- Available for key meetings to ensure the project momentum.

Senior Responsible Owner

- Provides strategic advice and direction to the Project
- Support for Project Sponsor
- Resolution of issues outside of the scope of the Project Sponsor
- Uses executive authority to overcome organisational barriers on behalf of the Project
- Advocates for high level support of the project, including resourcing.

Sponsor

- Guides and controls the project, lead project champion
- Works with Steering Group and advisory groups/ forums
- Holds and allocates project budget
- Change control: ensures all scope, time, cost, quality, risk, and business benefit parameters are met or the project plan is altered
- Key support for Project Manager in relation to the project
- Resolution of issues outside of the scope of the project manager or escalated to Steering Group or SRO as appropriate
- Communicates regular up-dates and review of the status of the project to SRO, Steering Group, or other key stakeholders and staff formally through agreed mechanisms
- Direct and immediate line of contact to project manager.

Project Management Office + Additional Project Assurance Roles

- Engaged by the project sponsor to provide pro-active input to assist and "assure" the project will: achieve planned benefits, meet quality requirements of customers, use best practice processes to create the deliverables and appropriately follow the project management processes.

Project Manager

Facilitates the project management process at all points as per HBDHB project management methodology including:

- Planning - Develops the project plan, stage plans, and detailed project delivery plans using available expertise and lessons learned.
- Delegating – Identifies and secures resources for the completion of all project delivery and ensures allocation of tasks to these resources with supporting workplans that clarify what is required by when.
- Monitoring – Monitors project delivery ensuring that all expectations are met in relation to time, cost, quality, scope, risk, and benefits.
- Controlling the project – ensure all issues and risks to project delivery are identified, analysed and responded to effectively using prescribed escalation routes and change control procedures including provision of information to the Steering Group and Project Sponsor to enable them to perform their function effectively.

Project Delivery Leaders and Provider Resources

- Complete tasks as identified in the agreed scope of work and project plan effectively.
- Work to agreed timeframes
- Report progress and elevates issues to the Project Manager in a timely way
- Effective team members demonstrating pro-active and constructive problem solving.

Ngātahi Core Competency Framework and Domains – April 2017

NGĀTAHI

WORKING AS ONE

HE KAUANUANU • ĀKINA • RĀRANGA TE TIRA • TAUWHIRO

Introduction to the framework

Welcome to the Ngātahi Core Competency Framework (the framework) for the vulnerable children's workforce in Te Matau-a-Māui Hawke's Bay. The framework uses the same six domains and 17 sub-domains of the Core Competency Framework for the Ministry for Vulnerable Children Oranga Tamariki (Oranga Tamariki CCF).

We are practitioners first, and have used a practice lens to group the Oranga Tamariki CCF 17 sub-domains into 11 that we believe

- Make sense in *practice*, e.g., child protection and family violence; adolescent development and mental health
- Are sensibly *taught together*, e.g., consent, privacy and information sharing; reflective practice, supervision and appraisal.

The sub-domains listed below should group together in a way that make it possible

- To clearly define the competencies within each sub-domain in tiers/ roles
- For leaders in each service or group of services to decide which tiers/ roles are appropriate for their practitioners
- To give guidance to leaders to work with their practitioners to appraise their current and desired future competency tiers/ roles
- To identify Tuakana (leaders) who can support others to achieve their desired level of competency
- For services and practitioners that would like to achieve a new tier of competency (Teina) to understand what that looks like and how that competency can be achieved.

We suggest preserving the tiers/ roles of the Oranga Tamariki CCF (Foundation, Practitioner, Leaders of Practice) in the Ngātahi CCF because we believe most competencies are common for all the vulnerable children's workforce, with a few exceptions due to Oranga Tamariki's legislative mandate and role. For a few sub-domains (e.g., assessment of parent mental illness and addictions, intimate partner violence, child development, adolescent mental health) we suggest the practitioner domain may need to separate out where a

practitioner's role is to assess and refer, and where the role includes to provide an intervention.

The framework emphasises the core *values* of the vulnerable children's workforce. They require all of us to consider the best interests of children at all times, ensure that children's voices are heard and included in all decisions affecting them and to ensure that we work in culturally safe ways at all times. The framework should promote collaboration between disciplines and sectors, the sharing of effective practices and improve the capacity of the workforce to work effectively with vulnerable children and their whānau.

In the vulnerable children's workforce roles cannot be rigid or exclusive. All levels require foundation-level competencies. The tiers build on each other and overlap, e.g., foundation level skills imply a basic assessment competency, and an effective intervention requires a competent assessment. However a leader need not have provided (or lead a service that provides) interventions. This emphasises that these are roles, rather than levels.

We recognise the important role of executive-level leaders in the vulnerable children's workforce (e.g., creating the correct policy environment, ensuring realistic caseloads, providing ongoing professional development and quality assurance) however the purpose of the Ngātahi project is to define the competencies for the vulnerable children's core workforce so, for now, we have limited the framework to leaders of *practice*.

Tuakana-Teina (ako) model

In this model, Tuakana (elder siblings) are identified by the community as leaders capable of supporting others to achieve new skills. Teina (younger siblings) self-identify as wanting to learn a new skill. Tuakana support teina to achieve the new level of skill through teaching, demonstrating, mentoring, guiding and appraising. Tuakana and teina are roles - not judgments - and each learns from the other in the process. In a large workforce development project like Ngātahi, most tuakana will also be teina in areas they want to learn in.

Russell Wills
Community and General Paediatrician
Ngātahi Project Sponsor

Bernice Gabriel
Senior Psychologist
Ngātahi Project Manager

Domains and sub-domains

Domain: Act in the best interests of children (Vulnerable Children's Workforce Core Competencies)		
Subdomains	**Our vision**	**Profile of a worker competent in this domain**
Champion the rights and interests of children **Work in a child-centred way** **Professional conduct and continual improvement**	A children's workforce that understands the rights and interests of children, and works in a child-centric way to act in the best interests of children.	• Understands relevant ethical codes, competency frameworks, and legalisation that govern practice and service delivery. • Promotes the rights of children and respects their dignity. • Committed to urgency when responding to children's needs and persistence to achieve outcomes. • Recognises the principle that the welfare and best interests of a child must be the first and paramount consideration when making decisions that may affect their welfare. • Able to put the child at the centre, and demonstrates child-centred decision-making that informs action, including recognising and responding to the vulnerability of children. • Works in a child-centred way. • Applies the least intrusive intervention necessary to protect vulnerable children. • Reflects upon and improves professional practice.

Domain 1: Act in the best interests of tamariki			
Sub-domains	**Foundation**	**Practitioner (plus Foundation)**	**Leaders of Practice (plus Foundation)**
1) Champion the rights and interests of tamariki and work in a child-centred way (including needs assessment, formulation and treatment planning)	• Advocates for the rights of the child, acknowledging their dependency on adults. • Recognises the child's best interests as the paramount consideration for decisions that may affect them. • Engages with and supports children in a manner that promotes their rights and respects their dignity. • Makes decisions that put the child's current and future wellbeing, needs and interests at the centre. • Reflects on and adapts their actions as the child's needs and views change. • Understands who is working with the child.	• Commits to applying the least intrusive intervention necessary to protect vulnerable children. • Motivates and encourages children to achieve their full potential. • Understands key principles of child-centred practice, including early intervention, holistic assessment of needs, promoting the voice of the child, and taking a collaborative approach. • Understands the elements of good quality assessments. • Assesses the holistic needs of children (including ecological, cultural and risk assessment), plans an appropriate response, and reviews the implementation of the planned response to check its effectiveness.	• Champions the use of evidence-based, holistic, and child-centred assessment practice to develop holistic understandings of the needs, strengths and risks of vulnerable children. • Understands the elements of quality assessment of vulnerable children, and can support colleagues in their assessment practice. • Understands how to establish meaningful and measurable goals for children, record these in an appropriate plan, and can support colleagues in this planning process. • Understands the importance of evaluation and review to supporting effective assessment, planning and implementation, and

	• Makes decisions based on child's developmental stage and needs. • Ensures that the child's voice is heard and uses the child's language. • Knows how to do a basic risk assessment.	• Uses evidence-based, holistic, and child-centred assessment practice to develop holistic understandings of the needs, strengths and risks of vulnerable children.	is able to support colleagues in this process. • Recognises training needs of self and colleagues • Participates in case consultations
2) Display professional conduct and seek continual improvement (including reflective practice, professional development, self care, appraisal, supervision, quality improvement, feedback and complaints)	• Understands and works within the legal requirements, policies and systems that govern practice in the sector. • Has a basic knowledge of ethical issues, confidentiality, and boundary issues. • Knows how to access support and knowledge, and how to meet development needs. • Has a basic understanding of linking theory to practice. • Has emerging skills in critical enquiry, reflective practice, and self-evaluation. • Understands the supervision process and uses supervision as needed.	• Uses theory, evidence, research, and experience to reflect upon and improve practice within the cultural context of child and family. • Understands and works within the legal requirements, policies and systems that govern practice in their sector. • Draws upon and supports other's perspectives to challenge personal thinking and improve practice. • Manages ethical dilemmas ~~with~~ through supervision, guidance, ~~or~~ and reference to relevant practice and organisation codes. • Uses self-reflection, critical inquiry and problem solving effectively ~~in~~ to improve professional practice. • Identifies when a working environment is unsafe (i.e. culturally,	• Champions and demonstrates the importance of using critical inquiry, problem solving and evaluation effectively in professional practice and supervision of colleagues, including engaging with evidence and professional literature that reflects best practice. • Ensures that supervision for practitioners occurs either internally or externally. • Supports and guides colleagues in using theory, evidence, research, and experience to reflect upon and improve practice within the cultural context of child and family. • Champions and enables a learning environment through induction of new staff, ongoing professional development, and clear pathways for staff to access support and self-cares.

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	• Has an awareness of own self-care needs and support. • Understands and appreciates the vision and values that underpin working with children.	bullying, not child-centred), raises this with colleagues, and elevates to management when needed.	• Leads self-reflection, critical inquiry and problem solving.

Domain: Be culturally competent (Vulnerable Children's Workforce Core Competencies)		
Subdomains	**Our vision**	**Profile of a worker competent in this domain**
Understand diversity in Aotearoa New Zealand **Work with diversity and difference** **Work with Māori**	A children's workforce that takes into account cultural perspectives, to engage and work with children and their parents, family, whānau and caregivers to understand and respond to their needs.	• Recognises and respects diversity within Aotearoa New Zealand. • Communicates and engages in culturally appropriate and inclusive ways. • Reflects upon own values, and their impact on professional practice. • Cultural awareness and sensitivity underpins culturally competent practice. • Recognises bicultural partnership in Aotearoa New Zealand and is able to reinforce the value, rights and mana of Māori, underpinned by the principles of Te Tiriti o Waitangi.

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Domain 2: Be culturally competent			
Sub-domains	**Foundation**	**Practitioner (plus Foundation)**	**Leaders of Practice (plus Foundation)**
3) Work effectively with Māori.	• Recognises bicultural partnership in New Zealand, underpinned by Te Tiriti O Waitangi, and the rights of mokopuna and whānau Māori to participate in their culture, practices and language. • Works in a way that demonstrates high aspirations for mokopuna and whānau Māori, recognises that Māori are not homogenous and that all tamariki and whānau are diverse, and may require different methods of engagement or assessment in order to facilitate a path towards equitable outcomes for all. • Has a broad understanding of local history and is aware of the effects of colonisation on the	• Respects the mana of people, by building respectful relationships with whānau, hapū, iwi and the wider community, acknowledging their expertise and enabling Māori to participate in decisions about mokopuna. • Values whakapapa, cultural narratives, and the cultural wisdom embedded in Māori ideological and philosophical beliefs, to the empowerment of Māori. • Respects and strengthens the voices and aspirations of Māori by championing and modelling the use of Māori cultural practices. • Uses appropriate Te Reo Māori throughout interactions with Māori whānau and or groups and or has the confidence to call upon appropriate Māori cultural support	• Advises colleagues on Māori theories and paradigms that affect positive interactions – for example, tūhonotanga, mana o te ao turoa, and wairuatanga – when working with Māori. • Understands the dynamics of whānau, hapū and iwi, and the relationships between them. • Advises colleagues on incorporating Māori culture (including ngā tikanga-ā-iwi) when engaging with Māori children, their parents, hapū, iwi and communities. • Supports staff to engage effectively with Māori parents, whānau, hapū and the wider community.

	local Māori community (iwi, hapū, marae, whānau) and the implications of this on socio-economic and cultural inequities for local Māori and their overall health and wellbeing today. • Understands the cultural wisdom embedded in Māori ideological and philosophical beliefs, including core values such as manaakitanga, mana whenua, rangatiratanga. • Values whakapapa, understanding the need to include parents, whānau, hapū, iwi and the wider community in decision-making about mokopuna and whānau Māori. • Consults with kaumatua, kuia, cultural advisors, or tohunga (either inside or outside their organisation) to support mokopuna and whānau Māori. • Acknowledges, respects and is inclusive of local marae and the local Māori culture(s) – ngā tikanga-ā-iwi of Ngāti Kahungunu and its many hapū and marae. • Uses Te Reo Māori in interactions with Māori that are	from someone with this capacity in order to facilitate mana enhancing interactions. • Understands and uses mana tamariki and mana ahua eke (the Māori view of child-centred) to guide practice with tamariki mokopuna Māori.	• Supports staff to share, learn, and implement practices which are working in other iwi or Māori organisations to support vulnerable mokopuna and whānau Māori. • Supports and encourages use of Te Reo Māori where appropriate in interactions with Māori.

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	mana enhancing for all where appropriate pronunciation of te reo Māori names and places and the use of greetings to open and close interactions is proper, respectful and 'normal'. • Recognises and or acknowledges that there shortcomings regarding personal knowledge and experiences with the above competencies and or that when the unknown arises, they will seek appropriate cultural support and advice in order to progress interactions with whānau. • Utilises existing Māori cultural knowledge and experiences and or organisational cultural frameworks alongside this competency framework to engage with tamariki and whānau in mana enhancing ways.		
4) Work with diversity and difference in Aotearoa New Zealand	• Knows when to consult with cultural advisors (either inside or outside their organisation) to support children and families.	• Engages and communicates in culturally appropriate, inclusive ways.	• Champions the importance or recognising diverse values, beliefs, theories, ideologies, paradigms, frameworks, perspectives, and worldviews.

	• Applies principles of cultural competency in their practice. • Knows when and where to seek help when engaging with people from diverse backgrounds. • Understands that New Zealand is culturally diverse, and that culture extends beyond ethnicity. • Understands that culture and beliefs influence interactions with children and their parents, family, whānau and caregivers. • Understands that positive outcomes for children and their parents, family, whānau and caregivers happen when there is mutual respect and understanding. • Understands that diversity and difference exists at both the group and individual level, and that general cultural information should not lead to stereotyping.	• Recognises, nurtures, and strengthens mana in others. • Identifies cultural issues that may be affecting how children, parents, family, whānau and caregivers engage with a service. • Acknowledges diverse values, beliefs, theories, ideologies, paradigms, frameworks, perspectives, and worldviews. • Reflects on the impact of their background (for example, their culture, values, and beliefs) on their practice, and adopts strategies to manage this. • Takes family and whānau-based approaches where doing so is appropriate. • Engages positively with children, parents, families, whānau and caregivers from diverse backgrounds on topics that may be sensitive or challenging. • Understands the effects of non-verbal communication such as body language, and that different cultures use and interpret body language in different ways. • Engages with children, parents, families, whānau and caregivers	• Encourages colleagues to reflect on the impact of their background on their practice. • Supports colleagues to integrate cultural knowledge and understanding into their interactions with persons from diverse backgrounds. • Advises colleagues on seeking cultural advisors and translators to support clients from diverse backgrounds to engage. • Supports colleagues to reduce inequities within marginalised societies, and promote fair access to entitlements.

		using their preferred language, or seeks the support of an appropriate independent translator if required. • Understands that cultural and historic context affects children, parents, families, whānau and caregivers, and informs effective practice. • Understands the contributors to vulnerability and inequities of diverse populations of Aotearoa New Zealand.	

Domain: Identify needs and respond to vulnerability (Vulnerable Children's Workforce Core Competencies)		
Subdomains	**Our vision**	**Profile of a worker competent in this domain**
Support a culture of child protection **Child protection policies and processes** **Understand child development** **Understand child health**	A children's workforce that recognises vulnerable children's needs and the response that is required to prevent harm occurring, including the implications of the paramountcy principle in practice.	• Considers the holistic wellbeing of the child within its wider ecological context. • Understands the importance of prevention and early intervention, alertness and preparedness to act to protect and improve children's wellbeing. • Identifies indicators of vulnerability and when children are not having their basic needs met. • Acts on unmet needs quickly and effectively and takes concerns seriously. • Committed to child protection culture and continuous improvement based on self-reflection, feedback and consideration of evidence-based practice. • Understands the child protection policies and protocols that govern their organisation and/or profession, including international and national legislation and policy to protect children

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Domain 3: Identify needs and respond to vulnerability			
Sub-domains	**Foundation**	**Practitioner (plus Foundation)**	**Leaders of Practice (plus Foundation)**
5) Support a culture of child protection (including assessment of intimate partner violence), adhere to child protection policy and process	• Recognises that the protection of children is a core duty of all children's workers. • Understands the importance of prevention and that early intervention produces the best long term outcomes for children. • Understands how legislation and policy about the protection of children apply to their practice and knows how to access relevant legislation and policy. • Recognises when something is not right or a child/whānau member is not safe, takes steps to seek advice and support, and responds quickly and effectively when needed.	• Identifies children that are not having their physical, emotional, cognitive and socio-cultural needs met, and responds quickly and effectively. • Recognises their role in modelling a culture of child protection and commits to continuous improvement in their child protection practices. • Understands the particular vulnerability and needs of children with disabilities, and their families. • Considers the wellbeing of children holistically, including their physical, emotional, cognitive, and socio-cultural needs. • Recognises indicators of vulnerability relating to child abuse and neglect.	• Works with colleagues to discuss concerns to promote early intervention and response. • Leads and supports colleagues to respond to concerns, especially in difficult or challenging cases. • Understands the policies and processes of the children's services in the community to support colleagues to make a referral and formulate a plan to follow up on the outcome. • Models and supports colleagues to build effective working relationships with children's services in the community. • Works with colleagues to understand types of abuse and neglect and signs or indicators for each.

	• Commits to following-up after a referral to make sure that the issue is being addressed and children are allocated and don't fall through the gaps. • Maintains appropriate and culturally aware physical, emotional and sexual boundaries in interactions with children and families. • Does not act on concerns alone, and consults with managers, supervisors or a designated person to get support and policy guidance to protect children. • Self-reflects on practice. • Seeks help to prevent problematic professional situations or behaviours.	• Understands connections between child vulnerability and family and intimate partner violence. • Recognises indicators of vulnerability in mother and baby including the unborn child. • Follows national, local and organisational child protection policies and procedures, including knowing who to contact, how to access advice, and how to make an appropriate report or referral with formulated plan and follow-up. • Seeks and uses specialist advice on organisational policies and handling challenging legal and ethical issues.	• Supports colleagues to navigate complex or specialist issues connected to abuse and neglect. • Seeks and provides specialist advice on organisational policies and handling challenging legal and ethical issues.
6) Understand child development and be trauma-informed	• Identifies children that are not having their physical, emotional, cognitive and socio-cultural needs met and responds quickly and effectively. • Is familiar with policies, procedures, regulations and legislation as appropriate to the role and workplace.	• Understands that there are various theories about how children develop, including the degree to which it is influenced by environmental and cultural factors. • Tracks children's development and takes action where there is an indicator of vulnerability.	• Leads, models and supports colleagues to navigate difference, current and evidence-based theories about how children develop. • Listens carefully to colleague's concerns about developmental or behavioural changes, supports analysis of potential issues, and

	• Understands child development and how physical, emotional, sexual, cognitive and socio-cultural development progresses in children. • Recognises that there are various theories about child development, including environmental and cultural influences. • Is aware that trauma can occur in any family or environment and keep an open mind. • Recognises the indicators of trauma. • Interacts with children in ways that support the development of the child's ability to think, learn, and increase competency and/or independence. • Recognises that the child is more than the trauma and disabilities – look for strengths and abilities	• Understands the need for assessment of holistic needs of the child and the support required during key points of transition. • Recognises the indicators of trauma and is well able to respond appropriately and implement recommendations to address the impact of the trauma. • Seeks to remediate trauma that may be experienced by children and support implementation of recommendations. • Increases experiences to aid development and resilience	planning of appropriate responses. • Recognises and addresses the trauma experienced by children and take steps to prevent their re-victimisation. • Supports, appraises, enquires, supervises, and consults with the practitioner.
Understand Child Health – divided into 7) Addressing unmet health needs (including	• Has a holistic approach to case management. • Includes the child's and whānau's assessment of the problems confronting them.	• Identifies signs of unmet health needs (such as common childhood illnesses), and responds appropriately, including making a	• Supports colleagues to understand health issues that contribute to the vulnerability of children

understanding the Health System)	• Has basic computer skills. • Understands the socio-economic and cultural determinants of health. • Understands that health is more than just the absence of disease.	referral to an appropriate specialist or service. • Applies Māori models of health care (e.g. Te Whare Tapa Wha). • Identifies children whose development is delayed or behaviour is disordered, discusses these with parents, and makes appropriate referrals.	• Supports colleagues to recognise unmet health needs and refer appropriately.
8) Adolescent development, mental health and addictions	• Is able to have conversations with children and family members about mental health and addiction issues. • Is able to ask about risk and suicide. • Knows when to share information and escalate issues. • Has an awareness of terminology commonly used. • Has an awareness of limitations of role or scope of practice. • Is able to link mental health and addiction issues with family, cultural and socio-economic context. • Identifies signs of potential substance misuse in youth and responds appropriately,	• Identifies signs of unmet mental health needs in children and responds appropriately, including making a referral to a specialist or service. • Is able to communicate effectively and appropriately with children and adolescents about their mental health and addiction diagnoses, using language that is developmentally appropriate and well-understood. • Has an awareness of the legislation relating to mental health and addiction issues. • Has knowledge of mental health and addiction theories.	• Supports and mentors colleagues to understand health issues (including mental health and substance misuse) that contribute to the vulnerability of children • Is able to undertake a comprehensive assessment of mental health and addiction problems. • Is able to provide evidence-based interventions for high prevalence conditions (e.g. anxiety and depression) appropriate to role and competency. • Is able to assess, undertake case formulation, and provide evidence-based specialist therapies and interventions. • Contributes to the strategic planning for the mental health and

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	including making a referral to a specialist or service.	• Has knowledge of mental health and addiction resources and matches resources to client's needs. • Has knowledge of presentation of mental health and addiction issues at different developmental stages. • Is able to do a screening assessment around mental health and addiction needs. • Has an awareness of the diagnostic processes for mental health and addiction problems. • Has dual diagnosis knowledge. • Uses brief motivational interventions. • Has knowledge of the effects of substances and withdrawal. • Understands, assesses, and treats issues from the child's, adolescent's and family's perspective. • Is able to develop a safety plan. • Is able to develop goals collaboratively with child, adolescent and family.	addictions needs of children and adolescents. • Has expert knowledge in the use of outcome measures. • Has expert knowledge of mental health and addiction theories.

Domain: Engage children (Vulnerable Children's Workforce Core Competencies)		
Subdomains	**Our vision**	**Profile of a worker competent in this domain**
Empower children **Communicate effectively with children**	A children's workforce with the interpersonal qualities and communication skills to engage with children in a manner appropriate to their developmental stage and abilities, to build positive and constructive relationships, and to establish a shared understanding of their perspectives in order to plan actions. A children's workforce that operates in accordance with the rights of the people of New Zealand, as defined in relevant legislation.	• Takes account of children's views of themselves, their lives, their future, their family whānau and community. • Uses a developmental perspective with age-appropriate engagement and communication, assessment and actions within each child's cultural context. • Communicate with children at a level appropriate to their developmental stage and ability, using language they can understand. • Listens to children and accurately convey their perspective so that the child's voice is heard. • Balances child-centred practice with other priorities and needs.

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Domain 4: Engage Tamariki			
Sub-domains	**Foundation**	**Practitioner (plus Foundation)**	**Leaders of Practice (plus Foundation)**
9) Empower and communicate effectively with Tamariki	• Is committed to giving children a voice in decisions that may affect them. • Recognises that children can communicate even when very young or non-verbal, and treats their communication with dignity, respect, and integrity. • Understands that the behaviours of vulnerable children may be the result of their attempts to cope with trauma and/or disability. • Actively engages and listens in a calm, non-judgemental, non-threatening way using open questions, consistent with the child's developmental stage • Ensures that parents, families, whānau and caregivers are	• Recognises the importance of presenting genuine choices to children, and being honest and open about the weight of their opinions and wishes. • Involves children in decision-making at the appropriate developmental level. • Helps children to express what they are experiencing, feeling and to describe their world. • Engages with vulnerable children using trauma-informed practices and approaches that are culturally responsive and evidence-based. • Understands theories about how children's communication skills develop. • Communicates effectively with children across their developmental	• Understands theories to help describe the child's world and how children's communication skills develop, and can support colleagues with this knowledge. • Supports colleagues to use the most appropriate forms of communication to meet the needs of the individual child. • Supports colleagues to address with children issues that are sensitive, challenging, or subject to stigma. • Knows where information, advice, advocacy and support services for children are available in the community, and supports colleagues to connect children to these services.

	aware of the feedback and complaints channels, and facilitates access as required. • Is receptive to feedback from children to inform continuous improvement and development. • Seeks guidance and support if unsure what to do with information given by children. • Understand principals and expectations of the United Nation's Convention on the Rights of the Child (UNCROC) • Has hope in children.	stages, meeting the needs of the individual child. • Is able to accurately listen, understand, reflect and respond to the child's voice, context, views and feelings. • Actively seeks and is receptive to feedback from children to inform continuous improvement and development. • Has a broad understanding on the ways children communicate and options available to them. • Is able to identify the strengths and potential of children. • Is able to recognise risk of collusion with parents. • Supports colleagues to understand that sometimes it is necessary to go against a child's expressed wishes to act in their best interests.	• Supports colleagues to actively seek feedback from children, through a range of mediums, informing continuous improvement of services and professional development of staff. • Supports colleagues to be courageous in supporting the child's goals and dreams. • Actively keeps up to date with best practice on engagement with children.

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Domain: Work collaboratively and share information (Vulnerable Children's Workforce Core Competencies)		
Subdomains	**Our vision**	**Profile of a worker competent in this domain**
Work collaboratively **Share Information** **Lead and sustain transformational change**	A children's workforce that works together until positive outcomes are achieved for children, as well as their parents, family, whānau and caregivers.	• Has sound knowledge, skills and values, and develops capability in collaborative working. • Understands the different roles, responsibilities and processes in the children's workforce. • Networks and operates effectively and ethically in a cross-agency environment • Committed to a culture of collaboration that enables clear and decisive action for children. • Lawfully shares information in a timely and accurate manner to effectively address the needs of children. • Organisational leaders lead and sustain transformational change in practice to reflect the values, skills and knowledge described in the core competency framework.

Domain 5: Work collaboratively, share information, lead and sustain transformational change			
Sub-domains	**Foundation**	**Practitioner (plus Foundation)**	**Leaders of Practice (plus Foundation)**
10) Work collaboratively	• Recognises they are part of the children's workforce if they plan, manage or deliver services to children, regardless of their role or profession. • Connects and communicates with others in the children's workforce in a respectful, open and honest way and values the expertise others bring. • Understands that the diverse roles in the children's workforce have their own practice frameworks, expectations and standards. • Seeks care for themselves, actively engages in reflective supervision, and seeks expert advice and guidance as needed.	• Recognises the criticality of collaborative working where it is in the best interests of the child. • Recognises that responsibility for children is on-going, carries across the process of referral, but also recognises the ethical and competency boundaries of their role. • Partners with other children's workers to create shared assessments of need, make joint decisions, plan together, and deliver agreed next steps to achieve good outcomes for children. • Understands that there are different perspectives, theories and drivers across the children's workforce, but is confident to challenge situations with considered questions.	• Champions collaborative working so it is in the best interests of the child. • Champions on-going commitment to the children's workforce learning community and collaborative professional learning opportunities. • Supports colleagues to use common tools, processes and procedures for collaborative working. • Leads or supports collaborative, multi-agency and multidisciplinary assessments using relevant, agreed, and common frameworks. • Navigates organisations to support others to access services

	• Responds appropriately and effectively to feedback and complaints, providing a resolution and escalating as required. • Recognises the importance of continual professional development, supports the learning of others, and encourages an environment that promotes learning. • Actively seeks and participates in collaborative professional learning opportunities. • Writes competent referrals to services to address issues confronting the client and their whānau. • Understands the structure of the multiple sectors within the community, including the roles, responsibilities, and obligations of each service. • Understands the legal obligations of all sectors (e.g., right to attend the closest school to where you live, right to be enrolled in a general practice, etc.) • Recognises barriers to successfully working	• Understands children's services in their community, and how to help children and their parents, family, whānau and caregivers to access them (including the appropriate referral pathways). • Uses common tools, processes and procedures for collaborative working. • Understands the assessment framework principles and processes • Networks with other children's workers to grow knowledge and improve practice.	using advocacy, negotiation, facilitation, and mediation skills. • Provides reflective supervision and encourage others to do so. • Supports colleagues when complaints are received, work to provide a resolution or escalate as required. • Is confident to respond to referrals/supports colleagues to respond collaboratively when referrals appear inappropriate. • Supports colleagues to write referrals to other agencies that meet their referral criteria. • Creates an environment/supports colleagues to create an environment where practice that is bullying, culturally unsafe, or not child-centred is not tolerated. • Creates an environment that supports the identification of children with delayed development or disordered behaviour. • Supports policies that encourage collaborative working and breaking down barriers.

	collaboratively and initiates actions for improvement.		
Share information, including working in multidisciplinary, multi-agency teams	• Commits to sharing information to achieve good outcomes for children. • Shares information in a timely, accurate and lawful manner, with support. • Understands how privacy legislation and policies and procedures surrounding confidentiality, consent and sharing are to be applied in their work.	• Champions the sharing of information to achieve good outcomes for children. • Openly and honestly communicates about the sharing of information. • Seeks consent to information sharing appropriately, unless this increases the risk of harm. • Is able to identify when there are too many services, conflicting goals or plans, and whānau are overwhelmed, and arrange an appropriate co-ordination mechanism (e.g. MDT, Strengthening Families meeting).	• Supports colleagues to share information in ways consistent with privacy legislation, policies and procedures, especially in difficult or challenging legal or ethical cases.
Lead and sustain transformational change	• Understands the content of the core competency framework (and role within it), can apply the descriptors in self-assessment, and in conversations with others about continuing professional development • Understands and applies the vision, values and behaviours	• Recognises the value of consistent evaluation and review of practice and services delivered. • Engages constructively with new practice, risk assessment and management frameworks, and other system-level and sector-specific changes.	• Supports colleagues to understand the vision and content of the core competency framework, and apply the descriptors in assessment of their competencies. • Supports colleagues to engage constructively with new practice, risk assessment and management

	related to this domain, i.e. 'A children's workforce that works together until positive outcomes are achieved for children, as well as their parents, family, whānau and caregivers. • Recognises that everyone has a role to play to get better outcomes for vulnerable children.	• Uses outcome measures to capture change.	frameworks, and other system-level and sector-specific changes.

Domain: Engage parents, family, whānau and caregivers (Vulnerable Children's Workforce Core Competencies)		
Subdomains	**Our vision**	**Profile of a worker competent in this domain**
Empower parents, family, whānau and caregivers **Communicate effectively with parents, family, whānau and caregivers**	A children's workforce with the interpersonal qualities and communication skills to engage with parents, family, whānau and caregivers in an honest and open manner to build positive and constructive relationships, establish a shared understanding of their situation, and collaboratively plan actions.	• Recognises parents, family, whānau and caregivers as the child's primary support system. • Uses interpersonal qualities and communication skills to engage effectively with parents, family, whānau and caregivers. • Maintains and strengthens, wherever possible and appropriate, the relationship between a child and their parents, families, whānau and caregivers. • Works in partnership with those that children depend on, including parents, family, whānau and caregivers to retain parental responsibility wherever possible and appropriate. • Able to communicate openly and honestly with parents, family, whānau and caregivers about concerns when this is in the best interest of the child.

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Domain 6: Engage parents, family, whānau and caregivers			
Sub-domains	**Foundation**	**Practitioner (plus Foundation)**	**Leaders of Practice (plus Foundation)**
11) Empower parents, family, whānau and caregivers, including rapport, engagement building working with resistance, courageous conversations, strengths-based practice, family therapy/systems approaches and interventions	• Commits to maintaining and strengthening the relationship between a child and their parents, families, whānau and caregivers. • Values whakapapa – particularly that of parents, families, whānau and caregivers, understanding their lead role and their responsibility for their children. • Understands that the behaviours of parents, families, whānau and caregivers may be the result of their attempts to cope with trauma. • Is able to use plain language and no jargon with families. • Has a clear understanding of role. • Has a solid understanding of the strengths-based model of practice.	• Works in partnership with parents, families, whānau and caregivers to maintain parental responsibility wherever appropriate. • Is able to engage in and lead courageous conversations with parents, families, whānau, caregivers and children to ensure the best interests on the child. • Recognises the right of parents, family, whānau and caregivers to information about their children, unless it is judged to be not in the best interests of the child. • Engages with parents, family, whānau and caregivers using trauma-informed practices and approaches. • Advocates, when appropriate, to other organisations and organisational leaders on behalf of	• Supports colleagues to respond appropriately where parents, family, whānau and caregivers are disengaging from their children, or where barriers to effective engagement are identified. • Supports colleagues to engage positively and constructively with parents, family, whānau and caregivers to address issues they are facing that impact on their parenting capacity. • Supports colleagues to understand issues within the community that may be impacting on parents', family, whānau and caregivers' interactions with services. • Ensures that leaders are modelling strengths-based and empowerment practices within each relationship, in the office and in the organisation.

	• Is committed to engaging in courageous conversations with parents, families, whānau, and caregivers where it is in the best interests of their child to do so. • Builds knowledge about the dynamics of families, how they interact with each other, and how to work with this.	parents, family, whānau and caregivers. • Values whakapapa and understands the role that parents, family, whānau and caregivers have in the decision-making for their tamariki. • Demonstrates the skill of understanding the different family dynamics at play, making an analysis of how this impacts on the wellbeing of the child, and working effectively with this. • Understands and recognises the resilience in children and their parents, families, whānau, and caregivers, and uses it to engage and empower them. • Participates in supervision that explores the impact of working alongside vulnerable families. • Recognises and reflects back the strengths identified in the child and family. Is able to recognise exceptions to the problem and work with them around this. • Is able to clearly explain to a variety of groups (including professionals) who you are, where you work, and what you are there for.	

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12) Listen and connect effectively with parents, family, whānau and caregivers, including assessment of, and working with, parents with mental illness and addictions.	• Communicates openly and honestly (includes active listening) with parents, families, whānau and caregivers, treating them with dignity, respect, and integrity. • Communicates in a positive and future-focused manner. • Ensures that parents, families, whānau and caregivers are aware of the feedback and complaints channels, and facilitates access as required. • Actively seeks feedback from parents, family, whānau and caregivers to inform continuous improvement and development. • Has an awareness of mental illness and addiction presentations in children and adults. • Recognises early sources and antecedents of conflict in families.	• Creates positive group dynamics, seeks solutions, and demonstrates the different roles of supporting, leading and facilitating when working with parents, family, whānau and caregivers. • Has conversations with parents, families, whānau and caregivers about personal issues or circumstances where these may be contributing to the vulnerability of their child or children. • Engages with parents, families, whānau and caregivers about potential intimate partner or family violence, connecting this if necessary to the vulnerability of their children.	• Supports colleagues to help parents, family, whānau and caregivers understand and interpret their child's needs. • Supports colleagues to discuss personal issues or circumstances with parents, family, whānau and caregivers where these may be contributing to the vulnerability of their child. • Supports colleagues to sensitively and confidently manage conflicts between the wants of parents, family, whānau and caregivers and what is in the best interests of the child. • Advises colleagues on different ways of communicating and to understand communication barriers that could affect parents, family, whānau and caregivers access to services. • Supports colleagues to actively seek feedback from parents, family, whānau and caregivers, informing continuous improvement of services and professional development of staff. • Develops robust service systems based on current best practices and feedback mechanisms that ensure

			participation and support of family and whānau.

HAWKE'S BAY District Health Board Whakawāteatia	**Ka Aronui Ki Te Kounga Focussed on Quality (draft)**
	For the attention of: **Māori Relationship Board, Clinical and Consumer Council**
Document Owner:	Kate Coley, Executive Director People and Quality
Document Author	Jeanette Rendle, Consumer Engagement Manager
Month:	August 2017
Consideration:	For Endorsement

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Council:

- Endorse the new format of the Quality Accounts and provide feedback on layout and content.

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OVERVIEW

The publication of the annual Quality Accounts was initiated in 2013, following the Health Quality & Safety Commissions (HQSC) guidance publication in July 2012 and the MOH's request that Quality Accounts should be produced annually. Since that time HB health sector has published four sets of accounts detailing our performance against both national and local quality and safety indicators.

The Quality Accounts are annual reports to the public from DHBs about the quality of services they deliver. As they are aimed at our community the aim is to keep them as short as possible, be visual, simple to read and understand, using photo's, images, stories, quotes, and examples to enhance the results and achievements.

The guiding principles are:-

- Accountability and transparency
- Meaningful and relevant whole of system outcomes
- Continuous quality improvement

FEEDBACK ON HB QUALITY ACCOUNTS 2016

Last year a working group was established to support the development and review of the Quality accounts publication for our community. It was a huge undertaking and presented multiple challenges. The link to last year's accounts as follows:
http://www.ourhealthhb.nz/assets/Publications/Our-Quality-Picture-2016-sml2.pdf

Previously the HQSC has reviewed all Quality Accounts providing annual feedback individually to DHB's and across New Zealand. From 2016, HQSC no longer provide feedback.

In 2016 around 400 publications and accompanying advertising posters were distributed across the community – to GP practises, health centres, public libraries, and community groups. The accounts were advertised in local newspapers and available on ourhealth website. It has been difficult to quanitify the level of readership. Feedback from the community was limited.

The feedback from stakeholders and community that we did receive resulted in the recommendation to have a smaller, more concise document this year with increased focus on the quality improvements that have come about from community feedback and consumer engagement. A ‘you said, we did” type format. Also, less emphasis on improvements and quality initiatives within services (which perpetuates the idea of working in silos) with increased emphasis on improvements as a result of working together across the sector; in particular more content from Primary care.

Recommendation:

The communications team have developed a template based on the recommendations and articles that have been gathered thus far. This is a starting point and provides a flavour for the document. We anticipate profiling another staff member (from PHO) and are waiting on content from Primary care which will include a day in the life of Te Mata Peak practise duting the gastro outbreak and will profile Totara and Choices new #whanau work.

I am looking for endorsement to proceed with this new tabloid publication and take any feedback on layout and content that will inform the final draft copy.

The final draft publication will come back to you next month before going to Board for endorsement in September.

KA ARONUI KI TE KOUNGA

FOCUSSED ON QUALITY

OUR QUALITY PICTURE 2017

Kia ora and welcome to the fifth edition of "Our Quality picture". This is a snapshot of how the health system is working to meet the needs of the Hawke's Bay community. People should be at the centre of health care and inside we focus on what we have done in the last year in response to feedback from our consumers and community.

We also recognise that providing healthcare is not without risks and sometimes people can be unintentionally harmed while undergoing care. Our aim is to reduce this harm and inside we outline our progress in this area, and how we measure up nationally against patient safety priorities and national health targets.

Kate Coley, Executive Director of People and Quality

Our Quality Commitment

Our commitment and pledge to you is:

That as individuals, and as a health sector, we continually improve the safety and quality of health care for all

To ensure that we have a blame free culture that embraces consumer involvement

That we put the patient at the centre of everything we do and focus on continuous improvement

That we ensure all of our teams are well supported and have the skills to deliver high quality and safe patient care, every time.

Ko ā koutou whakahokinga kōrero
Your feedback

We welcome and appreciate receiving feedback. To improve our services we need to hear your story. Whether compliments, comments, questions or suggestions, complaints or a mixture, your feedback is valuable. It helps us see where we are performing well and where we could improve.

You can give feedback in a number of ways:

- email us: feedback@hbdhb.govt.nz
- complete an online feedback form: www.ourhealthhb.nz
- Phone us: 0800 000 443
- complete a freepost feedback form which may be given to you when you visit, or which can be found in many areas across the DHB's sites.

You may receive a phone call or receive a request to complete a survey based on your experience. It is your choice to take part or not.

Ngā whāinga hauora ā-motu
National health targets

HEALTH TARGET	TARGET	OUR RESULT (04 2015/16)	TREND (since last year)	COMMENT
Shorter stays in Emergency Department	95%	Not achieved (93%)	↓	Hawke's Bay DHB continues to focus on improving flow through the Emergency Department. Additional staff are being employed to support this.
Improved access to elective surgery	100%	Exceeded (105%)	↑	This year we have continued to focus on Operation Productivity and increasing Hip and Knee surgeries to increase the number of people receiving surgery.
Faster Cancer Treatment	85%	Not achieved (63%)	N/A	This is a new national health target. The Faster Cancer Treatment team are working with improved processes to identify patients on the cancer pathway and we expect to see improvement in the coming year.
Increased immunisa	95%	Achieved	-	Hawke's Bay DHB remains one of the top performers in this Health Target. All immunisation service providers are working well together.
Better help for smokers to quit (Hospitals)	95%	Exceeded (99%)	-	Hawke's Bay DHB has achieved this target for the last three years.
Better help for smokers to quit (Primary Care)	90%	Not achieved (81%)	↓	Health Hawke's Bay continues to work with general practices to improve smokefree interventions.
More heart and diabetes checks	90%	Not achieved (88%)	↓	Health Hawke's Bay continue to focus on priority groups who are most at risk of heart disease and diabetes.

2015/16 DATA
NEW DATA TBC

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KEY:

↑ Improved our performance against the health target.

↓ Our performance against the health target has declined

– Our performance against the health target has stayed the same.

You asked, we did

The following articles are examples of some of the things you told us through your feedback and what we are doing about it.

Youth Consumer Council

The Hawke's Bay Health sector has its own youth consumer council (YCC). The first of its kind in the country!

The formation of YCC was recommended as part of the youth health strategy that was finalised in July 2016. The development of this involved lots of consultation with health sector staff, community groups and youth in Hawke's Bay.

We learned that youth partnerships, leadership and collaboration across the health system was really important. YCC was initiated in late 2016 to help make this happen!

Aged between 12 and 24, the members of YCC ensure the youth voice is heard. They will also help the health system with ideas and concepts so it can be better connected with young people.

Charged with getting out and about, the council also meets with individuals in the community, other organisations and established youth groups so they can be well informed about what motivates young people to be proactive about their health. By engaging with youth face to face and interacting in different forums YCC were able to confirm their three priorities:

- Teen Suicide Awareness
- Drug and Alcohol culture
- Mental Healthcare Hawke's Bay

Dallas Adams, Chair off YCC and member Kylarni Tamaiva-Eria attend monthly Hawke's Bay Health Consumer Council meetings. Whilst they found it intimidating at first they have now made positive connections and feel confident they have a platform to voice youth opinion and influence decision making in the health system. "They encourage us to have a say and that makes us feel valued" says Dallas.

Did you know

There are 19,300 15-24 year olds in Hawke's Bay. This is 12% of the total population.

Around 2,019 (11%) youth live in rural areas and 15,984 live in urban areas (based on 2013 census)

YCC member Deveraux Short-Henare has enjoyed learning about the health system and how in his role he can influence changes to better meet the needs of youth. "I accepted the nomination because I honestly believe that youth need to be represented and have a say on what a 'youth' health system looks like and I think this group can enable that to happen". Deveraux and fellow member Tremayne Kotuhi recently represented YCC at Festival for the Future 2017. Hundreds of young innovators and influencers all gathered in Auckland to connect, explore issues, be inspired, and build ideas and skills to create the future. Tremayne came back motivated with new connections and ideas to test in Hawke's Bay.

The council has its own Facebook page, HB Youth Consumer Council ,where you can keep up-to-date with what they are up to.

Improving how we communicate with you

"He did not tell us what he was going to do. He went ahead without informing us or including us in the decision."

It is not uncommon for you to tell us, as health profesionals, that we could do better at listening to what you have to say, understanding what is most important to you and including you and your whanau in decisions about your care and treatment.

To support our staff in improving communication with consumers we started a training programme in March 2017 called "relationship centred practice" which has so far been delivered to over one hundred Allied Health Professionals (Physiotherapists, Occupational Therapists, Social Workers etc..). Online learning modules and face to face training workshops were developed with consumer involvement.

The training is a sustainable, skills based training package which is aimed at providing health professionals with practical methods and strategies to enhance their interactions with consumers and their whanau. This includes working in partnership, finding out what is important, what really matters to the consumer in terms of healthcare, and working together to come up with solutions.

This mana enhancing practice clearly puts the consumer and their whanau at the centre of their own healthcare - working in collaboration, building on strengths and being well supported to achieve the goals that are important in the context of their lives. It is focused on improving the connection and quality of interactions with consumers who in turn get greater engagement and thereby health outcomes are improved.

We have plans to roll this out to other health professionals in the hospital and communtty settings in 2017/18.

Staff have found this training valuable and it has allowed them to reflect on and improve their practise.

"I am much more aware of focusing on what the families want, how important it is to them and changing my approach to empower them more".

"The facilitator delivered the message effectively and simply and made me see how vital whakawhanaungatanga is, with every patient I see".

Health literacy – making healthcare easy to understand

Health literacy is about making sure healthcare is easy for people to find, understand and use so that they can look after their health and wellness.

To do this HBDHB has committed to changing the way we deliver health care to the people of Hawke's Bay. We have taken the first step by setting some rules around how we provide information such as pamphlets and letters, as well as how our health professionals talk to you about your health and wellness.

The next step is to make sure everyone working in the HBDHB is aware of the importance of making healthcare easy to understand. This involves working alongside our services and health professionals to help them make the changes that are needed to ensure this happens.

Ultimately, we want to make it as easy as possible for people to find the correct information or get to the right healthcare services, so they understand how they are best to take care of themselves.

Achieving this will take time, but people will progressively notice a difference in the way they receive information and healthcare services in Hawke's Bay.

To make this easier, we need the help of our consumers to tell us how we are doing throughout this journey and where we need to make improvements and changes. Feel free to email us at feedback@hbdhb.govt.nz with your thoughts.

This will go a long way in making sure healthcare is easy to understand to help you be well, get well and stay well.

National Patient Safety Priorities

The Health Quality and Safety Commissions (HQSC) key role is to publish information including targets about the quality of health care in New Zealand. By having a target we can monitor how we compare with other DHB's which will challenge us to do better. For more information look at the website www.hqsc.govt.nz.

The four main ways we can monitor how we compare with other DHBs are by:

- reducing the number of injuries from a fall while in hospital or residential care by assessing people and having a plan to look after them
- stopping people from getting an infection while in hospital or during surgery by having good hand hygiene and giving antibiotics before surgery
- preventing people from having more problems because of medication they require
- decreasing problems just from having surgery.

We know we are getting better at this because our results in the January to March 2017 quarter tells us that Hawke's Bay compared to other DHB's are in the top areas for three out of the four areas and we are working hard to improve the fourth area which is the safer surgery marker. The safer surgery marker compares how well surgical staff complete safety checklists and although we know they are doing it – we need to get better at proving it.

Staff and visitors participating in a Tai Chi taster class lead by Sport Hawke's Bay.

Our Falls Campaign across the whole region focused on improving balance and strength, we had a great month working with other providers and we ended up being recognised nationally for our work. This is something everyone can do to help themselves – as we age its harder to keep our balance and keep strong in our legs. But there are a lot of community programmes to help – staff and visitors tried Tai Chi this year – thanks to Sport HB. Look at their website for a list of programmes www.sporthb.net.nz

Other national programmes which are coordinated by the HQSC include:

- Recognising Detoriating Patients - Getting better at identifying when someone is getting sicker while in hospital and having a plan to help them faster;
- Medication Management - Helping people who are in pain and need strong medication to help them, which sometimes means they get constipated – ie. you can't have a 'poo' as often as you would normally, this is a problem so we are doing some things to stop this, for example: making sure if strong medication is needed, medicine to make you poo is also given.
- National Patient Experience Survey (in hospital) – this has been running for three years now and the feedback informs national improvement campaigns for example: medication safety. HBDHB are measured on four main domains – communication, coordination, partnership and physical and emotional needs. (insert table with our scores).

Let's Talk - Patient Safety Week

Patient Safety is top of mind every day in healthcare. "Let's Talk" was the theme at Hawke's Bay Hospital during Patient Safety Week in November 2016 when we highlighted better communication between patients, whānau and health professionals. We had displays to highlight the Let's Talk campaign making sure we got the attention of staff, patients and visitors to the hospital and our "what matters to you" whiteboards reinforced that whānau/family matters most.

Patient Safety Week is a Health Quality and Safety Commission initiative which we embrace every year. The theme for 2017 will be medication safety. This topic has been chosen because the in-patient experience survey question "Did a member of staff tell you about medication side effects to watch for when you went home?" consistently gets one of the lowest scores from consumers and there are a large number of medication errors in hospitals.

CEO Dr Kevin Snee checks out a display alongside Jane Bailey, Patient Safety Advisor and Jeanette Rendle, Consumer Engagement Manager.

How to keep yourself safe when in hospital – here are our top tips:

- **Talk** with your doctor and nurse and tell them what you know about your illness or injury.
- **Ask** questions to help you understand your treatment – why you are having it, the choices, what will happen and the risks and benefits.
- **Clean** your hands often to help stop infection, and ask your visitors to clean their hands.
- **Keep** a list of and learn the names of the medicines you are taking, the reasons you are taking them and when and how to take them.
- **Ask** for the results of any tests you have and what happens next.
- **Get** to know your ward and make sure the call bell is always within easy reach.
- **Before** leaving hospital, ask what you and your family/whanau need to do at home.

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National Patient Safety Priorities **In hospital**

The Health Quality & Safety Commission is driving improvement in the safety and quality of New Zealand's healthcare through the national patient safety campaign 'Open for Better Care'. All of New Zealand's district health boards need to report on how well they are doing against key targets. These targets are about making sure consumers are not harmed from a fall when in our care, that we reduce the number of infections and that we make sure that when consumers have surgery they receive the necessary medicines, and that we work as part of a team.

This is how we are doing (results for Jan-Apr 2016 unless otherwise specified):

✓ **93%** **Falls prevention 1**: Older consumers assessed for risk.. Target 90%

✓ **94%** **Falls prevention 2**: Percentage of older patients assessed as at risk of falling who receive an individualised care plan addressing these risks. Target 90% (an increase of 8% from last year).

✓ **89%** **Hand hygiene:** Percentage of health professionals who clean their hands before and after having contact with a patient. Target 70%.

✓ **100%** **Surgical site infection 1:** Antibiotic administered in the hour before surgery. Target 100%

✓ **98%** **Surgical site infections 2:** Right antibiotic in the right dose. Target 95%

open FOR BETTER CARE Hāpai ake te toiora

Hand Hygiene

Hand hygiene is recognised worldwide as the single most effective way to prevent the spread of infection and improve the quality and safety of patients in our care. The 5 moments for Hand Hygiene is a programme developed by the World Health Organisation (WHO), and implemented across all New Zealand district health boards (DHBs).

HBDHB continues to achieve a high level of compliance with the 5 moments for Hand Hygiene when compared to other NZ DHBs. The quarter ending March 2017, HBDHB achieved a compliance rate of 88.7%, the highest in NZ.

On 5 May, HBDHB celebrated World Hand Hygiene Day. Wall displays across the hospital were created by enthusiastic staff members, an information board was created in the main entrance, and a competition 'guess the hands' was run that created a sense of fun and engagement with staff, patients, and visitors.

It was also a time to celebrate and thank the Hand Hygiene champions within the hospital for their passion and dedication to the programme and ultimately the positive impact it has on patient safety.

Go Well Travel plan

We know that prior to March 2017 our community were having real trouble finding car parking at Hawke's Bay Hospital – whether coming to an outpatient appointment, or visiting loved ones. In 2016 a lack of car parks was one of our top complaint themes.

"trying to find parking can take up to 30 minutes. I ended up missing my appointment".

"I had an appointment for my moko at 9am. I couldn't find a park. When I did find one we were 50 minutes late for his appointment…"

Feedback like this was not unusual. Missing an appointment is inconvenient for our patients, impacts negatively on their overall experience of care and doesn't allow us to best manage our time and resources.

We listened to you. The introduction of paid car parking in March 2017 and the promotion of alternative modes of transport has eased congestion. Patient and visitor parks are now freely available with about 30 spaces available at any given time. It is working well with plenty of positive feedback from people who are grateful to be able to easily find a park and this means a better overall experience, people attending appointments on time and less stress.

"I have used the car park twice this week for appointments, it was so nice to just be able to drive straight in and park without having to drive around endlessly. I was more than happy to pay the $1 each time for such an easy stress free arrival". (Lucy Billings, Facebook).

Tom Wihapi (pictured below), is our friendly parking officer overseeing the paid parking scheme. Tom averages 15km per day on the job and is only too happy to help visitors and patients with parking queries, lost car keys or machine issues.

"It has been going very smoothly, people are very understanding of the pay scheme and visitors especially are only too happy to be able to find a car parking space."

As well as paid car parking, we have also worked with GoBay to bring you other transport options. Outpatients are making the most of the free bus transport option, with 519 trips to attend their appointments at the hospital or Napier Health in May alone. That's a staggering 122% increase on May last year!

Tom (pictured right) says he enjoys catching the bus to his hospital appointments.

If you have an upcoming outpatient appointment at the hospital or Napier Health, you too can jump on the goBay network for free, together with a support person. Simply show your appointment letter or text reminder to the bus driver and you'll be on your way!

"It's completely hassle free, it's an easy way of getting across from Napier and I don't need to rely on anyone else."

Adverse events

Adverse Events are events which have resulted in serious harm to patients. This harm may have led to significant additional treatment, have been life threatening or led to a major loss of function or unexpected death.

Adverse events are uncommon but taken seriously. For each event we conduct a formal review which follows the patient's journey through the hospitals systems and processes.

What we learn from these reviews is important and we recognise that each event provides an opportunity to improve the care we provide.

Adverse events 2016/17

Data TBC

Learning from Adverse Events

Several reviews at HBDHB have led to significant improvements on the front line, examples are:

- The appointment of more senior doctors
- Reducing delays to reach definitive diagnosis
- Education opportunities
- Improvements to the transfer of care – communication information gathering tools have been developed.

"[we] would like to thank you for investigating [his] death and providing a clear report. My primary intention was to ensure any lessons that could be learnt from this tragedy would possibly prevent others having to experience this and to that end we were heartened to see the changes in DHB operating procedures.

…the family was happy to see that our concerns were taken seriously by the depth and openness of the DHB report and the remedial actions that have since been implemented".

Future Focus

The organisation has invested in a new integrated risk management system which is intended to be rolled out at the end of 2017. This new system brings new capabilities and allows the DHB to better monitor and manage its associated risks. We hope to bring the primary care sector on board with the system in 2018.

We value the input of consumers into decision making about our healthcare and improvement activities and as such in 2018 we intend to invite consumers and/or their whanau to be involved in the review process.

Staff profile

Wairoa's Rural Nurse Specialist Nerys Williams is relishing the opportunity to make a difference in people's lives by helping them in whatever way she can. Her experiences, she says, have reinforced the importance of her role in keeping people out of hospital and delivering care in the home for rural patients.

Wairoa people are benefitting by having the opportunity to reduce travel to Hastings for procedures that can be provided by Nerys in their own home.

One experience, in particular, has had a positive impact on Nerys and listening to her recount the story of two sons who cared for their terminally ill father is touching.

"It was their Dad's dying wish to return to his papakāinga (original home)," says Nerys, who was determined to try and make that happen. With Nerys' training, the sons were able to inject medication into their Dads muscle over a period of four to five days, being fully responsible for the drug application, and providing constant attention to their Dad in the comfort of their home.

"The training was robust and this was supported by phone calls and daily visits by me to ensure the sons and wider whānau were supported well," said Nerys.

"Just as important was coordinating the wider support network including district nurses, occupational therapists and Cranford Hospice and I am proud of how well everyone pulled together to do their respective jobs with very short notice."

Primary Care

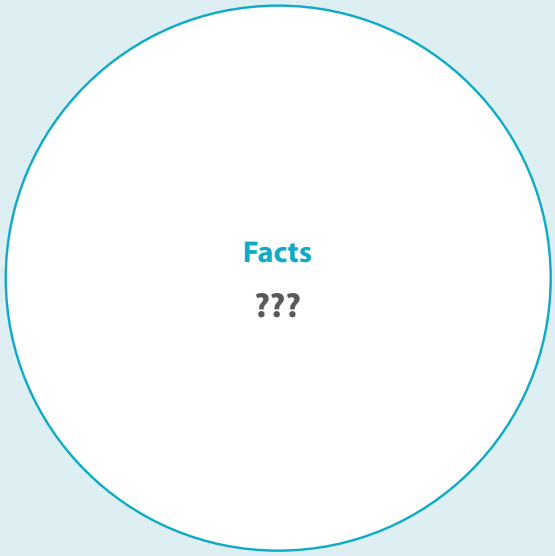
TBC

Heading

text

Gastro Outbreak

lText



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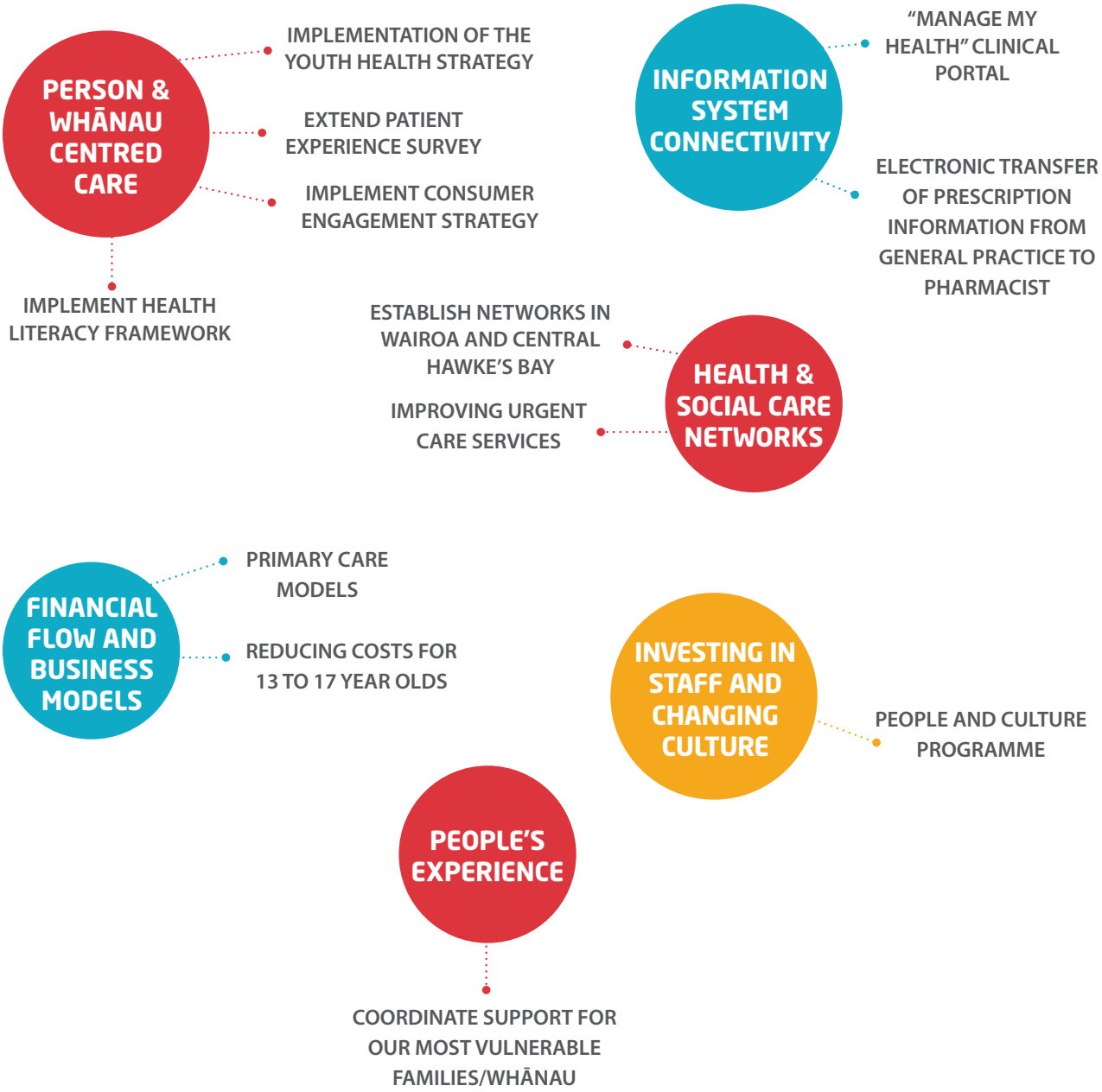
#whanau

Text

TŌ TĀTOU ARONGA MŌ ĀPŌPŌ
OUR FUTURE FOCUS

With the refresh of the New Zealand Health Strategy, we will be working to ensure that: **All New Zealander's live well, stay well, get well in a system that is people powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system.**

We have reviewed our 5 year strategy Transform and Sustain which aligns to the New Zealand Health Strategy. We will support the elimination of inequity and prepare our health services for more numbers of younger Māori and growing numbers of older people and people with chronic conditions. Over the next two years we will identify further projects to respond to the changes in our population. We have included examples under each theme. To meet the needs of the Hawke's Bay population we need to continue to improve what we do.



I MŌHIO RĀNEI KOE IA RĀ...
DID YOU KNOW THAT EVERY DAY...

3 children will receive one of their vaccinations

6 babies will be born

10 fragile babies will be cared for in the special care baby unit

16 people will get their free annual diabetes check

22 women will have a mammogram and a further 29 a cervical smear test

35 operations will be completed in one of Hawke's Bay Hospital's theatres

NEW DATA TBC

200 visits/appointments will be made to support people with mental health issues

209 visits will be made by district nurses and home service nurses

245 children will be seen for their free dental health check

1,454 people will see their family doctor

4,662 prescriptions will be filled out

5,680 laboratory tests will be completed

15 km an orderly can walk on average of 15km

85 people will be admitted to Hawke's Bay Hospital

350 meals on wheels will be delivered

5,870 items of laundry will be delivered to the hospital

Icons made by Freepik from www.flaticon.com

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Māori Health Plan Q4 April - June 2017 Full Report**
	For the attention of: **Executive Management Team and Māori Relationship Board**
Document Owners:	Tim Evans, General Manager Planning, Informatics and Finance Tracee Te Huia, Executive Director, Strategy & Health Improvement Patrick Le Geyt, General Manager Māori Health (Acting)
Document Author(s):	Justin Nguma, Senior Health & Social Policy Advisor Māori Health Peter Mackenzie, Business Intelligence Analyst
Reviewed by:	Not applicable
Month:	August 2017
Consideration:	For Monitoring

RECOMMENDATION

That EMT and the Māori Relationship Board:

Note the contents of this report.

CONTENTS OF THE REPORT

This is a report on the Māori health indicators agreed as part of the development of 2016 /17 Annual Māori Health Plan.

A quick reference summary dashboard is included and shows our position as at the end of this quarter for all indicators. The dashboard uses traffic light methodology (as described in the key on page 6) to represent this.

As this report is for the period ending June 2017, some results may vary to those presented in other reports.

KEY FOR DETAILED REPORT AND DASHBOARD

Baseline	Latest available data for planning purpose
Target 15-16	Target 2015/16
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target
Trend direction ▲	Performance is improving against the previous reporting period or baseline
Trend direction ▼	Performance is declining
Trend direction -	Performance is unchanged

Table of Contents

2016-2017 ANNUAL MĀORI HEALTH PLAN QUARTER 4 PERFORMANCE HIGHLIGHTS

Achievements

1. Māori Workforce grew from 12.5% in Q1 to 14.3% in Q4and met the annual target of ≥13.8% for 2016/17 by 15 positions *(Page 61)*

The Māori Staffing Recruitment Plan initiatives this year moved the focus from just Nursing to all occupational groups and has resulted in an increase of Māori staff across all Services. Over the last 12 months 20.1% of the new staff employed at the DHB identified as Māori.

Areas of progress

1. Immunization rates for 8 months old Māori dropped slightly from 94.4% in Q1 to 94% in Q4 but still trending positively towards the expected target of ≥ 95%.

   The disparity gap between Māoriand non-Māori in Q4 is1.6% compared to 2.1% in Q1.This trend can partly be attributed to the growing publicity against immunization. The national coverage has also dropped by 0.4% to 91.9%. *(Page 8)*

   Efforts have been focused on raising awareness among whānau through Health HB Whānau Wellness sessions and we are planning to provide education to Family Start workers in the coming quarter. We are also exploring the use community champions in promoting immunization among the whānau.

2. Ambulatory Sensitive Hospitalization (ASH) for 0-4 year old Māori dropped significantly from 91.7% in Q1to79.5% in Q4 but trending positively towards the target of ≤82.8%. The disparity gap between Māori and non-Māori slightly increased from 11.4% in Q1 to 12.6%in Q4. *(Page 46)*

   The equity gap between Māori and non-Māori is being addressed through collaborative programmes with key stakeholders. These include: i) the “Under 5 years caries free equity project”; and ii) respiratory initiative focused on exploring respiratory pathway post presentation to secondary care services.

   ASH rates for 45- 64 year olds dropped significantly from 196% in Q1 to 178.5% in Q4 and trending positively towards the target of ≤138%. The disparity between Māori and non-Māori has increased from 87% in Q1 to 110.9 in Q4.

   Cardiac admissions continue to be a major concern and there are several initiatives currently in place to address this challenge.

3. Cervical screening for 25-69 year old Māori women in Q4 was 73% up by 0.3% from 72.7% in Q1and trending positively towards the expected target of ≥ 80%. On the other hand the disparity gap between Māori and non-Māori has narrowed to 2.2% in Q4 compared to 5.5% in Q1. *(Page 52)*

   HBDHB remains the 1st in cervical screening coverage for Māori women out of the 20 DHB’s. This success is a result of good collaboration between primary care, population health and Māori providers. The addition of Pacific Community Support worker has also increased our coverage among the Pacific women and we are now looking at the logistics of extending our services to the growing Asian population.

   Breast screening for 50-69 year old Māori women has dropped slightly from 67.1% in Q1 to 66.2% in Q4 but still trending positively towards the target of ≥ 70%. The disparity gap between Māori and non-Māori has grown slightly from 7.4% in Q1 to 8.7% in Q4.

4. The Māori staff cultural competency training has grown by 4% over the year from 77.5% in Q1 to 81.5% in Q4. Medical and Support Staff consistently remain well behind the other areas and at 36.9% are well below the expected target of ≥100%. *(Page 63)*

   Concerns about the low participation of the medical staff in the training have been shared with the CMO. The Strategy & Health Improvement Directorate is working with the CMO to address the attendance bottleneck for the medical staff.th

5. Access to referral services for Alcohol and Other Drugs for 0-19 year old Māori within 3 weeks decreased slightly from 81.61% in Q1 to 78% in Q4 but trending positively towards the expected target of ≥80%. *(Page 69)*

   On the other hand, referral services for 0-19 year olds within 8 weeks increased slightly from 91.7% in Q1 to 92.8% in Q4 and trending positively towards the target of ≥ 95%. There is no disparity gap between Māori and non-Māori in Q4.

   This progress is partially attributed to the efforts of the Kaitakawaenga active focus on linking with whānau and continued collaborative work with other providers.

6. PHO enrolment has increased by 1.3% from 96.6% in Q1 to 97.9% in Q4 and trending positively towards the ≥100%. The disparity gap between Māori and non-Māori has gone down from 0.3% in Q1 to 0.2% in Q4. *(Page 40)*

   Within the last quarter the PHO has worked to increase the number of practices that are now open for enrolment.

Challenges

1. Acute hospitalization for Rheumatic Fever has risen from 4.82% in Q1to 7.23 in Q4 (one new case for the quarter) and trending away from the expected target of ≤1.5. The disparity gap between Māori and non-Māori has grown from 2.96 in Q1 to 6.54 in Q4. *(Page 15)*

   There has been an increasing interest in knowing whether the presentation of the new cases with increased complexity (e.g. presenting with chorea) and among the young adults represents a genuine national trend as overall rheumatic fever rates decline. The information will help us understand this phenomenon better, for effective interventions.

2. Māori under Mental Health Act compulsory treatment orders (CTO) has slightly decreased from 183.9 in Q1 to 175.1 in Q4. This shows a reduction in rate ratio of Māori to non-Māori under compulsory treatment orders from 3.2:1 in Q1 to 2.8:1 in Q4. While still far away from the MOH target of 81.5 the data is trending in the right direction and our aim is to bring it down to a sustained rate ratio of 2:1 Māori to non-Māori as this would represent a significant change from the current rate ratios. *(Page 32)*

   High numbers of patients under CTO is a product of many factors including the problem of schizophrenia. Broadly, with regard to the prognosis in treatment of schizophrenia, there are two key factors which impact significantly, including: (a) longer duration of untreated psychosis and (b) higher functional impairment. Early treatment of initial onset of psychosis is likely to mitigate the impact of functional impairment resulting in less number of patients under CTO. Other measures include: home based treatment; provision of acute day services; targeted treatment pathways; and greater use of longer interval injectable antipsychotic medication.

Please note:

- Unless otherwise stated the results presented in this dashboard are for Māori.

- The approximated gap to achieving target numbers stated may only be one of a range of possible values that could deliver the targeted level/result.

ANNUAL MĀORI HEALTH PLAN, QUARTER 4 APRIL – MAY 2017 DASHBOARD REPORT

Immunisation

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Immunisation at 8 Months (3m)	92.6%	95.4%	94.0%	95.6%	≥ 95%	-3		↑
65+ Influenza (12m)	68.0%	21.0%	54.0%	59.0%	≥ 75%	-578		↑

Rheumatic Fever

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Total	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Hospitalisation rate (6m)	2.48	7.23	9.64	3.1	≤ 1.5	-1		↓

Breastfeeding

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Total	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
QIF Data (6m)								
At 6 Weeks	58.0%	66.0%	No new data, waiting for the publication of the QIF		≥ 75%	-		↑
At 3 months	46.0%	39.0%			≥ 60%	-		↑
At 6 months	46.0%	50.0%			≥ 65%	-		↑

Oral Health

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Pre-school enrolment rate (12m)	65.3%	72.7%	Reported Annually in Q3		≥ 95%			↑
% Caries Free at 5yrs (12m)	36.0%	44.0%			≥ 67.0%			↑

Tobacco

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Smokefree 2 weeks postnatal (6m)	53.0%	65.6%	No new data, waiting for the publication of the QIF					↑

Mental Health & Addictions

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Mental Health Act community treatment orders (per 100,000) (3m)	196	175.9	175.1	61.5	≤ 81.5	-		↓

Access to Care

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
PHO Enrolment (3m)	97.2%	97.5%	97.9%	98.1%	≥ 100%	-890		↑

The number in brackets identifies the frequency at which data is updated:
(3m) 3 months
(6m) 6 months
(12m) 12 months

ASH Rates

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
0-4 years (6m)	82.1%	84.9%	79.5%	66.9%	≤ 82.8%	-		↓
45-64 years (6m)	172.0%	211.3%	178.5%	67.6%	≤ 138%	-		↓

Cancer

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Cervical screening (25-69 yrs) (3m)	74.1%	73.1%	73.0%	75.2%	≥ 80.0%	-644		↑
Breast screening (50-69 yrs) (3m)	68.4%	66.7%	66.2%	74.9%	≥ 70.0%	-135		↑

Maori Workforce

Indicator	Baseline	Prior period result	Actual to date Maori	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	2.9%	4.7%	5.2%	≥ 13.8%			
Management & Administration	16.5%	19.1%	19.9%	≥ 13.8%			
Nursing	10.6%	11.6%	12.1%	≥ 13.8%			
Allied Health	12.6%	13.2%	4.3%	≥ 13.8%			
Support Staff	28.2%	29.3%	31.6%	≥ 13.8%			
Māori staff - HBDHB (3m)	12.3%	13.5%	14.3%	≥ 13.8%	-		↑

Cultural Responsiveness

Indicator	Baseline	Prior period result	Actual to date	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	19.2%	37.5%	36.9%	≥ 100.0%			
Management & Administration	79.1%	88.5%	89.4%	≥ 100%			
Nursing	70.0%	85.6%	86.0%	≥ 100%			
Allied Health	77.3%	89.9%	90.8%	≥ 100%			
Support Staff	35.6%	64.9%	64.4%	≥ 100%			
HBDHB (3m)	65.6%	80.9%	81.5%	≥ 100%	-		↑

*Obesity still to be confirmed

Alcohol and Other Drugs

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
% of 0-19 year olds seen within 3 weeks of referral (3m)	63%	74.1%	78.0%	72.6%	≥ 80%	-		↑
% of 0-19 year olds seen within 8 weeks of referral (3m)	86.5%	92.0%	92.8%	89.7%	≥ 95.0%	-		↑

Indicator Legend
Target attained
Within 10% of target
10-20% away from target
Greater than 20% away from target

QUARTERLY PERFORMANCE AND PROGRESS UPDATE

1. Increasing Immunisation

Outcome: 95% 8 month olds completing primary course of immunisation

Key Performance Measures	Baseline [1]	Previous result[2]	Actual to Date[3]	Target 16-17	Trend direction
Māori	92.6%	95.4% (F)	94% (U)	≥95%	▼
Pacific	100.0%	94.6% (F)	100% (F)	≥95%	▲
Other	93.3%	93.5% (U)	95.6% (F)	≥95%	▲
Total	93.3%	94.4% (U)	95% (F)	≥95%	▲

Comments:

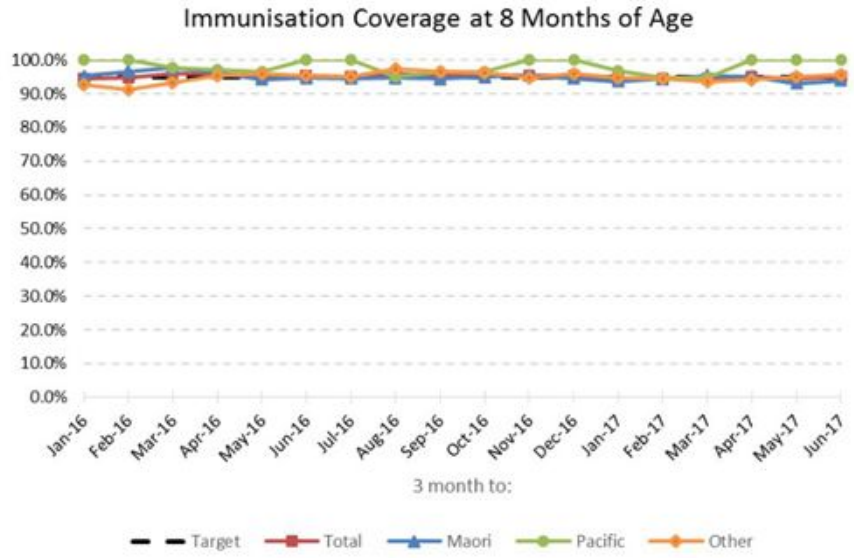
234 out of 249 Māori infants up to date with immunisation this quarter a drop in coverage by 1 %.

We have contacted all families but we think the publicity against immunisation has had an effect this quarter. Nationally the coverage has also dropped by 0.4% to 91.9%

24 out of 24 Pacific infants are up to date this quarter which is a great result.

There has been awareness raising at the HealthHB Whanau Wellness sessions and we are planning to provide education to Family Start workers in the coming quarter and investigating community champions in the 2016 – 2017 year.

Time series



Source: National Immunisation Register, Ministry of Health

1 October to December 2015

2 January to March 2017

3 April to June 2017

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
1.1	**INCREASE IMMUNISATION COVERAGE IN CHILDREN**						
1.1.1	Continue to facilitate successful Hawke's Bay Immunisation steering group quarterly and use this group to monitor coverage rates, equity and outreach activity.	Quarterly	Fiona			On track	Meeting held 25 May - minuted
1.1.2	Continue to implement strategies in the Immunisation Action Plan *'Improving Childhood Immunisation On Time Rates in Hawke's Bay'.* These involve but are not limited to, identifying and referring due and overdue children who present in hospital services and monitoring and maintaining equity.	Quarterly	Fiona	**Health Target:** 95% of eligible children fully immunised by 8 months **PP21:** 95% of eligible children fully immunised by 2 years **PP21:** 95% of eligible children fully immunised by 5 years by June 2017	Equitable coverage across Māori, Pacific and Other		8 month target 95% overall, Māori 94%% - 3.9% decline overall **PP21:** 2 year target 94.7% overall, Māori 95.7% - 4.2% decline overall **PP21:** 5 year target 93.2%, Māori 91.8% - 4.6% decline overall
1.1.3	Use Datamart reports regularly to measure the coverage rates by ethnicity and deprivation status, and identifying increased numbers of declining or opt-offs or other gaps in service delivery. Tailor the response to data appropriately using the variety of access options available.	Quarterly	Fiona				No changes here. Datamart reports are checked fortnightly to identify trends and NIR forecast ahead for declining children. This is business as usual.
1.1.4	HHB to support practices to review, audit and manage their Patient management systems for the systematic and timely review of children.	Quarterly	Victoria				Close monitoring of HHB general practices via Dr info and other PMS tools ongoing
1.1.5	HHB and HBDHB to work collaboratively on promotion of Immunisation week in Q4 2017	Quarterly	Fiona/ Victoria		Report on plan for Imms week		Immunisation Awareness workshop run in Immunisation week - 15 attended. 3 staff from From Te Kohanga Reo and 1 from Māori Women's Welfare

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
							League were among the attendees. Resource made available to all Public Health nurses to put article in High School Newsletters and to present at High School assemblies.
1.1.6	Immunisation team to maintain working relationships with age appropriate services such as Tamariki Ora, Plunket, community oral health services and B4 School Checks to ensure efficient use of resources for tracking children and appropriate service provision.	Six-monthly	Fiona		Conversations occurring 6-monthly	On track	Plunket and Tamariki Ora nurses have had education workshops in the last 6 months. Most B4SC nurses are authorised vaccinators and so are regularly updated with ongoing education. There is constant communication with these and other age appropriate services.
1.2	**Support the strategy goal of reducing the incidence of cancer thorough primary prevention by increasing HPV immunisation rates.**						
1.2.1	Facilitate quarterly HPV stakeholders group, which is a sub group of and reports to The immunisation Steering Group.	Q4	Fiona	**PP21:** 70% of eligible girls fully immunised with HPV vaccine	Equitable coverage across Māori, Pacific and Other	On track	The HPV stakeholders group has been discontinued and HPV coverage and actions are agended at the quarterly Immunisation Steering Group which is minuted. Coverage for 2003 birth cohort of girls ending June 2017, completing 3 doses. Total coverage 66%, Māori 78%, Pacific 68%.

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
1.2.2	In Q4, provide a list to GPs of those who have declined immunisation through the school based programme for follow up.	Q4	Fiona	All girls with GPs identified on their school consent form will be referred to the general practice for follow up	Number of girls referred for follow up.		Lists provided to GPs mid June. This list now includes boys due to the schedule change in January. 687 boys and girls notified to GPs for follow up. This included those declining and those who indicated that they would prefer to have the immunisation at the GP.
1.2.3	Provide education sessions to Nurse vaccinators, public health nurses and smear takers	Quarterly	Fiona	1 education session for each group			One update this quarter.
1.2.4	Ensure all major milestones on the HPV immunisation communication plan are achieved to ensure a systematic process and avoid gaps in service delivery.	Q4	Fiona		All major milestones achieved	On track	HPV Plan updated to reflect the changes that have occurred due to the national schedule change from January 1st. All major milestones achieved on the communication plan.

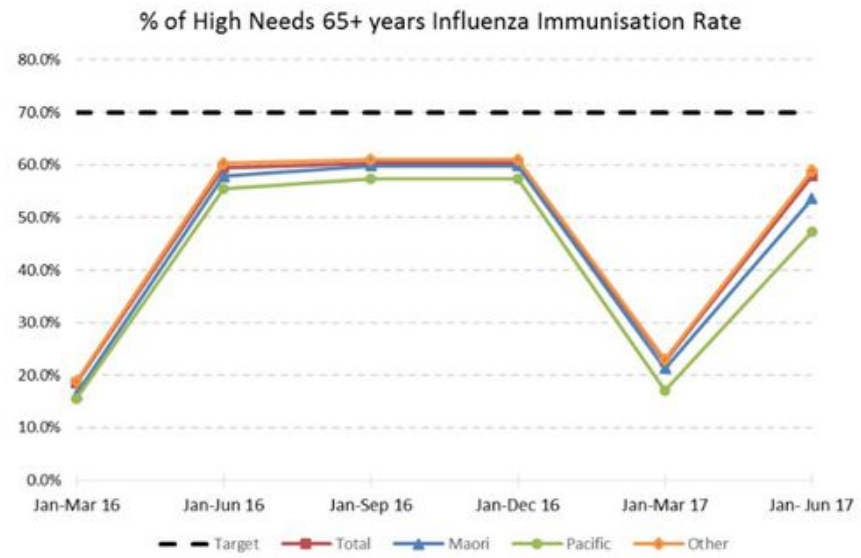
Outcome: Increase the percentage of Māori≥65 years having annual influenza vaccination

Key Performance Measures	Baseline[4]	Previous result[5]	Actual to Date[6]	Target 16-17	Trend direction
Māori	67.9%	21% (U)	54% (U)	≥75%	▲
Pacific	68.0%	17% (U)	47% (U)	≥75%	▲
Other	70.7%	23% (U)	59% (U)	≥75%	▲
Total	67.6%	23% (U)	58% (U)	≥75%	▲

Comments:

HBDHB comment:
At the end of quarter 4, 53% of Māori 65 years or older have had influenza vaccination as recorded on NIR. Coverage for the total HB population 65 years and older is 58%. This coverage data remains incomplete due to the NIR not having all influenza vaccines given recorded on it so the coverage will be higher than this.
There is inequity in coverage.
We are working hard to try to address the disparity by working with and providing support to NGOs providing immunisation services for Māori.

Time series



Data Source: National Immunisation Register

17

4 January to December 2014
5 January to March 2017
6 January to June 2017

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
1.3	**Increase the rate of seasonal influenza immunisations in over 65 year olds**						
1.3.1	Continue to fund immunisation contracts with three NGOs including two Māori providers to ensure a range of access options for flu immunisations.	Q4	Fiona	75% of the eligible population over 65 are immunised against influenza annually	Equitable coverage across Māori, Pacific and Other	On track	Takapau Health Centre, Central Health and Te Kupenga Hauora have contracts to provide 175 influenza immunisations.
1.3.2	Work with Māori providers and other organisations to improve their capability by: - Providing educations sessions - Ensuring there are authorised vaccinators - Providing support with the cold chain - Ensuring consistent health messages	Quarterly	Fiona				This remains unchanged. All Māori Health providers excluding Kahungunu Executive have cold chain systems in place and authorised vaccinators within their workforce to be able to provide influenza vaccination. The Immunisation team has worked with Central Health, Te Kupenga Hauora Ahuriri and Te Taiwhenua O Heretaunga to support Cold Chain and administration of Influenza immunisation to their communities.
1.3.3	Analyse the Winter 2016 influenza immunisation data to show patterns of access and use this to create a strategy for promoting early engagement for winter 2017	Q4	Victoria				High Needs Flu Vaccinations Coverage Rates, 4454 Vaccinated - 65%. Increase of 2222 since last quarter. NB: Information sourced from Dr Info as at 30 June 2017. 23/27 Practices
1.3.4	Promote influenza immunisation through Whānau Wellness education session 'Preparing for Winter' in Q4	Q4	Victoria				Completed during Q3. Provision of Flu Vaccination administered by HBDHB Immunisation Coordinator. The number of flu vaccinations provided during sessions were as follows: Hastings - 8 flu vax administered

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
							Napier - 2 Wairoa – 8 Whānau encouraged to engage with their general practice and to book apts for whanau members over the age of 6 months. The following Flu Vax statistics highlight general practice administered vaccinations to WWRP participants, age ranges are not available at this time: Māori – 13 Pacific - 27
1.3.5	Practice PMS audit systems will be used to identify those eligible for influenza vaccination. The practice will then actively recall these people	Q4	Victoria			Ongoing	Review and monitoring of HHB general practices via Dr info and other PMS tools

2. Reducing Rheumatic Fever						
Outcome: Reduced incidence of first episode Rheumatic Fever (Hospitalisation Rate per 100,000 population)						
Key Performance Measures	Baseline [7]	Previous result [8]	Actual to Date[9]	Target 16-17	Trend direction	
Māori	2.48	7.2 (U)	9.6 (U)	≤1.5	—	*there was 1 new case in Q4 however one of the cases reported in Q3 is no longer counted so I have updated the Q3 and Q4 data.
Pacific	-	16.5 (U)	16.5 (U)	≤1.5	—	
Total	0.6	2.5 (U)	3.1 (U)	≤1.5	—	

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
2.1 REDUCED INCIDENCE OF FIRST EPISODE RHEUMATIC FEVER							
2.1.1	Implement Healthy Homes programme targeting 150 annual referrals to prevent Rheumatic Fever	Quarterly	Liz	40 per quarter	Māori and Pasifika engagement	Achieved	55. Target exceeded
2.1.2	Hold meetings to promote participation and cross agency work in Hawke's Bay housing coalition	Quarterly	Shari	# of meetings held for the quarter	Membership represents Hauora and Māori social service organisations	On track	Housing Coalition is reviewing its structure and is being linked into the Social Inclusion Strategy. There continues to be wide cross sector engagement
2.1.3	Hold regular meetings of the multiagency Rheumatic fever prevention steering group.	Quarterly	Nicky	# of meetings held as per schedule	Attendance by key stakeholders – e.g. HHB, HBDHB and TTOH	On track	Steering Group has met and reviewed its purpose and will no longer meet. The operational group will recommence its meetings and the Governance Group will continue meeting quarterly.

7 July 2014 – June 2015

8 July 2016 – December 2016

9 July 2016 – March 2016

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
2.1.4	Develop strategic framework and implementation plan to raise community awareness and health literacy on rheumatic fever	Quarterly	Nicky	Strategic framework and implementation plan in place	PP28: Progress against DHBs Rheumatic fever prevention plan	Complete	Pre and post survey monkey to workforce across Hawkes Bay to see if we have increased level of knowledge and awareness of Rheumatic Fever. 201 responses indicated knowledge had increased amongst the community. Coordinated Rheumatic Fever awareness campaign across Hawkes Bay. Highlights were Te Taiwhenua O Heretaunga's video about a whanau rheumatic fever journey and Hawkes Bay Samoan rugby's video in English and Samoan. Both have been featured in MoH's Friday Fever promotions to all DHBs.
2.1.5	Set up a Governance group Rheumatic Fever by end Q1	Q1	Nicky	Governance group established	Governance group constituted by key strategic partners	On track	Rheumatic fever governance group in place. Membership includes Housing, MSD, PHO, and Paediatrics. 1 meeting held during last quarter.
2.1.6	Implement Say Ahh programme in targeted schools and in primary care	Quarterly	Nicky/Liz	9 Flaxmere & Hastings primary schools have Say Ahh programmes in place. In addition, 6 low decile secondary schools are covered by the youth pilot programme and 2 Teen Parent Units	Say Ahh CFA variation Reporting		Say Ahh programme fully operational in the 9 Flaxmere and surrounding district primary schools. Pilot throat swabbing and treatment programme in 6 secondary schools and 2 Teen Parent Units completed end of Q2, December 2016 but school based health service is continuing to provide sore throat

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
							management in decile 1-3 high schools
2.2 Effective follow up of Identified Rheumatic Fever Cases							
2.2.1	Monitor time between admission and notification of all new cases of rheumatic fever to the Medical Officer of Health.	Quarterly	Rachel	% of cases being notified within 7 days of diagnosis	PP28 Report	100%	1 case notified within the last quarter which was notified within the 7 day period for notification.
2.2.2	Monitor and carry out an annual audit of Rheumatic fever secondary prophylaxis coverage.	Annually Q4	Liz	% of people receiving secondary prophylaxis within 5 days of due date	PP28 Report PP28 Report with breakdown of people under secondary prophylaxis coverage for children aged 0-15 years, youth aged 15-24 years and adults aged 25+ years	On Track	Child Health Team monitoring all cases of RF on antibiotic prophylaxis (children and adult). We have stable compliance rates across the age span although the majority of 'non-compliance' clients are within the 15-24 year age group. Weekly audit of compliance, means Kaiawhina and public health nurses have early identification of at risk clients.
2.2.3	Undertake case reviews of all Rheumatic fever cases and address identified system failures	Quarterly	Liz	100% of notified RF cases have case review and actions addressed from lessons learned.	PP28: Report on the lessons learned and actions taken following reviews	100%	One case in last quarter had root cause analysis meeting. Whilst risk factors identified there were no specific actions required.
2.2.4	Follow up on issues identified in the 15/16 audit of recurrent hospitalisations of acute rheumatic fever and unexpected rheumatic disease	Quarterly	Rachel		PP28: Reports on progress in following-up known risk factors and system failure points in cases of first episode and recurrent acute rheumatic fever	On track	There were no specific issues around risk factors or system failure points for our DHB to address.

3. Child Health						
Outcome: Breastfeeding of pēpi improved						
Key Performance Measures	Baseline	Previous result	Actual to Date	Target 16-17	Trend direction	
Infants are exclusively or fully breastfed at 6 weeks						
Māori						No update and might not be one for this quarter. Currently chasing up the data source
Pacific						
Total						
Infants are exclusively or fully breastfed at 3 months of age						
Māori						
Pacific						
Total						
Infants are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)						
Māori						
Pacific						
Total						

Planned Activities and Progress

ID	Actions/Activity	Date	Lead	Quantitative Measures	Qualitative Measures	Progress	Progress Comments
3.1	**IMPROVE THE BREASTFEEDING RATES AT 6 WEEKS**						
3.1.1	Hold quarterly Hawke's Bay Breastfeeding Governance Group meeting to provide strategic direction for breastfeeding activity, monitor KPIs and	Quarterly	Nicky	1 meeting held	Meetings attended by key stakeholders including LMC representation		Breastfeeding Governance meeting deferred this quarter.

	drive performance in Māori and non-Māori.						
3.1.2	Hold bi-monthly Hawke's Bay's Breastfeeding multi-agency clinical group meetings to support breastfeeding workforce in Hawke's Bay.	Quarterly	Tracy	1 meeting held	Meeting attended by key stakeholders from multi-agency clinical group		Meetings held, communication planning focus HB Breastfeeding week August 2017.
3.1.3	Maternity staff will give a take home guide to Breastfeeding, Smokefree and safe sleep to every mother delivering in the DHB maternity unit.	Q2	Jules	100% of mothers offered take home guide	Proposed evaluation by Q4		Not able to be currently captured as a dataset from Maternity but include the guide with every child's WC/TO book. New postnatal documentation is in process and will incorporate this measure. See 3.2.1 for community feedback via WCTO providers.
3.1.4	Carry out a review of current breastfeeding services in Q1 to inform better service planning.	Q1	Nicky	Information gathered by Q1, used in redesigning services by Q3		**Complete**	
3.1.5	Using the results of the review, the DHB will develop a plan to redesign effective breastfeeding interventions for Māori women by Q3	Q3	Nicky	Service redesign completed and funding confirmed by Q3		Behind Schedule	Breastfeeding Support Service (DHB based) redesign proposal completed will be relooked at for budget bid in 17/18 year. See 3.2.2 for progress.
3.1.6	The Women, Children and Youth (WCY) directorate to meet with providers of all antenatal classes in Hawke's Bay to investigate what breastfeeding information is given and promote consistent breastfeeding messages	Q2	Jules	Meetings with all antenatal class providers held		**Complete**	

3.1.7	Maintain Baby Friendly Hospital Initiative (BHFI) and prepare for Accreditation to by February	Q3	Jules		Accreditation Achieved	**Complete**	
3.1.8	Provide access to lactation support in the community through drop-in Baby Café sessions.	Quarterly	Liz Banks	37 sessions held in this quarter 116 baby contacts (110 mothers) Māori: 13 = 11.2% Pacific: 2 = 1.7% NZE 95 = 81.8% Other: 6 = 5.1%			From the previous quarter's results Māori attendance has decreased from 19% (Q3) to 11.2% this quarter.
3.1.9	WCY directorate to carry out a review of babies that received donor milk and the rate that were still breastfed at 6 weeks, 3 months and 6 months	Q 3	Liz Banks		Report effectively address the objectives of the review		No donor milk has been accessed this quarter as we have ongoing issues finding an approved donor
3.1.10	Build a breastfeeding room at the hospital for staff to express in a comfortable and accessible space	Q3	Jules	Breastfeeding room at the hospital in place	Build meets the breastfeeding privacy of mothers	Behind schedule	The Whanau/staff breastfeeding and expressing room on hold until foyer redesigns are completed in main hospital entrance.
3.1.11	The Population Health Team to develop a communication plan for Hawke's Bay breastfeeding campaign to promote local resources, support and services.	Q1	Tracy	Comms plans delivered		**Complete**	Communications to go live 1 August 2017 for HB Breastfeeding week including mama and local whanau sharing breastfeeding stories.
3.1.12	The Population Health Team will localise content of Breastfed NZ app from the Central Region which will be used as an education and support tool. Availability of the app will be promoted through the campaign above	Q1	Tracy	App available		**Complete**	

3.2	**Infants are receiving breast milk at 3 months and 6 months**						
3.2.1	The WCY directorate to carry out a 'Plan Do Study Act' (PDSA) cycle on consistent breastfeeding messages amongst Well Child Tamariki Ora (WCTO) providers and LMCs in Hawke's Bay	Q4	Nicky	PDSA Cycles completed		**Complete**	Plan Do Study Act (PDSA) on the Mama Aroha reference card. PDSA of 65 new parents (Plunket) 67% received a Mama Aroha leaflet from maternity services. Rates of artificial and partial breastfeeding were higher in the groups who had not received a Mama Aroha leaflet. Tamariki Ora (TToH) identified similar findings to Plunket but the other benefits were mothers found the cards useful for the smoke free and SUDI information.
3.2.2	Managers of the WCY and Māori Health portfolios will meet fortnightly from Q1 to progress breastfeeding strategy across Hawke's Bay.	Quarterly	Nicky	# of fortnightly meetings held	The meetings look at current contracts and their utilisation by breastfeeding mothers by ethnicity to ensure we have the best accessible timely support in the right areas of the community		Working collaboratively to align contracts and opportunities on model of care and consider options to better support Māori and pacific whanau post discharge from Maternity services.
3.2.3	The Executive Management Team Sponsor to present a Te Ara Whakawaiora (TAW) report to the various governance committees on progress with	Q3	Nicky	Annual TAW report		**Complete**	

	Breastfeeding rates and agree on any new activity that is recommended						

4. Sudden Unexplained Death of Infant						
Outcome: Reduce the number of SUDI deaths per 1,000 live births - Target <0.5 deaths per 1,000 live births.						
Key Performance Measures	Baseline [10]	Previous Result[11]	Actual to Date[12]	Target 16-17	Trend Direction	Time series
Māori						Awaiting final SUDI deaths for 2016 from the coroner however this dataset now includes 2011-2015 and shows a positive trend.
Total						
Comments:						

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
4.1	**REDUCE THE RISK OF SUDI IN HAWKE'S BAY**						
4.1.1	Coordinate quarterly multi-sectoral Safe Sleep Action Group meetings.	Quarterly	Denal	1 meeting held	Participants drawn from Smokefree, Iwi, community providers, Public Health, WCTO, breastfeeding advocates and Women, Children and Youth, PHO & early childhood representatives on safe sleep action group		Meeting not held in Quarter 4 due to unavailability of key members and not enough content needing to be discussed. Next Meeting scheduled to be held early in quarter 1
4.1.2	Provide training and support in the provision of safe sleep education through online resources such as 'baby essentials	Quarterly	Denal	# of training sessions held	- Yearly education planner in place - All new staff receive safe sleep		5 Professional development safe sleep education sessions 1 Community safe sleep education session

10 2010-2014 average annualised

11 2010-2014 average annualised

12 2011-2015 average annualised

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
	online' and 'through the tubes' and Safe Sleep Champion Days				- training during orientation - Records of attendance from external agencies to Champion Days		Total of 20 new safe sleep champions. 6 New safe sleep device Distributors 30 Extended whanau members recieved safe sleep education along with parents who recieved wahakura for identified vulnerable infants.
4.1.3	Complete annual audit of safe sleep messages provided by health services by Q2 and implement recommendations from audit by Q3	Quarterly	Denal	Annual audit report of safe sleep messages	% of mothers and whānau who have safe sleep conversations at discharge	**Behind Schedule**	Scheduled for next quarter
4.1.4	Improve the provision of antenatal education which is responsive to the needs of Māori and includes advice on safe sleep practices and the benefits of breastfeeding and being Smokefree.	Quarterly	Jules	% and number of Māori, Pasifika, teen and those for whom English is a second language attending DHB funded antenatal education			Data unavailable for past 2 quarters due to loss of administrative PPE support.
4.1.5	Socialise pathway for local health professional response when whānau are identified as requiring supported access to a safe sleep space for their infant's first year, or referral for tobacco cessation support.	Quarterly	Jules	Number of Safe sleep champions trained in a quarter	Safe sleep coordinators to ensure that Safe sleep training covers availability of funding for a safe sleep device (post pēpi pod) through WINZ and links to smoking cessation services		Total of 20 new safe sleep champions. 6 New safe sleep device Distributors 83 Pēpi pods distributed in Q4 63 Wahakura distributed in Q4
4.1.6	Collaborate with Child and Youth mortality Review Committee to provide recommendations on SUDI activities.	Quarterly	Nicky	Attendance at quarterly meeting		On track	No HB SUDI deaths recorded on CYMR database for 2017

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
4.1.7	'Early engagement with LMC' Project on the campaign for 5 key things in the first 10 weeks of pregnancy; and education of primary care practitioners to support early enrolment.	Quarterly	Jules	% of women booked with an LMC by week 12 of their pregnancy Booked by week 12 of pregnancy – this data is always a quarter behind –Q3 data: Jan 1 – April 30 2017 Māori: 55.7% Pacific: 46.5% All ethnicities: 64.8%	Target achieved across ethnicities		Increased rate of Māori booking by week 12 of pregnancy this quarter from 43.3% to 55.7%. Overall also an upward trend across population from 62.5% to 64.8%. Local public campaign just launched on "Top 5 for my baby to thrive" to encourage booking early with LMC's – highly visual and linked to social media, bus backs and messaging across settings.

Outcome: Caregivers are provided with SUDI prevention information – Target % of caregivers of Māori infants are provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1						
Key Performance Measures	Baseline [13]	Previous Result[14]	Actual to Date[15]	Target 16-17	Trend Direction	Time series
Māori	72.8%	-	-	-	-	*No data available this quarter* No update this quarter
Pacific	78.6%	-	-	-	-	
Total	80.7%	-	-	-	-	

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
4.2 Caregivers are provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1							
4.2.9	Support WCTO Quality Improvement group with a focus on timely provision of core contact 1	Q2 & Q4	Nicky	Number and % of referrals to WCTO completed by 6 weeks post-birth Number and % of infants receive Core Contact 1 by 6 weeks post-birth Number and % of infants receiving safe sleep information at WCTO Core Contact 1	Target across ethnicities		No information available.
4.2.10	Implement recommendations from WCTO quality improvement group derived from a review of current practices in other DHBs to improve timeliness of referral to WCTO	Q4	Nicky				Collaborative hui on 'Working Better Together' in May 2017 with 65 attendees work

13 2014

14 2014

15

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
							shopped recommendations for action.

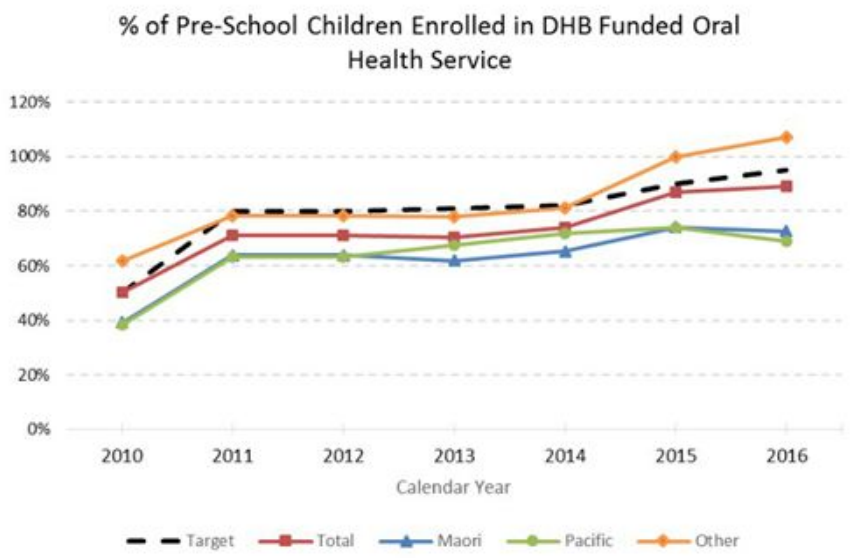
5. Oral Health

Outcome: More children enrolled in Community Oral Health Services – Target % of eligible pre-school enrolments in DHB-funded oral health services

Key Performance Measures	Baseline[16]	Previous result[17]	Actual to Date[18]	Target 16-17	Trend direction
Māori:	65.3%	72.7% (U)	-	≥95%	*
Pacific:	71.7%	69.1% (U)	-	≥95%	*
Other:	81.3%	107% (F)	-	≥95%	*
Total	73.9%	89.2% (U)	-	≥95%	*

Data reported Annually. Next update Q3 2017/18

Time series



Comments

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

Preschool children enrolled in DHB oral health services have increased rapidly as the DHB has focused on the national priority of earlier preschool enrolment in oral health services. However, as the DHB gets close to the overall target of 95% of children enrolled, quality of the ethnicity coding is becoming of concern. The 2016 data suggests that over 100% of non-Māori and non-Pacific children are enrolled. Meanwhile there has been a small drop in the percentage of Māori and Pacific children indicated as enrolled.

These data are obtained from the Community Oral Health Service's Titanium clinical record database. Enrolment data is now populated by parental self-declared ethnicity data obtained through a quadruple enrolment alongside enrolment for primary care,

16 2014 calendar year

17 2016 calendar year

18

Well Child Tamariki Ora and Immunisation. However, this has operated for only 2 years. It is likely that the discrepancy is in part a legacy issue that relates to the older (3-4 years) preschool children and will improve as quadruple enrolment has been the basis of data for all age groups, in a further 2 years' time. The denominator for the numbers in each ethnicity group are based on Statistics New Zealand data provided through the Ministry of Health and based on census projections. It is also possible that the denominators are providing misleading percentages. The overall level of preschool enrolment and improvement is very pleasing. The discrepancy with Māori and Pacific enrolment is concerning and will require ongoing attention to data quality and checking the system/ quadruple enrolment. **Te Whakawaiora Report.**	

Outcome: Improved Oral Health of five year olds – Target % of 5 year old examined who are carries free

Key Performance Measures	Baseline[19]	Previous result[20]	Actual to Date[21]	Target 16-17	Trend direction
Māori:	36.0%	44% (U)	-	≥67%	*
Pacific:	30.5%	31% (U)	-	≥67%	*
Other:	70.1%	74% (F)	-	≥67%	*
Total	54.4%	59% (U)	-	≥67%	*

Data reported Annually. Next update Q3 2017/18

Comments

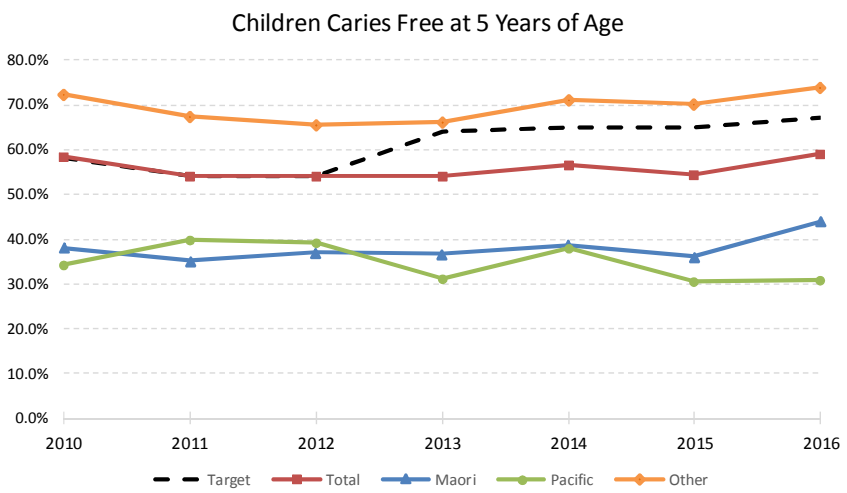
The 2016 results represent a substantial improvement in outcomes for all groups except Pacific where only a small improvement is noted. Results for Māori represent an 8% improvement and non-Māori, non-Pacific a 4% improvement meaning, that there has also been a small improvement in a long standing inequity for Māori.

Results for Māori and non-Māori, non-Pacific represent the best outcomes for Hawke's Bay DHB that have been achieved. Trend analysis also indicates that the inequity between Māori and non-Māori, non-Pacific is slowly closing, albeit very slowly.

However the target of 67% caries free has not yet been achieved for Māori.

TE WHAKAWAIORA REPORT

Time series



19 2015 calendar year

20 2016 calendar year

21

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
5.1	**IMPROVE THE ORAL HEALTH OF 5 YEAR OLDS**						
5.1.1	All babies are seen by an oral health clinician at a HBDHB Community Oral Health Clinic by 12 months of age	Q4	Ruth	PP11: 67% of 5 year old examined who are carries free	Data for Māori, pacific and other Exception report and resolution plan for non-performance		We continue to examine new babies by 12 months of age. Under the new Well Child Tamariki Ora contracts support to connect hard to reach Whanau to the oral health service will assist this.
5.1.2	All Māori, Pacific and high risk children have fluoride applications at 6 month intervals	Q4	Ruth			**ongoing**	
5.1.3	Implement initiatives from the Improving Access to Oral Health Services for Māori Tamariki (0-4 years) Project	Q4	Ruth			ongoing	
5.1.4	Continue Quadruple New Born Enrolment (National Immunisation Register, GP, Well Child Tamariki Ora, and Oral Health) for all babies born in HBDHB Maternity Services.	Q4	Ruth	PP13: 95% of pre-school children are enrolled in the COHS	Data for Māori, Pacific and other	Ongoing business as usual	
5.1.5	Ensure babies not born in HBDHB Maternity Services are enrolled through Well Child Tamariki Ora providers at Core Check 5 (9 months of age)	Q4	Ruth			This will be introduced with the WCTO contracts started 1 July 2017	

6. Smokefree
Outcome: Less women smoke during pregnancy – Target: % of Māori women are smoke free at two weeks postnatal

Key Performance Measures	Baseline[22]	Previous result[23]	Actual to Date[24]	Target 15-16	Trend direction	Time series
Māori						*Data Source: Tamariki Ora Quality Improvement Framework*
Pacific						
Total						
Comments: Please see comments under 6.1.5 No update and might not be one for this quarter. Currently chasing up the data source						

22 June 2014

23 January to June 2016

24 July to December 2016

Planned Activities and Progress							
ID	**Activity/Action**	**Date**	**Lead**	**Quantitative Measure**	**Qualitative Measure**	**Progress**	**Progress Comments**
6.1	**REDUCE THE NUMBER OF PREGNANT WOMEN WHO ARE NOT SMOKEFREE**						
6.1.1	Evaluate recent changes to documentation to ensure accurate data is being captured when being booked into the Maternity Unit.	Quarterly	Shari/ Johanna	HT: 90% 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 Two study days and one update	Ensure Systems and Processes collect accurate data		The Maternal and Child Health Coordinator has met with the maternity coders to discuss difficulty in capturing up-to-date statistics when they are playing catch-up with file coding and Midwives are not completing the smokefree pathway form in its entirety. Projects for the next six months include: • Reviewing the pregnant woman's smokefree pathway and smokefree referral forms • Surveying midwives Surveying pregnant women who smoke and decline the Increasing Smokefree Pregnancy Programme.
6.1.2	Scope opportunities to provide smokefree education to LMCs	End of year	Shari/ Johanna		Opportunities to keep LMC's abreast with Smokefree		The Maternal and Child Health Coordinator has provided smokefree education and training to LMC's at DHB midwives and LMC's combined meetings.
6.1.3	Expand incentivised programme targeting young Māori women and their whānau by implementing recommendations from the recent evaluation of the programme and focussing on improving the proportion of referrals that quit long-term.	Quarterly	Shari/ Johanna	90% of young pregnant Māori women are referred to cessation support	Number of GP Practices engaged in Early Intervention Programme.	On Track	The HBDHB's maternity service in partnership with the HBDHB Smokefree team have completed GP visits, providing Increasing Smokefree Pregnancy Programme (ISPP) education, referral pathway to Choices and Wāhine Hapū resources. All General Practices who showed an interest and willingness to participate have been seen.

							The Smokefree team will continue to provide Wāhine Hapū resources for the next year.
6.1.4	Continue to screen inpatients, offering support to quit for mothers and whānau and monitor Smokefree Rates at discharge from Maternity Unit	Quarterly	Roisin	% of Women smokefree at discharge from maternity unit			The percentage of maternity smoke-free on discharge from April to June 2017 is 77.4% (384/496).
6.1.5	Continue to monitor the number of Māori Women that are Smokefree at 2 weeks postnatal	Quarterly	Shari/ Johanna	95% of pregnant Māori women are smoke free at two weeks postnatal	SI5: Whānau Ora	Challenging Issue Solution	In 2016 324 pregnant women were referred to ISPP, only 50 have been successful in becoming smokefree, 33 were antenatal, 4 postnatal and 13 whānau members. Of the antenatal women, 72% identified as Māori. All of the postnatal women were Māori and in the whānau category 69% were Māori. Those who are not smokefree at discharge to this target. Currently, there is only one stop smoking practitioner (European) working with pregnant women, providing behavioural and motivation support. • Increase stop smoking practitioner capacity to include all stop smoking practitioners under Te Haa Matea (HB Stop Smoking Service) • Create a Stop Smoking Practitioner role within the HBDHB Smokefree Team to provide cessation support to

							Maternity services including DHB midwives.

7. Mental Health

Outcome: Reduced rate of Māori under compulsory treatment orders to < 81.5 per 100,000 (total population)

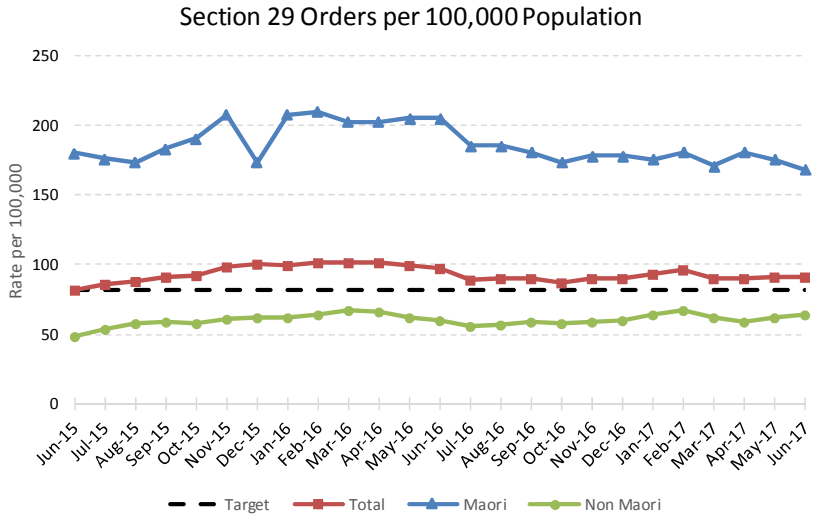
Key Performance Measures	Baseline[25]	Previous result[26]	Actual to Date[27]	Target 15-16	Trend direction
Māori (per 100,000)	196	175.9 (U)	175.1 (U)	≤81.5	▲
Non Māori (per 100,000)	93.4	64.6 (F)	61.5 (F)	≤81.5	▲
Total (per 100,000)	97	93.2 (U)	90.7 (U)	≤81.5	▲

Comments:
In Q4 2016/17 the rate ratio of Māori to non-Māori for compulsory treatment orders was 2.8:1 a reduction from 3.2:1 in Q1. This is trending in the right direction however the 95% Confidence Interval for the rate ratio for Hawke's Bay for the calendar year 2015 were approx. 2.8:1 to 5.7:1

Our current target is to achieve reduction to a sustained rate ratio of 2:1 Māori to non-Māori as this would represent a significant change from the current rate ratios.

Broadly, with regard to the prognosis in treatment of schizophrenia, there are two key factors which impact significantly, including: (a) longer duration of untreated psychosis and (b) higher functional impairment. Assertive services, especially at initial onset of psychosis, which support functional gain are crucial to generating positive outcomes.

Actions being taken to achieve plan include:



25 *October to December 2015*

26 *January to March 2017*

27 *April to June 2017*

• Home Based Treatment team to provide services closer to home, to prevent mental health conditions worsening and reduce the need for people to be admitted to Nga Rau Rakau when acutely unwell, hence reducing the need for compulsory treatment. • Provision of Acute Day Service for the community, based in Nga Rau Rakau will be operational in 2017/18, again reducing the need for admission. • The Clinical Risk Management System is being used to provide expert review of risk management for high risk patients, reducing the need for longer term compulsory treatment. • Te Ara Manapou, the newly founded pregnancy and parenting service for women and whanau with addictions problems who are not engaged with services, will help give children a better start in life and may have impact on compulsory treatment in the long term • Extended whanau are increasingly being used in reviews of compulsory treatment, by both community key-worker and psychiatrist. This will enable the whole network around the person to provide alternatives to continuing compulsory treatment orders. • Targeted treatment pathways have been developed with wider availability of evidence-based therapies, such as Dialectical Behavioural Therapy to treat emotionally unstable personality disorder with associated suicide risk. Trauma-based Cognitive Therapy is being used to treat Post Traumatic Stress Disorder and reduce the severity and duration of some conditions. • Greater use of longer interval injectable antipsychotic medication will well reduce the need for compulsory treatment associated with refusal to continue necessary treatment and subsequent relapse.	

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
7.1	**REDUCE THE RATE OF COMPULSORY TREATMENT ORDERS (RATE OF COMPULSORY TREATMENT)**						
7.1.1	Home-based treatment team increases family involvement with planning and crisis intervention	Q4	CNM Adult CMH	Compare historical admission data of patients in HBT care	Patient/Whānau survey	Not on track	Patient/Whanau feedback is positive however audit of admission data against this activity has not been completed with timeline for completion needing to be extended.

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
7.1.2	Ongoing daily step up step down with Ngā Rau Rākau, CMH, HBT, EMHS, Wai-O-Rua and TTOH to improve discharge and admission communication	Q3	CNM Intensive	Audit and compare discharge numbers for first two quarters and measure trends to 'step down' services		Not on track	Now termed 'Service Coordination' meetings, these are held 3 x weekly and are reported to be working well in terms of referrals and communication between services. Audit not completed in this quarter with timeline for completion needing to be extended.
7.1.3	Implement intensive day programme	Q1	CNM Intensive	Length of stay trend data		Not on track	Recruitment issues, reduced programme implemented Oct 2016. Secondment placement into the coordinator role.
7.1.4	Staff education around sensory modulation and trauma informed care to help reduce restrictive models of care	Q3	CNM Intensive	100% of intensive service staff trained		Not on track	Sensory modulation: a training programme is near completion; will be for service wide participation (Community and Intensive). Trauma Informed care postponed till September 2017 due to this being a regional initiative
7.1.5	Increase availability of treatment options across community mental health services	Q3	CNM Adult CMH	# referrals to specific services		On Track	Working with PHO on introducing new model of care including collaborating of provision of Group interventions (e.g. youth). Piece of work to review secondary MH services intervention will be longer term but will be along similar lines of expanding Group type interventions.
7.1.6	Building networks within the community – increased use and referrals to NGOs within the	Q2	CNM Adult CMH	Referral flow data and regular meeting with Community providers as		On Track	CCS now implemented and CMH Clinical Coordinator roles currently being recruited to.

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
	community for follow up; meetings with NGOs and whānau/families to agree on and document plans & outcomes			part of CCS implementation and increased CMH Clinical coordination structure.			

8. Access to Care

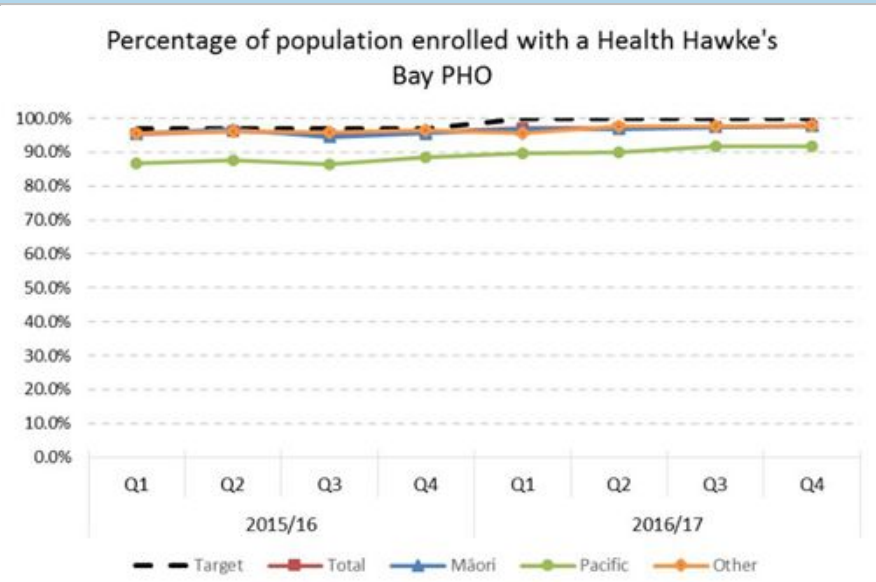
Outcome: Increase enrolment in the PHO – Target: % of the population enrolled in the PHO

Key Performance Measures	Baseline[28]	Previous result[29]	Actual to Date[30]	Target 16-17	Trend direction
Māori	97.2%	97.5% (U)	97.9% (U)	≥100%	▲
Pacific	88.7%	91.7% (U)	91.9% (U)	≥100%	▲
Other	96.5%	97.6% (U)	98.1% (U)	≥100%	▲
Total	96.4%	97.3% (U)	97.8% (U)	≥100%	▲

Comment:

The PHO has worked within the last quarter to increase the number of practices that are open for enrolment which was 75% (one of the lowest in the country. Four practice have now been incorporated into the larger practices which has meant that access has increased for all geographical localities of Hawke's Bay – Wairoa, Hastings, Napier and Central Hawke's Bay. Addressing equity of access for our rural communities is a priority.

Time series



Planned Activities and Progress

ID	Actions/Activity	Date	Lead	Quantitative Measures	Qualitative Measures	Progress	Progress Comments
8.1	**INCREASE ENROLMENTS IN THE PHO**						

28 October 2015

29 April 2017

30 June 2017

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
8.1.1	Continue focus on new born enrolments	Quarterly		98% of new-borns are enrolled with a PHO by 6 weeks of age			97%, third highest across 20 DHBs
8.1.2	Encourage people to reconnect with primary care providers when attending ED and provide GP enrolment packs for high needs, Māori and Pacific	Quarterly	Honoria	% of the population enrolled with a PHO			Those patients engaged with the PCED programme are already enrolled with HHB general practices. HN enrolment packs are made available to ED, other DHB services, community and social providers to encourage and support enrolment. Promotion of 24 hour 7 day per week free Healthline service and appropriate use of general practice and appropriate use of ED services to WWRP cohort during this quarter.
8.1.3	Health HB to audit all Med-Tech General Practices on a quarterly basis to ensure practices are following the right process for new-born enrolments	Quarterly	Nicola				General Practice Facilitators have been working with practices to ensure they are following processes. Video link sent to practices for new staff members
8.1.4	All GP practices to have a designated staff member overseeing new-born enrolments	Quarterly	Nicola				General Practice Facilitators have been working with practices to ensure they have a dedicated New-born Enrolment Champion. B-Code Enrolment is automatic for the four Houston VIP PMS System practices

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
8.1.5	All people who identify as Māori, Pacific or live in quintile 5 who are not enrolled with Health Hawke's Bay will be offered a one-hour nurse consultation and a 15 min GP consultation free of charge to remove the cost barrier to enrolment.	Quarterly	Nicola				High Needs Enrolment Programme – Invoices submitted up to 30/06/17 Māori - Q4 35, Annual 167 Pacific – Q4 5, Annual 37 Quintile 5 – 13, Annual 47
8.1.6	Work with a number of GP practices to ensure systems adequately identify challenges for enrolment.	Quarterly	Victoria				5 x Enrolling (GREEN) 11 x Enrolling with conditions (AMBER) 12 x Not Enrolling (RED)
8.2 Improve access to primary care for Māori							
8.2.1	Engage practices in a formal support quality programme 'He Taura Tieke' to increase the responsiveness to their Māori population	6 monthly	Lillian Ward	Annual GP utilisation rate by ethnicity (Note. Ko Awatea does not require a clinician to enter their ethnicity	13 practices 2016/17 with self-assessment and annual plan		2/13 achieved **2017 Reassessment:** 2/22 practices completed their reassessment 6/22 practices were due to complete within the month of June 2017 2/22 practices reassessment due in Sept 17 4/22 practices declined to participate 8/22 practices not engaged 2017 Action Plans completion rate: 2/22 completed *Reasons for general practices not participating are due to the following:*

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
							- *Restructures/new management and staff* - *Heavy workload* - *Loss of general practice HTT Champions to drive and encourage participation within each practice* Note: As HTT is a requirement within HHB's clinical and quality scorecard results reflecting non-engagement and declines will be evident when the results are published for HHB's Board of Directors and all general practices.
8.2.2	Implement Health Literacy programme into General Practice over the next 12 months	6 monthly	Lillian Ward		Evaluation of the training and customer service		Number of organisations and staff engaged in training programme: • 3 HHB General Practices and 15 staff • 4 HB other providers and 14 staff • 9 national providers and 16 staff • 10 staff from unidentifiable organisations • Taranaki DHB & Counties-Manukau DHB have copied

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
							programme to local Ko Awatea platforms Plan in place to re-socialise the programme to general practice. Seeking RNZCGP accreditation for Continual Medical Education Training Points.
8.2.3	Continue to implement Health Literacy Campaign with actions to support more understanding in Māori communities of identified health issues	6 monthly	Andre LeGeyt				4 community-based initiatives concept planning underway. • *Bariatric Surgery project* • *Dementia HB Māori Responsiveness Project* • *Rangatahi Sexual Health Arotahi Waiora Project* • *Whānau Initiative - Every Body Get Healthy Project* – Focus on Action research evaluation placed. Project plans co-designed alongside stakeholders.
8.2.4	Continue to fund Whānau Wellness programme from SIA funding, providing 12 months of GP services free of charge to up to 300 whānau	6 monthly	Lillian Ward			Ongoing	175 Whānau on board for the 2017 cohort. Funding dedicated to the new WWRP cohort who commence on 01/01/18

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
8.3	**Improve access to primary care for Youth**						
8.3.1	HBDHB to invest up to $520,000 per annum into zero fees co-payment subsidies for 13-17 year olds in Wairoa and Dep 8-10 geographic regions in HB.	Q4	Jill	Proposition Paper developed Funding released to general practices that meet criteria and take up programme		**Completed**	Free 13-17 program offered to 14 practices within HB. Program commenced in 9 (VLCA) practices as of 1 July. 4 Practices working towards commencement and 1 opting out.
8.3.2	HBDHB to engage rangatahi Māori and Dep 8-10 youth populations into a co-design of improved access to general practice.	Q1	Patrick	Two hui held in Dep 8-10 communities			Youth, connected to each of the 13-17 clusters of practices involved in the free 13-17 program, and the HBDHB youth council are assisting general practice in identifying areas in which they can become more youth friendly.
8.3.3	Develop a health assessment programme for 0-18 year olds in Hawke's Bay	Q4	Nicky	Assessment Programme developed			

9. Ambulatory Sensitive Hospitalization (ASH)

Outcome: Reduction in Ambulatory Sensitive Hospitalisation (ASH) rates in 0-4 year olds.

Key Performance Measures	Baseline [31]	Previous result[32]	Actual to Date[33]	Target 16-17	Trend direction
Māori	82.1%	84.9% (U)	79.5% (F)	≤ 80.6%	▲
Other	66.1%	66%	66.9%	-	▼
Total	73.0%	77.8%	75.6%	-	▲

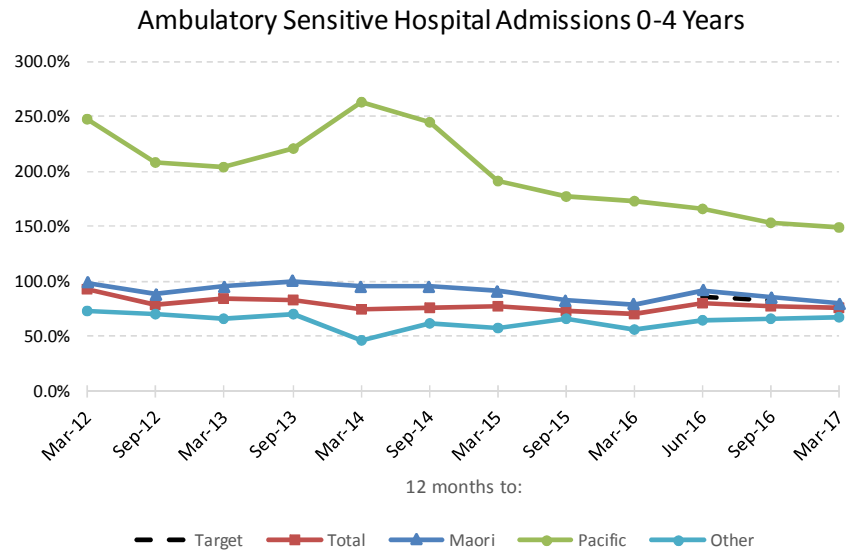
Comments:
O-4 years: We are working to decrease ASH rates and reduce the equity gap between Māori and Other ethnicities. For the 12 month period ending March 2017 the rate for Māori has improved and continues to decrease for the second success quarter. We have also seen a closing of the equity gap by 5% which is very pleasing.

The following actions for collaborative programs of service improvement are underway:.

Oral health: Implementation 'Under 5 years caries free equity project' - to improve oral health status by addressing inequity in caries free under 5 years via education packages, public health policies, consumer input, model of care changes, WC/TO provider outreach services and early intervention in general practice.

Respiratory: Investigation into the respiratory pathway post presentation to secondary services to implement and monitor best practice with focus on timeliness, quality, referral to services (healthy homes, smoking cessation) and consistent regional approach.

Time series



Source: Ministry of Health

31 12 months to September 2015
32 12 months to September 2016
33 12 months to March 2017

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
9.1	**REDUCE AMBULATORY SENSITIVE HOSPITALISATIONS FOR CHILDREN AGED 0-4**						
9.1.1	Implement and socialise the Clinical Pathway 'Wheeze in Preschool children' to primary care, Breathe HB and Central Health to standardise care for reducing hospital admission	Q2 & Q4	Trish & Nora	Increased number of 0-4 year olds referred to Breathe HB by GPs	SI5: Whānau Ora	**Complete**	
9.1.2	Review Breathe Hawkes Bay respiratory contract and ensure health education services are focused on 0-4 year old children and their whānau	Q4	Patrick	A review report of Hawkes Bay respiratory contract	Reports from Breathe HB include number of referrals by age and ethnicity.		Portfolio managers met with Breathe HB to update on alignment and opportunities to capture and support respiratory 0-4 quality improvement project.
9.1.3	Paediatric respiratory clinical nurse specialists to hold an education session on paediatric Respiratory conditions for community Pharmacy and one for Māori Providers by Q3	Q3	Nora/Sue Ward	2 sessions held		Complete	
9.1.4	Clinical Nurse Specialist Paediatric Respiratory will receive notification of all paediatric patients that have been admitted to hospital for Asthma and wheeze and follow up by linking them to their general practice and any other relevant actions.	Q2 & Q4	Nora	# of children notified to Clinical Nurse Specialist Paediatric Respiratory and linked to GPs			A email based process has been developed and communicated with all Respiratory Nurse Champions, feedback is being sought from champions as to gaps and opportunities as part of wider ASH respiratory 0-4 investigation.
9.1.5	Opportunistic flu vaccinations given to children seen in hospital with chronic respiratory conditions and those living with them	Q4	Nora	# of children treated with opportunistic flu vaccinations			

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
9.1.6	Review the criteria for referral to the PHO healthy homes programme through SIA funding by Q2 to ensure the households most in need are receiving the funding	Q2	PHO Project manager - equity	Criteria for referral to the PHO healthy homes programme reviewed		**Completed**	27 homes were identified as needing insulation as of March 2017 and 49 were to be assessed. 24 homes insulated during Q3 and Q4 – eco friendly wall panel heating to be installed. 13/49 completed referrals to insulation provider during this quarter to assess and install insulation where appropriate.
9.1.7	Public Health nurses to visit all Kōhanga Reo to provide advice and education around all leading ASH conditions by end of Q2.	Q2	Liz	All Kōhanga visited by end Q2		On track	Business as usual. Te Kohanga Reo visited regularly by Public Health Nurses and Vision/Hearing Technicians. Several meetings with Leon Hawea, Te Kohanga Reo regional office. Puripuri meetings underway to discuss skin project
9.1.8	Health Hawkes Bay to distribute bilingual skin resources to general practice for wider communication reach	Q4	Trish	Number of practices displaying and distributing skin resource			Additional skin resources are currently being developed as part of the skin project for the Early Childhood Education sector and will be distributed to General Practices by the end of 2017
9.1.9	Expand the 'Clean It, Cover It, Treat It, Love It' Skin Programme implementation standing orders for skin infections in low decile schools and Kōhanga Reo.	Q3	Liz	All 56 decile 1-3 schools and 61 Te Kōhanga Reo	Additional 1FTE PHN to work on skin programme	On track	Programme operational across 56 low decile schools and 61 Te Kohanga Reo. Additional PHN fully operational. Action plan is currently being implemented.

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
9.1.10	Provide consistent messages regarding health initiatives through Hawkes Bay Child Interagency Network Group (CING) with representatives from HBDHB child health team, early childhood centres, kindergartens and home-based childcare.	Q3	Liz		Representatives from HBDHB child health team, early childhood centres, kindergartens and home-based childcare reached with consistent messages regarding health initiatives.	On track	Collaborative model between CING and Ministry of Education to provide health related professional development and consistent health messages to Early Childhood Education Sector continues to be successful with large numbers of ECEC providers attending workshops and reporting high levels of satisfaction with the model.

Outcome: Reduction in ASH rates in 45-64 year olds.

Key Performance Measures	Baseline[34]	Previous result[35]	Actual to Date[36]	Target 16-17	Trend direction	Time series
Māori	172.0%	211.3% (U)	178.5% (U)	≤138%	▲	
Other	81.8%	85.8%	67.6%	-	▲	
Total	98.0%	110%	89.2%	-	▲	

3412 months to September 2015

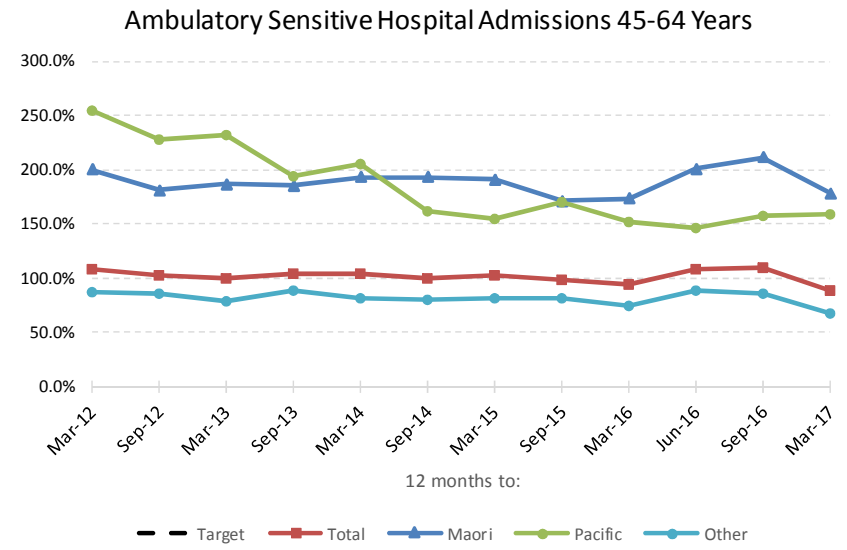
3512 months to September 2016

3612 months to March 2017

Comments:
There has been a marked shift since the end of the last report towards target, however cardiac admissions continue to dominate the stats.

To address this the following is in place:

- Appointment of cardiac specialist nurse who is employed jointly between primary and secondary in the early detection, prevention and early intervention space. CVDRA have increased and are capturing a higher proportion of our Māori population.
- Diabetes and Renal services are utilising CNS roles across the sector and building capacity within the primary work force which has resulted in 26% reduction in FSA – Diabetes
- Respiratory program has continued with renewed funding and works now in a whanau vs individual care basis, as well as moving more towards management and self-management focus due to capacity within primary care in early detection and diagnosis, leading to earlier management.
- Collaborative pathways continue to have an impact on management with primary care – DVT-Cellulitis and COPD



Source: Ministry of Health

17

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
9.2	**Reduce Ambulatory Sensitive Hospitalisations for people aged 45-64**						
9.2.1	Develop a clinical pathway for Cellulitis to standardise practice by Q1	Q1 & Q4	Sonya	ASH rates	Pathways developed and implemented		
9.2.2	Implement and socialise the recently developed clinical pathway for Congestive Heart Failure by Q2	Q2	Gay Brown	ASH rates		HF Clinical pathways shared with GP's	

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
						(evening session)	
9.2.3	Secure sustainable funding to continue to provide nurse led respiratory clinics. The clinics are a joint Health Hawke's Bay and HBDHB initiative which has proven to be effective at encouraging self-management resulting in clinical, financial and organisational efficiency. A reduction in hospital admissions resulting from acute exacerbations of chronic respiratory disease has been noted and may be attributable to the respiratory project. This is currently a pilot so sustainable funding will embed the programme into the community.	Q2 & Q4	Jill G	ASH rates	Funding approved and sustainable service provided	Completed	Program in place and demonstrating results in reduced respiratory admissions in this age band.
9.2.4	Clinical Nurse Specialist and Breathe HB will provide two Respiratory training sessions in Primary care by Q4	Q2 & Q4	Jill G	ASH rates		Completed	Complete with good attendance at both
9.2.5	Following allocation of funding through new investment prioritisation process, appoint a Congestive Heart Failure nurse practitioner to work in the community alongside primary care with the aim of supporting Heart failure patients to self-manage and avoid hospitalisations	Q4	Gay Brown		Nurse Practitioner appointed	Completed	Intern Nurse Practitioner appointed and has initiated working with the LTC portfolio manager and HHB Innovations and development manager
9.2.6	Develop a reporting structure by Q2 which provide reports to general practices to show their admission rates to hospital and emergency department attendances. This will allow the DHB and PHO to identify practices where admission rates for particular conditions are high and work with the practice to identify causes and solutions.	Q2	Jill G		Reporting structure in place and link with key practice liaisons	In Progress	The PCED (primary Care ED) project was poorly reported on which worked with 6 General Practices to look at managing ED7+ presentation. New management of this program has commenced, to redefine the scope of the work, draw together a common data set and agree on reporting

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
							measures and common strategies

10. Cancer Screening

Outcome: Achieve the National Cervical Screening Programme (NCSP) national – Target: 80% of 25-69 years

Key Performance Measures	Baseline[37]	Previous result[38]	Actual to Date[39]	Target 16-17	Trend direction
Māori	74.1%	73.1% (U)	73% (U)	≥80%	▼
Pacific	71.2%	73.6% (U)	74% (U)	≥80%	▲
Other	76.5%	77.8% (U)	75.2% (U)	≥80%	▼
Total	75.8%	76.6% (U)	76.9% (U)	≥80%	▲

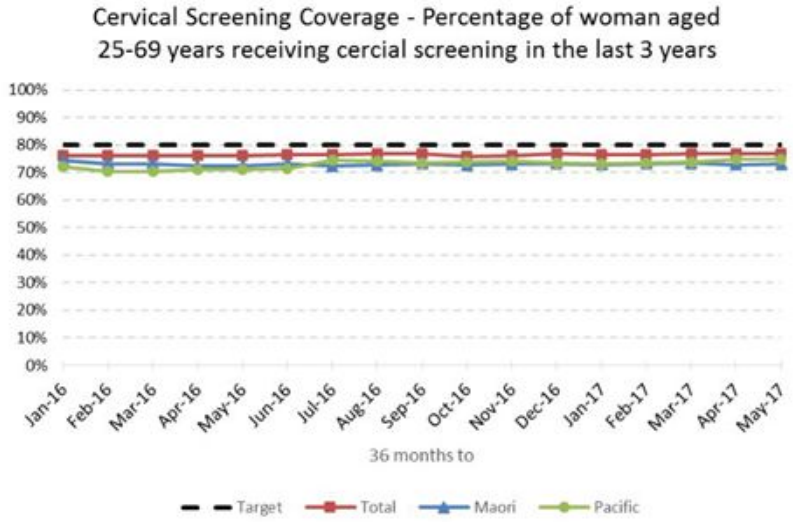
Comments:
We remain 1st in coverage for Māori women out of the 20 DHB's. Our coverage rate has decreased due to the annual adjustment to the denominator. The equity gap between Māori and Pakeha has increased form 5.5% to 6.1%, this is effected by the small decrease in the Pakeha eligible population and the increase in eligible Māori. Pakeha coverage rate has increased to 79.1%. To achieve coverage for Māori we need to screen an additional 631 Māori women.

Our Kaiawhina and Pacific Community Support worker have continued working with Totara Health, but only one day a month, all other times they have been supported by a nurse smeartaker from either Choices or Te Taiwhenua. The Doctors-Napier were unable to provide a nurse in this quarter but have booked in dates for the August 2017.

We have received positive feedback form our Māori women whom have had smear in their home. One women said 'it was my home, my linen, my clean'. Others have felt safe which has enabled further conversation with the nurse about other health issues.

Kanohi kit e Kanohi has shown a positive benefit 30 women spoken to directly by either our Kaiawhina or Pacific Community Support worker about the benefits and importance of having a smear have subsequently been screened in their Health Centre, 11 of these women had never had a smear and a further 8 women were 5 years overdue.

Time series



Source: National Screening Unit

37 3 years to December 2015
38 3 years to February 2017
39 3 years to May 2017

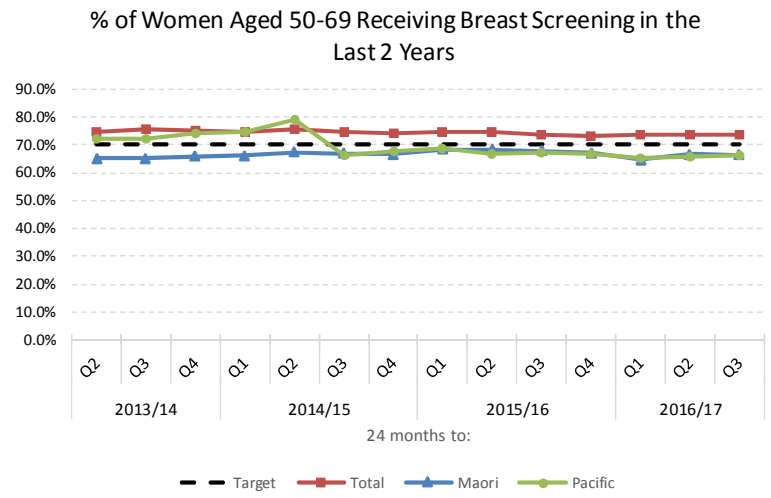
Our Pacific Community Support worker is now with us for a further 12months two days a week, but we are struggling to sustain a nurse smeartaker. We will need to focus our energies into increasing coverage for our Asian population, which is growing faster than our Pacific community.	

Outcome: Achieve the National Breast Screen Aotearoa (BSA) national – Target: 70% of 50-69 years

Key Performance Measures	Baseline[40]	Previous result[41]	Actual to Date[42]	Target 16-17	Trend direction
Māori	68.4%	66.7% (U)	66.2% (U)	≥70%	▼
Pacific	66.5%	65.8% (U)	66.1% (U)	≥70%	▲
Other	76.0%	74.9% (F)	74.9% (F)	≥70%	—
Total	74.7%	73.4% (F)	73.4% (F)	≥70%	—

Comments:
HHB:
During this quarter, in partnership with the Population Health Team a campaign was launched between May – August encouraging Māori who had never had a mammogram or those who were overdue for a mammogram were offered a HHB funded $20.00 PaknSave voucher as an incentive to screening.
Unfortunately Population Health team also extended the target group to the 'new to screening group' i.e. 45-49yr old women, this age group is not monitored in the above coverage target therefore the result to date is disappointing. HHB has provided the Population health team with 70 x $20.00 voucher to date with 27 Māori wahine 50 yrs and over have completed their mammogram as of 18/7/17, no further data has been received from the Population Health team however we do know 50 vouchers have been given out to Māori and Pacific women and another 20 vouchers has been given to the Population Health team.

Coverage data for quarter 4 has not been released by the BSA.



Source: National Screening Unit

40 24 months to December 2015
41 24 months to December 2016
42 24 months to March 2017

The new process agreed with Breast Screening Coast to Coast for priority women who do not respond to recall when receiving an appointment for the BSA mobile to be referred to an ISP was implemented for the visit to Wairoa. Kahungunu Exec contacted 79 women 67 were subsequently screened. The report from Breast Screen Coast Coast states that overall DNA rate for the visit was 7% with a DNA rate for Māori at 11%. BSCC will implement the referral process for all mobile visits.  Wairoa Mobile Report 2012-2017.d	

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
10.1	**ACHIEVE THE NATIONAL CERVICAL SCREENING PROGRAMME (NCSP) NATIONAL TARGET**						
10.1.1	Continue regional coordination of services across the National Cervical Screening Programme - entailing collaborative partnerships, joint planning, coordination of services and activities, effective communication and strengthening supportive networks	Quarterly	Annette	Four steering group meetings held per annum.	70% of NCSP service providers participate in regional coordination activities.		Held our May Steering group meeting. 50% participated in our May meeting.
10.1.2	Health Hawke's Bay (PHO) will continue to offer promotional $20 voucher to Māori, Pasifika and Asian women when their cervical smear test is completed.	Quarterly	Victoria	Number of vouchers given to NCSP Māori, Pacific and Asian women.			171 Smears completed this reporting ¼ Māori – 171 Pacific – 26 By Provider: 22% Māori Smears completed by Choices 10% Māori Smears completed by TToH

<table>
<tr><th colspan="8">Planned Activities and Progress</th></tr>
<tr><th>ID</th><th>Actions/Activity</th><th>Date</th><th>Lead</th><th>Quantitative Measures</th><th>Qualitative Measures</th><th>Progress</th><th>Progress Comments</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>68% of Māori smears completed by general practices

Note: Asian women are not eligible for promotional voucher.</td></tr>
<tr><td>10.1.3</td><td>Encourage nurses to attend smear-taker training and mentor and/or supervise them to pass their assessments, with specific focus on Māori and Pacific nurses and cultural competency.</td><td>Annual</td><td>Annette</td><td>Increased number of Māori and Pacific nurses completing smear taker training and passing their assessments.</td><td>Percent increase of Māori and Pacific nurses completing smear taker training and passing assessments.</td><td></td><td>Our Kaiwhakahaere continues to provide support and encouragement to our Māori and Pacific Nurses in the General Practice and our Independent Providers. Our Kaiwhakaere is no longer able to complete smeartaker assessments due to being an Enrolled Nurse.</td></tr>
<tr><td>10.1.4</td><td>Continue recruitment and retention strategies targeting Māori and Pasifika populations using a mix of kanohi ki te kanohi, settings and community development approaches.</td><td>Annual</td><td>Annette</td><td>Number of Māori and Pasifika women able to be identified as completing screening as a direct result of these strategies.</td><td></td><td></td><td>Totara Health is only able to provide a nurse smeartaker one day per month due to lack of staffing. We have been supported by Choices and Te Taiwhenua and our Kaiwhakaere has been working in the community regularly. Over this quarter 83 smears were completed in homes. 74 were Māori.

<table>
<tr><th>Month</th><th>Māori</th><th>Unscreened</th><th>Under screened</th></tr>
<tr><td>April</td><td>2</td><td>1</td><td></td></tr>
<tr><td>May</td><td>43</td><td>13</td><td>12</td></tr>
<tr><td>June</td><td>29</td><td>6</td><td>11</td></tr>
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Thirty six women were provided information why cervical screening is important for their health and have</td></tr>
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Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
							subsequently been screened at their Health Centre, 22 of which were Māori
10.1.5	Manage a campaign during cervical screening month and provide support to community promotional events where there are a high number of Māori women present and where there is involvement of rural communities.	Annual	Victoria/ Annette	Number of events 'supported'. Number of Māori women able to be identified as completing screening as a direct result of campaign and promotional events.		On track	Quarter 4: Nil
10.1.6	Identify unscreened, under screened and priority women on the PHO Cervical Screening Data Match monthly report by Practice. Contact the women through phone, text, letter and/or home visiting to invite them to have a smear test. Arrange appointments and support them to screening.	Quarterly	Annette	Number of general practices data matched. Number of unscreened and under-screened priority women who have a cervical smear after being contacted.	% of general practices data matched. % of unscreened and under-screened priority women who have a cervical smear after being contacted.		Continued working on Totara Health and The Doctors Napier list. Completed 12 data matches over Quarter three and Quarter four. There have been 21 visits in the community over this quarter. We have screened 74 Māori women over this quarter 20 were unscreened **(27%**), 23 were underscreened **(31%)**
10.1.7	Identify a range of options to improve screening recall processes for Māori women within General Practice to	Quarterly	Victoria	Increase in number of Māori women having had a cervical smear test in the past three years.	80% of Māori women having had		HHB Equity Project Manager and HBDHB GM Māori are working to partner Hauora Māori Providers with key General Practices whereby

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
	encourage them to have their smear every three years				a cervical smear test in the past three years.		Hauora Mobile Nursing Outreach teams can work with general practice to identify, follow up and provider screening services. (Lillian Ward)
10.1.8	Continue the quality improvement initiative 'Best Practice in Primary Care' (BPPC) project, focussing on NCSP systems and processes within general practice including improving access, service quality, data quality, patient management systems, compliance with NCSP Policies and Standards and HPV testing.	Annually	Annette	BPPC established in four new general practices by Q4.			Data is available but requires analysis. Reviewing what we have on indicates the mobility of staff within Practices has an effect on what is available for women in HB and how to access information
10.1.9	Continue focus on improving data quality through data matching between NCSP and general practices, and working with smear takers, laboratories and the NCSP register regarding recording ethnicity data.	6 Monthly	Annette	A reduction in the number of ethnicities corrected each month.	98% of the Priority group women checked monthly have a correct ethnicity		The number of Māori, Pacific and Asian ethnicities identified through the Health HB PHO monthly reports updated on the NCSP-Register and ECA this quarter (20%).
10.2 Improve the timeliness and experience of colposcopy for Māori Women							
10.2.1	Continue to refine the referral process from primary care into colposcopy and work towards reducing DNAs for FSA and follow-up appointment, particularly for Māori women with high	Quarterly	Annette	Reduction in DNA rates for colposcopy FSA and follow-up appointments for Māori women with a high grade cytology result.	90% of eligible Māori women with a high grade cytology		Data available for April and May of this quarter. Five Māori women were booked for a FSA, 1 DNA'd. We introduced a new referral process for all HG referrals for Māori and Pacific, to enable earlier contact

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
	grade cytology results (CIN2 and CIN3).				result attend colposcopy FSA and follow-up appointments.		by our ISP's. The new process only began mid June.
10.3 Achieve the Breast Screen Aotearoa (BSA) National target							
10.3.1	Continue regional coordination of services for Breast Screen Aotearoa screening pathways - entailing collaborative partnerships, joint planning, coordination of services and activities, effective communication and strengthening supportive networks.	Quarterly	Annette	Four Population Screening Steering Group meetings held per annum. Two ISP provider hui held per annum. One Regional Action Plan jointly developed by BSA service providers.	70% of BSA service providers participate in Steering Group meetings and ISP provider hui. 100% of BSA service providers contribute to the development of the Regional Action Plan.		We continue to regularly meet with Breast Screen coast to Coast Primary Care Nurse Co-ordinator, who also attends our Population Screening Steering Group. Our Regional Plan is on track.
10.3.2	Conduct a health promotion campaign to improve participation rates for Māori and Pacific at the breast	Q2	Annette	Number of additional Māori and Pacific new screens and rescreens.	% of additional Māori and		Held two successful Health Promotion days in collaboration with Kahungunu Executive staff, Primary Clinical Nurse from BSCC and our

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
	screening mobile unit located at the Cook Islands Community Centre, Flaxmere, and Hastings in September and Wairoa in March – April 2017				Pacific women new screens and rescreens.		Population Kaiawhina outside of New World, we enrolled women onto the BSA, updated addresses and confirmed bookings for the BSA mobile. Seventy five referrals have been generated to the end of March for Māori women who have either DNA'd or DNR (Did not Respond) to appointments for the BSA Mobile visit to Wairoa. These were sent to Kahungunu Executive team, they contacted 79 women in total 67 were screened. Evaluation of the BreastScreening mobile visit to Wairoa (see attached) Wairoa Mobile Report 2012-2017.d
10.3.3	Continue focus on improving data quality through data matching between BreastScreen Coast to Coast and general practices. Birthday letters for women turning 45 years and recall letters will be sent to unscreened and under-screened women.	Quarterly	Victoria	Number of general practices data matched.	% of general practices data matched.	Not on track	Challenges experienced this reporting quarter to access data matching services from BSCC due to their on capacity challenges. HHB will continue advocating for up to date information via the HBDHB Cancer Screening Team
10.3.4	Hold annual Continuing Medical Education and Continuing Nursing	Q4	Annette	One annual CME/CNE session for BSA		On track	Speakers are organised, venue booked. It's a joint update Cervical and Breast Screening

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
	Education session on BSA for practice nurses and general practitioners.						

11. Data Quality
Outcome: Improved collection and reporting of Māori ethnic data.

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
11.1	**IMPROVE THE COLLECTION AND REPORTING OF MĀORI ETHNICITY DATA**						
11.1.1	Provide individual General Practices with monthly reports of patients with an 'unknown' ethnicity to follow up.	Quarterly	Victoria		Training delivered		23/27 Practices provided with monthly DrInfo Reporting to identify practices with patients with unknown ethnicity.
11.1.2	Provide practices with enrolment training based on the results of the March 2016 Survey	Quarterly	Victoria	% Unknown ethnicity The baseline for unknown ethnicity recorded as at 31 March 2016 is 0.76% (1188			As at 30 June 2017, only 120 patients did not have an ethnicity recorded. HHB have identified the four practices that make up 73% of the unknown ethnicity recorded.
11.1.3	Health Hawke's Bay will provide a training session to general practice administration staff in the 2016/2017 year. The training will include improving data quality with a focus on ethnicity	Quarterly	Victoria		Training delivered		To be developed

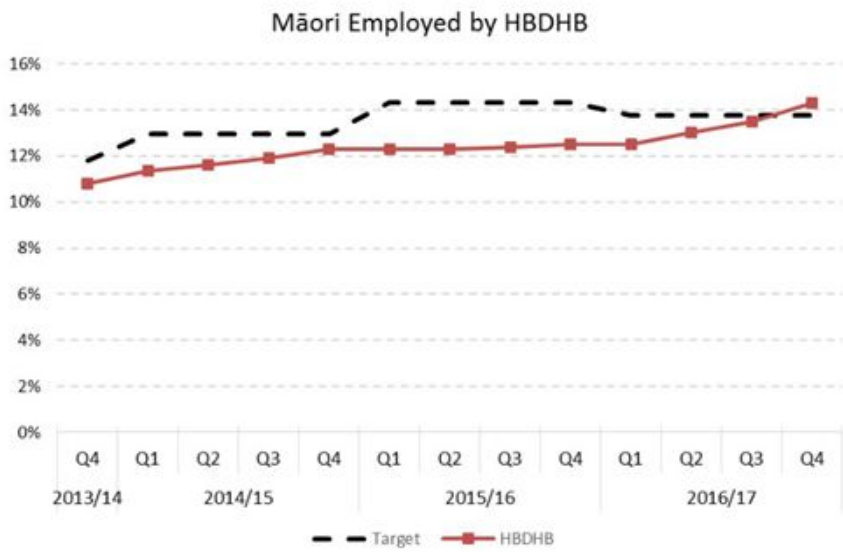
12. Māori Workforce and Cultural Competency

Outcome: Increased proportion of Māori employed by 10% yearly across HBDHB. Target 16/17 year 13.75%

Key Performance Measures	Baseline[43]	Previous result[44]	Actual to Date[45]	Target 16-17	Trend Direction
Medical	2.90%	4.7% (U)	5.2% (U)	≥13.75%	▲
Management & Administration	16.50%	19.1% (F)	19.9% (F)	≥13.75%	▲
Nursing	10.60%	11.6% (U)	12.1% (U)	≥13.75%	▲
Allied Health	12.60%	13.2% (U)	14.3% (F)	≥13.75%	▲
Support Staff	28.20%	29.3% (F)	31.6% (F)	≥13.75%	▲
HBDHB	12.30%	13.5% (F)	14.3% (F)	≥13.75%	▲

Comments:
The 2016/17 year target is 13.75% while the actual at 30 June 2017 is 14.25% which means we have achieved the 2016/17 target and are currently 15 positions above target. The Māori Staffing Recruitment Plan initiatives this year moved the focus from just Nursing to all occupational groups and has resulted in an increase of Māori staff across all Services. Over the last 12 months 20.1% of staff who have started work at the DHB identified as Māori.

Time series



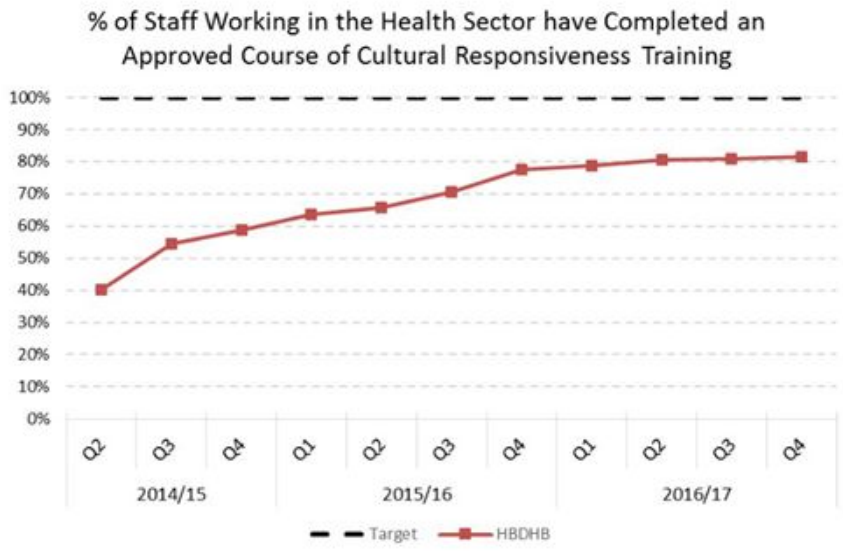
43 December 2014
44 March 2017
45 June 2017

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
12.1	**IMPROVED RECRUITMENT AND RETENTION OF MĀORI EMPLOYEES IN AREAS WITH HIGH PROPORTION OF MĀORI CUSTOMERS RESULTING IN AN INCREASED PROPORTION OF MĀORI EMPLOYED BY HBDHB TBC TARGET**						
12.1.1	Maintain target focus and promote recruitment of Māori to all hiring managers	Quarterly	Di Wepa Paul Davies	All hiring managers engaged in recruitment programme	Hiring Managers in all DHB departments provided with monthly reports. All interview panels now require a Māori staff member on the panel. Interview questions include questions on EEM and the DHB values.	20.1% of staff recruited over last 12m identified as Māori	We have endeavoured to move our hiring managers from taking on board the challenge of recruiting more Māori staff members and meeting a target to not only understanding it in their heads but to taking it into their HeARTs and aligning with our core values
12.1.2	Develop Māori staff recruitment plan to incorporate nursing, allied health, management and administration	Quarterly	Di Wepa Paul Davies	% of Māori staff employed and retained increased. Variances are explained	Māori Staffing Recruitment plan jointly developed HR and Turuki	All occupational groups have had in an increase in Māori staff over the past 12m	A combined team from Recruitment, Māori Health and Education & Development developed a series of initiatives to support hiring managers, improve communication with candidates, support applicants and support new staff.
12.1.3	Connect Māori students with opportunities for health sector careers and career development through Tūruki Māori Health Workforce Kia ora Hauora and Incubator programmes	Quarterly	Di Wepa	% of Māori students enrolled in Incubator programme matches the Māori population in Hawke's Bay	Database developed by December 2016		Database is now operational. Māori students that are enrolled in the Kia ora Hauora programme have now been included. Awaiting student information from Programme Incubator to complete information.

Outcome: All staff working in the health sector have completed an approved course of cultural responsiveness training.

Key Performance Measures	Baseline[46]	Previous result[47]	Actual to Date[48]	Target 16-17	Trend direction
Medical	19.20%	37.5% (U)	36.9% (U)	≥100%	▼
Management & Administration	79.10%	88.5% (U)	89.4% (U)	≥100%	▲
Nursing	70.00%	85.6% (U)	86% (U)	≥100%	▲
Allied Health	77.30%	89.9% (U)	90.8% (U)	≥100%	▲
Support Staff	35.60%	64.9% (U)	64.4% (U)	≥100%	▼
HBDHB	65.60%	80.9% (U)	81.5% (U)	≥100%	▲

Time series



Comments:

- The Engaging Effectively with Māori [cultural] training was reignited in March/ April 2017 after the previous course facilitator finished mid-2016. Consequently, workshop sessions were not as frequent as they formerly were. The frequency of these has now increased to three workshops per calendar month.
- Similar to the previous quarter and compared to the other Baseline areas, Support Staff and more so Medical lag considerably behind the other areas / contexts.
- Recent discussion and hui with the CMO, Dr John Gommans, revealed a number of reasons, no excuses but reasons nonetheless why the SMO / RMO participation

46 December 2014
47 March 2017
48 June 2017

is poor, including ignorance in terms of the training curriculum, unsuitable timings, course dates needing to be scheduled two months in advance to allow SMOs time to enrol.	

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
12.4	**Improve Māori cultural competencies employees**						
12.4.1	Increase online cultural competence training through PHO and NGOs			Two providers are engaged in initiative	Continued engagement of stakeholders		James Graham to comment
12.4.2	Promote inter-sectorial partnerships in health related industries				Promotion to Hastings Health Centre to engage in initiative	Meetings occurred with MSD, Turuki and HHC.	Hastings Health Centre are awaiting the remodelling of their new building before engaging in initiative.

13. Obesity

Outcome: Reduce the incidence of Obesity in Hawke's Bay – Target: 95 percent of children with BMI ≥98th percentile identified in the Before School Check (B4SC) programme will be referred on for nutrition, activity and lifestyle interventions.

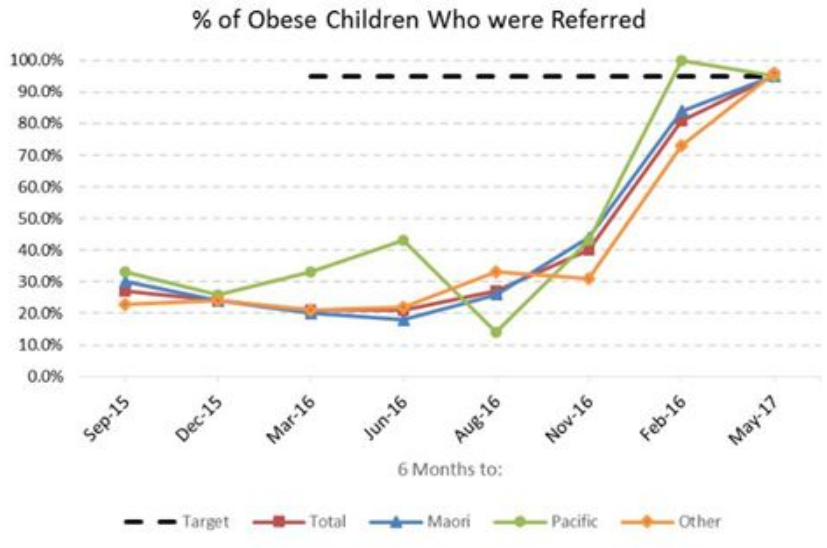
Key Performance Measures	Baseline [49]	Previous result [50]	Actual to Date [51]	Target 15-16	Trend direction
Māori	30.0%	84% (U)	95% (F)	≥95%	▲
Other	23.0%	73% (U)	96% (F)	≥95%	▲
Total	27.0%	81% (U)	95% (F)	≥95%	▲

Comments:

Every quarterly results have tracked upward and this quarter we have met the target for all ethnicities. This is 6 months ahead of the Government's expectation. The Māori rate reached target prior to Other and the Total.

This result has been support by a systematic professional development programme for key stakeholders, clear and supported systems and quality whānau based resources to support conversations and lifestyle changes.

These interventions are supporting lifestyle change and have the potentially to achieve long term benefits.



Planned Activities and Progress

ID	Actions/Activity	Date	Lead	Quantitative Measures	Qualitative Measures	Progress	Progress Comments
13.1	**INCREASE AWARENESS OF HEALTHY EATING FOR CHILDREN**						

49 6 months to September 2015

50 6 months to February 2017

51 6 months to May 2017

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
13.1.1	Support the Big change Starts Small campaign with four local initiatives over the year	July 2017	Pop Health	# initiatives completed		Complete	Resources used in DHB, schools and two other workplaces (Tumu and Wharehouse Hastings)
13.1.2	Delivering the healthy first food programme via a train the trainer approach which targets Māori and Pasifika families	Q2 & Q4	Tracy	# of training sessions held # of trainees attending the sessions	Participants drawn from Māori and Pacific population	Complete	To respond to whānau needs mixed delivery was used form individual whānau to group sessions. 120 whānau received the first foods package. 90 were Māori
13.1.3	Collaborate with a range of stakeholders for the implementation of 'Best Start: Start: Healthy Eating and Activity Plan' Activities: - Increase healthy eating and activity environments by increasing healthy choices in settings where children engage i.e. marae, schools, events - have healthy weights via screening, increased food literacy and whānau programmes - Provide leadership in healthy weight by developing and implementing a DHB healthy Eating Policy	July	Shari	3 decile 1-3 schools engaged in a healthy food environment programme	Programme are noting self-reported changes in healthy lifestyle behaviours	**Behind schedule**	Collaboration is happening at a number of levels and stakeholders are delivering the Best Start Plan – including PHNs supporting water only policies in schools, workplaces adopting healthy eating policies (DHB, Tumu Timbers, EIT), Waitangi Day and Te Matatini implemented healthy kai choices and Kahungunu have endorsed the Healthy Event resources. Only one school has been engaged. Working with HB Fitness Trust to support a pre-pilot with Kimi Ora school Moved to a project plan approach to support progress and clarify expectations for the school programme
13.2	**Increase referrals of obese children to support services including clinical assessment, family based nutrition programmes and activity and lifestyle interventions**						

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
13.2.1	Children identified as obese in B4 School check are referred to services including, clinical support, family based nutrition programme and lifestyle interventions	Quarterly	Pop Health	95 percent of obese children identified in the Before School Check (B4SC) programme will be referred on for nutrition, activity and lifestyle interventions. # of referrals declined by ethnicity	SI5: Whānau Ora Key Indicator	Complete	Target met – current supporting maintenance and increases
13.2.2	Increase skills and resources to support referrers to increase whānau knowledge of healthy weight, eating and activity and awareness of referral options	January 2017	Pop Health	100% of practises receive resource pack and training support		Complete	Resources are being reviewed – as part of a continued quality improvement approach
13.2.3	Develop and implement a kaupapa Māori whānau based nutrition and lifestyle intervention with local providers Engage consultant to work with healthy lifestyle Māori provider collective and develop programme in Q1, Whānau based nutrition and lifestyle intervention programme developed by Q2, Whānau based nutrition and lifestyle programme implemented by Q3	Quarterly	Pop Health Patrick	# of referrals by ethnicity # and % of referrals declined by ethnicity # and % of referrals completed programme by ethnicity # and % of individuals/whānau completed programme with self-reported lifestyle changes by ethnicity	Programme developed and implemented Referral Source	Incomplete	A kaupapa Māori programme was not developed – providers have existing kaupapa Māori approaches and the focus was on developing skill/knowledge to respond to children's developmental needs. Three workshops held with provider group – covering data/research/ national direction, working effectively with whānau in schools, and fundamentals of movement. Iron Māori contracted to deliver Active Family programme – Hastings focus area

<table>
<tr><th colspan="8">Planned Activities and Progress</th></tr>
<tr><th>ID</th><th>Actions/Activity</th><th>Date</th><th>Lead</th><th>Quantitative Measures</th><th>Qualitative Measures</th><th>Progress</th><th>Progress Comments</th></tr>
<tr><td>12.2.4</td><td>Continue to fund Active Families Under 5 programme/s, targeting high prevalence populations- Māori and Pacific with children under 5 years</td><td>Quarterly</td><td>Pop Health</td><td># of referrals by ethnicity

and % of referrals declined by ethnicity

and % of referrals completed programme by ethnicity

and % of individuals/whānau completed programme with self-reported lifestyle changes by ethnicity</td><td></td><td>Complete</td><td>
<table>
<tr><th>Ethnicity</th><th>Jan - Jun 2016</th><th>Jun - Dec 2016</th><th>Jan – June 2017</th></tr>
<tr><td>NZE</td><td>26%</td><td>18%</td><td></td></tr>
<tr><td>Māori</td><td>54%</td><td>59%</td><td>73%</td></tr>
<tr><td>Pacific</td><td>13%</td><td>14%</td><td>23%</td></tr>
<tr><td>Other</td><td>7%</td><td>9%</td><td>4%</td></tr>
</table>
Whānau engaged and completd Active Families

For this quarter 95% of children in the 98th weight percentile where referred to a GM appointment. Over the 12 months 100% received support, information and a plan to support lifestyle changes.

Referals have exceeded volumes for provider. 73% of referrals are Māori whānau increase from 59% last quarter.</td></tr>
<tr><td>13.2.5</td><td>The population health team will work with the PHO to meet the health target</td><td>Dec 2017</td><td>Shari</td><td></td><td>Joint DHB/PHO initiatives</td><td>Complete</td><td>Joint initiative included – training sessions for Nurses and GPs, the implementation of a Healthy Conversation Tool and establishing a referral pathway.</td></tr>
</table>

14. Alcohol and Other Drugs

Outcome: % of 0-19 year olds seen within 3 weeks of referral

Key Performance Measures	Baseline[52]	Previous result[53]	Actual to Date[54]	Target 16-17	Trend direction
Provider Arm and NGO: Seen within 3 weeks Ages 0-19					
Māori	63.2%	74.1% (U)	78% (U)	≥80%	▲
Pacific	75.0%	76.5% (U)	72.2% (U)	≥80%	▼
Other	56.9%	72.3% (U)	72.6% (U)	≥80%	▲
Total	60.1%	73.2% (U)	74.8% (U)	≥80%	▲

Māori aged 0 – 19 years seen within 3 weeks of referral has increased from 74.1% to 78% between Q3 and Q4; a 3.9% improvement.

In Q4 Māori aged 0 – 19 years seen within 3 weeks of referral was 5.4% higher than rate for Other, and 3.2% higher than for Total.

Overall in Q4 improvement in % of referrals seen within 3 weeks is improving, acknowledging Pacific declined in Q4 following improvement between Q2 and Q3.

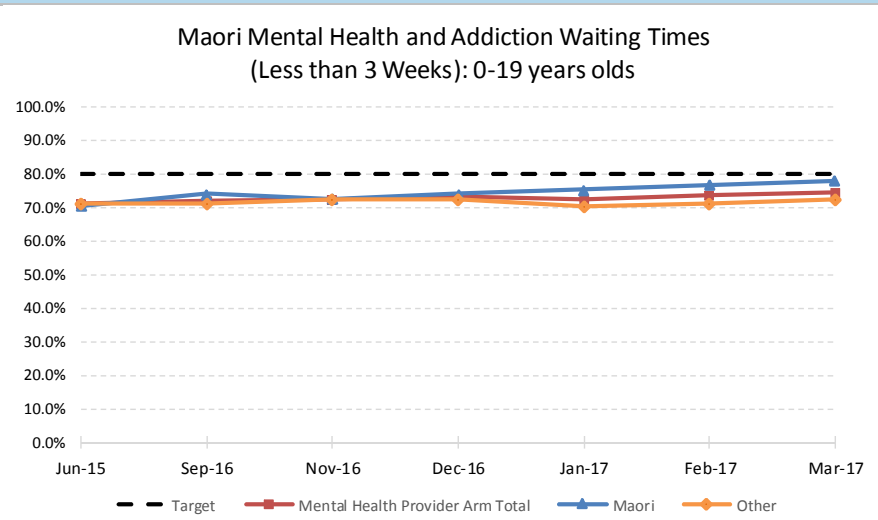
- Why are Māori Favourable

Waiting times are a significant focus for CAFS.

- What are you doing about it? In order to maintain / improve results?

Our highly engaged Kaetakawaenga also makes a significant contribution for her active focus on linking with whanau. This role is of considerable benefit to CAFS.

Time series



52 January 2015 to December 2015

53 January 2016 to December 2016

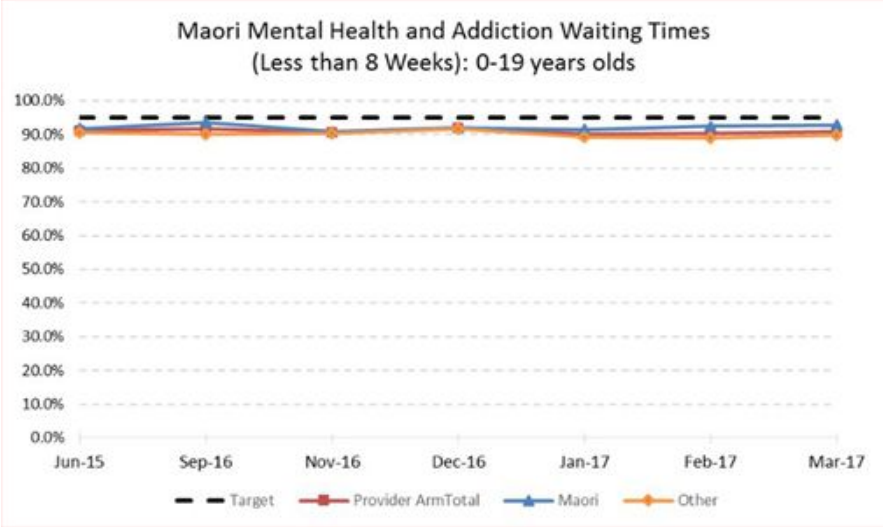
54 April 2016 to March 2017

We are continuing to work closely with other providers to work collaboratively to improve and maintain results. ▪ When are you likely to see improvements? The Wait times KPI is most directly affected by staffing against referral volumes, so recruiting as early as possible is key. We have had vacancies over time, and in particular over the March, April, May period. We are endeavouring to recruit as quickly as possible, but of course need to balance this with getting the required skill mix. Improvements are likely to be incremental in nature, and depends on staffing and developing capacity in the NGO and primary sector.	

Outcome: % of 0-19 year olds seen within 8 weeks of referral

Key Performance Measures	Baseline[55]	Previous result[56]	Actual to Date[57]	Target 16-17	Trend direction
Provider Arm and NGO: Seen within 8 weeks Ages 0-19					
Māori	86.5%	92% (U)	92.8% (U)	≥95%	▲
Pacific	91.7%	94.1% (U)	88.8% (U)	≥95%	▼
Other	85.3%	91.7% (U)	89.7% (U)	≥95%	▼
Total	81.5%	91.9% (U)	90.9% (U)	≥95%	▼

Time series



In reviewing the data, Māori generally similar to non-Māori in terms of KPI.

Percentage of Māori aged 0 – 19 seen within 8 weeks of referral in Q4 has remained similar to Q3 (92.8% vs 92%)

The percentage of Māori aged 0 – 19 seen within 8 weeks continues to be higher than Pacific, Other, and Total.

- Why are Māori Favourable

Our highly engaged Kaetakawaenga also makes a significant contribution for her active focus on linking with whanau.

This role is of considerable benefit to CAFS.

- What are you doing about it? In order to maintain / improve results?

55 January 2015 to December 2015

56 January 2016 to December 2016

57 April 2016 to March 2017

Waiting times are a significant focus for CAFS. We are continuing to work closely with other providers to work collaboratively to improve and maintain results. ▪ When are you likely to see improvements? The Wait times KPI is most directly affected by staffing against referral volumes, so recruiting as early as possible is key. We have had vacancies over time, and in particular over the March, April, May period. We are endeavouring to recruit as quickly as possible, but of course need to balance this with getting the required skill mix. Improvements are likely to be incremental in nature, and depends on staffing and developing capacity in the NGO and primary sector	

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
14.1	**WORK TOWARDS DEVELOPING A COMMON AGENDA FOR REDUCING ALCOHOL RELATED-HARM AS A HEALTH ISSUE ACROSS OUR DHB AND WIDER COMMUNITY.**						
14.1.1	Develop an 'Engagement and Communications Plan' – Q1	Q1	Rachel Eyre		Position paper signed off in Q2		
14.1.2	Develop an Issues paper and present to governance committees (Q1)	Q1	Rachel Eyre				
14.1.3	Develop a Draft Position paper (detailing DHB commitments) for the Board's consideration and sign-off in October. (Q2)	Q2	Rachel Eyre				
14.1.4	Carry out an investigation to identify current practice of alcohol screening and brief intervention for pregnant						

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
	women engaged with LMC midwives						
14.2	**Implement new regional model for adult AOD services**						
14.2.1	Complete strategic options analysis of local response to regional model by Q1	Q1	Paul Malan				
14.2.2	Finalise preferred option for all components of new service by Q2	Q2	Paul Malan				
14.2.3	Implement procurement processes in time for commencement in July 2017	Q4	Paul Malan				
14.2	**Improve the follow-up care for those discharged from Child and Adolescent Mental Health Services (CAMHS) and Youth Alcohol and Other Drug (AOD) services**						
14.2.1	Formalise implementation of Transition Planning Checklist as standard practice	Q1	CAFS Team Leader	PP7: 95% of clients discharged with a transition (discharge) plan + Exception reporting		Completed	
14.2.2	Amend discharge documentation to include standard prompt to primary referrer	Q1	CAFS Team Leader			Completed	
14.2.3	Introduce “error flag” in patient administration system to prompt completion	Q2	MH analyst			On Track	This is dependent on IS resource, and is less of a focus given more useful reporting.
14.2.2	Ongoing monthly audit and performance monitoring of compliance with transition plan policy	Monthly	CAFS Team Leader			Completed	Part of business as usual.

Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
14.3	**Improve access to CAMHS and youth AOD services**						
14.3.1	Trial an initial phone contact by Choice Clinician and implement as standard practice if successful	Q1	CAFS Team Leader	**PP8:** 80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks this year + Narrative report		Completed	Trailed and not continued. Admin team now making phone contact for booking initial appointment.
14.3.2	Liaise with KPI Forum stakeholders and other DHBs regarding "face-to-face" rule for first contact with children and families by Q2	Q2	CAFS Team Leader			On Track	This is an ongoing discussion within the KPI forum.
14.3.3	DNA's and joint appointments – review policy and impact of current practice by Q3. Redesign if necessary	Q3	CAFS Team Leader			Completed	Joint appointments is having positive impact on patient experience and will be continued.
14.3.4	Scoping of potential for alternatives to admission for youth to be developed by Q2, e.g. Home-Based Treatment, and the mechanisms by which this would be sustainable.	Q2	CAFS Clinical Manager			On Track	Discussion with new clinical lead for HBT. Awaiting HBT increase in staffing prior to further discussion.

15. Whānau Ora							
Planned Activities and Progress							
ID	**Actions/Activity**	**Date**	**Lead**	**Quantitative Measures**	**Qualitative Measures**	**Progress**	**Progress Comments**
15.1	**CONTRIBUTE TO ACHIEVING WHĀNAU ORA ACROSS THE WHOLE OF THE HEALTH SYSTEM FOCUSING ON PROGRESS IN FIVE KEY AREAS - MENTAL HEALTH, ASTHMA, ORAL HEALTH, OBESITY AND TOBACCO – TO ACHIEVE ACCELERATED PROGRESS TOWARDS HEALTH EQUITY FOR MĀORI**						
15.1.1	Form working relationships with local Whānau Ora collectives and support them in the developing their capacity and capability 1. Stocktake of their IT systems to assist in the compatibility and connectivity of the wider IS strategy by Q4 2. Liaise with Te Pou Matakana and Pasifika Whānau Ora Commissioning Agencies to gain an understanding of contracted providers' development needs by Q1 3. Align Māori Provider Development Scheme (MPDS)funding allocation to development needs of providers by Q4	Q4	Patrick		SI5: Report on progress in the 5 priority areas and impact on whānau, and how we are engaging with Whānau Ora commissioning agencies		
15.1.2	Define what whānau centric services are to inform a model to influence future service delivery.	Q4	Patrick				
15.1.3	Focus on achieving health equity in the Whānau Ora key performance indicators through Māori Health Plan reporting. Specific actions to improve performance in each area can be found in the relevant sections of the Plan	Q4	Patrick	KPIs reported in relevant sections			

Definitions of Vulnerable Children

The White Paper for Vulnerable Children 2012
Vulnerability can mean different things to different people. Our definition is:

> *Vulnerable children are children who are at significant risk of harm to their wellbeing now and into the future as a consequence of the environment in which they are being raised and, in some cases, due to their own complex needs. Environmental factors that influence child vulnerability include not having their basic emotional, physical, social, developmental and/or cultural needs met at home or in their wider community.*

Vulnerable Children Act 2014
Vulnerable children means children of the kind or kinds (that may be or, as the case requires, have been and are currently) identified as vulnerable in the setting of Government priorities under section 7.

New Zealand Productivity Commission report, *More effective social services* 2015
Vulnerable groups are defined here as children, young people, adults, families and whānau who are experiencing multiple risk factors (e.g., family violence, unemployment or social isolation).

The Growing Up in New Zealand Study 2014
The Growing Up in New Zealand Study has identified a set of 12 risk factors that are linked with a child's vulnerability to poor health, social, educational and developmental outcomes.

1. Teenage Mother
2. Mother has no secondary school qualifications
3. Living in public rental
4. Mother unemployed
5. Poor/fair maternal physical wellbeing
6. Mother with no current partner
7. Maternal smoking in pregnancy
8. Household overcrowding
9. Maternal depression
10. Family in recipt of income tested benefits
11. Reporting regular financial stress
12. Live in depreived area

The study found that when a child is exposed to several of these risk factors at any one time, as well as over time, they are more likely to have poor health and behavioural outcomes during the first 1000 days (three years) of development.