Māori Relationship Board Meeting

Date:	**Thursday, 7 September 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.

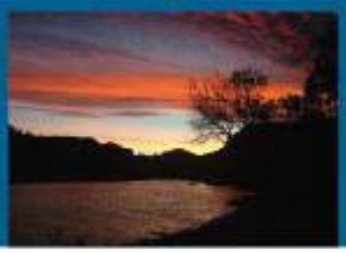
Our values

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: For Discussion	**9.30am**
11.	Metabolic (Bariatric) Surgery - in the context of a Healthy Weight Strategy for Adults – Jill Garrett	20-mins
12.	Position on Reducing Alcohol Related Harm – progress – Nick Jones	20-mins
	Section 3: Presentation	**10.10am**
13.	Waioha Primary Birthing Unit Benefits Realisation - Jules Arthur	20-mins
	Section 4: For Information only	**10.30am**
14.	Te Ara Whakawaiora: Healthy Weight (National Indicator) – Shari Tidswell	5-mins
	Section 5: General Business	**10.35am**
15.	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, 09 AUGUST 2017, IN TE WAIORA MEETING ROOM, DISTRICT HEALTH BOARD (DHB) ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS COMMENCING AT 9.00AM

Members:	Ngahiwi Tomoana (Chair) Ana Apatu Dr Fiona Cram Hine Flood Na Raihania George Mackey Heather Skipworth (Deputy Chair) Lynlee Aitcheson-Johnson Tatiana Cowan-Greening Trish Giddens
Apologies:	Kerri Nuku Dr Kevin Snee (CEO HBDHB) Kevin Atkinson (Chair Hawke's Bay District Health Board) Matiu Eru (Pouahurea, Māori Health HBDHB) Tracee Te Huia (Executive Director of Strategy & Health Improvement HBDHB)
In Attendance:	Chrissie Hape (Iwi/CYF Partnership Advisor, Ngāti Kahungunu Iwi Incorporated) Graeme Norton (Chair of HB Clinical Council) 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) 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 paid his respects to the Stone and Andrews whānau for the passing of Dave Stone and Dick Andrews.

3. APOLOGIES

Apologies were received from K Nuku, K Snee, K Atkinson, M Eru, and T Te Huia.

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 12 July 2017 were taken as read and confirmed as a correct record, pending the following amendments:

MRB Hosting the next Te Whiti ki te Uru.

Tatiana's expression of resignation from Te Whiti ki te Uru is pending a replacement. Her resignation will take effect when a successor is appointed. MRB are seeking registrations to replace Tatiana.

Moved: A Apatu
Seconded: H Flood
CARRIED

6. MATTERS ARISING FROM THE PREVIOUS MINUTES

There were no matters arising from the July minutes.

REVIEW OF ACTIONS

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

Māori Representation in the workforce - Grouping of ethnicities, British and Irish

The grouping of British and Irish statistics is not a standard grouping but one HBDHB has historically shown. However HBDHB is changing the way they report to mirror Statistics NZ and DHBSS and that is to show 4 main groups: NZ Māori, Pacific, Asian, Other.

Cultural Competency training restrictions of RMOs

Dr James Graham and Patrick Le Geyt have been working with Dr John Gommans (Chief Medical & Dental Officer) specifically tailoring Engaging Effectively with Māori training schedules for SMOs. This training will take place over the next two months.

Engaging Effectively with Māori training has been designed with patient care in mind, however the philosophy of this training and behaviour is significant to all Māori, including staff.

Māori representatives in the workforce – a brief update of feedback from exit interviews of Māori staff including the position/income level data.

Human Resources advised they do not have any records of exit feedback/interviews to-date. Furthermore, the interview and the feedback form are in-confidence therefore obtaining position and salary data may not be feasible.

MRB hosting the next Te Whiti ki te Uru:

Tatiana will remain MRBs representative until a replacement is appointed.
ACTION NKII to discuss and develop an agenda.

Review form and function of MRB and Youth Representative

Chrissie Hape and Ngahiwi Tomoana will bring a paper to MRB in September that will clearly define the purpose for the establishment of the Toiora Board.

George Mackey arrived at 9.20am

7. MRB WORKPLAN 2017

The workplan as at August 2017 was taken as read. There is a Hawke's Bay Leadership Forum scheduled for 6 September therefore there is no MRB meeting scheduled for that month. However as there is a number of strategic papers due in September, MRB **endorsed** holding a special meeting on 7th September 2017.

8. MRB CHAIR'S REPORT

The Chairs Report for July 2017 was taken as read and the contents noted.

9. GENERAL MANAGER (GM) MĀORI HEALTH REPORT

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

The following matters were discussed and information advised:

Māori Provider Integration Project
Acting GM Māori Health, Patrick Le Geyt, has met with Māori Health providers and some GP practices. Nine GP practices have expressed their interest. There is an opportunity to bring services together around an integrated care model with shared health priorities and a shared agenda to support families to achieve health outcomes. It was suggested that Dr Fiona Cram's evaluation of Kaitakawhānau could potentially be integrated into the potential model.

Sharon Mason (Acting CEO) arrived at 9.33am

Oral Health Services and Kōhanga Reo

The GMs report prompted MRB to briefly discuss issues with non-Māori speaking providers entering Kōhanga Reo. MRB noted the HBDHB have a Memorandum of Understanding (MOU) with National Kōhanga Reo Trust Regional Office, however it is not stipulated that staff must be te reo Māori speakers. Thus reinforcing the importance of employing the right people into the roles, including teachers.

MRB **recommend** the HBDHB updated the MOU to include the provision of te reo Māori speaking staff when working with Kōhanga Reo as business partners. The DHB confirmed that te reo Māori speaking staff were available and work with Kōhanga Reo.

In addition, it was suggested the HBDHB could attract te reo speaking staff with additional remuneration benefits within employment agreements. The DHB confirmed that staff are supported with te reo Māori training including paid training and study leave.

10. CLINICAL COUNCIL UPDATE

MRB noted the contents of the written update.

SECTION 2: PRESENTATION

11. TE ARA WHAKAWAIORA - MENTAL HEALTH (NATIONAL AND LOCAL INDICATORS)

Justin Lee (Acting Service Director for Older Persons, Mental Health, NASC HB and Allied Health), Peta Rowden (Acting Nurse Director MH/OPMHS/Allied Health) and Allison Stevenson (Acting Chief Operating Officer - COO) were in attendance for the Te Ara Whakawaiora / Mental Health (national and local indicators) report. Apologies were received from Dr Simon Shaw.

MRB **noted** the contents of the report and was supportive of the work being undertaken however would like the DHB Mental Health Services to recognise the importance of addressing the wider determinants of health and the requirement for more involvement in whole of sector approaches. MRB also **recommended** DHB Mental Health Services develop opportunities to work more with whānau and community groups as part of the whole sector approach to eliminate inequities.

MRB acknowledge there is consumer opportunity to feedback to the DHB through the Big Listen project and agreed the voice of the leadership needs to be consolidated with the voice of the whānau. In addition the clinical services plan of biomedical answer to Māori health issues that are not biomedical will not provide the required direction forward to improve Māori health. The system should facilitate the owner's needs, taking services to culture through a whānau centred model.

ACTION Mental Health Services to develop proposal, including whānau and community groups, to have greater input into whole of sector approaches, i.e. the Intersectorial Forum.

12. HEALTH LITERACY (MAKING HEALTH CARE EASIER TO UNDERSTAND)

Andre Le Geyt (Project Manager Innovation and Development, PHO) and Lillian Ward (Senior Māori Advisor/Equity Project Manager, PHO) were in attendance to present Health Hawke's Bay's Health Literacy plan. The presentation was a collaboration with the DHBs, Kate Coley (Executive Director of People & Quality) however Kate was unavailable to present today.

MRB **noted** the contents of the report and was very supportive of the work that needs to be undertaken.

MRB would like to see the term 'Consumer' changed to 'Whānau' as health and long term conditions impact all whānau rather than solely an individual consumer/patient.

13. TE ARA WHAKAPIRI HAWKE'S BAY (LAST DAYS OF LIFE)

Leigh White (Portfolio Manager Long Term Condition) was in attendance to present Te Ara Whakapiri Hawke's Bay's (Last Days of Life), palliative care plan. MRB **noted** the contents of the report and was supportive of the work being undertaken pending further consultation with Patrick Le Geyt and Sharon Mason as MRB noted the omission of cultural responsiveness in the evaluation and were surprised this project was not piloted with more Māori.

ACTION

- GM Māori Health and Chief Operating Officer to support Leigh to make amendments to this care plan with reflection of Māori. Leigh is to continue the current work however make appropriate changes to include spiritual aspects to support whānau beliefs and empowering staff around spiritual values.
- GM Māori Health will align Dr James Graham (Senior Advisor Cultural Competency) and Laurie Te Nahu (Programme Administrator) to work with Leigh White to ensure this plan is appropriate.
- Hine Flood will coordinate with Leigh to present the updated plan to Kaumatua in Wairoa for feedback.

14. PROPOSAL - REQUEST FOR ALCOHOL FREE HEALTH AWARDS

Heather Skipworth presented the Proposal - Request for Alcohol Free Health Awards and was seeking endorsement from MRB to take this proposal to the Board.

MRB **endorsed** the proposal going to the Board and was very supportive of the proposal given the current alcohol related harm statistics in Hawke's Bay and DHBs Position Statement recently approved by the Board.

SECTION 4: FOR INFORMATION ONLY (NO PRESENTER)

15. NGĀTAHI VULNERABLE CHILDREN'S WORKFORCE DEVELOPMENT PROGRAMME

MRB noted the content of the report. The Acting GM Māori Health provided his feedback to Dr Russell Wills (Medical Director) on the report and highlighted the expectations to training from a higher competency level, including NGOs.

MRB agree the workforce needs cultural responsiveness/leadership. The competency framework should not be built around academic credentials as that would potentially exclude whānau, kaiāwhina and kaimahi who are engaged with vulnerable children, however utilise and strengthen the existing relationships. MRB see there is a danger this could be driven from a clinical perspective rather than a whānau one. MRB suggested that the employment of more Māori into the workforce would largely address issues of cultural competency and engaging effectively with Māori.

MRB **recommends** cultural expertise be used to develop the training programme for the Ngātahi Competency Framework.

16. KA ARONUI KI TE KOUNGA FOCUSSED ON QUALITY (DRAFT)

MRB noted the contents of the report.

17. ANNUAL MĀORI HEALTH PLAN Q4 APR-JUN 17 REPORT AND DASHBOARD

MRB noted the contents of the report. Patrick Le Geyt advised this will be the last Māori Health specific quarterly report as DHB is moving to one annual plan report that will be reporting ethnicity for all indicators currently reported.

18. MOH VULNERABLE CHILDREN DEFINITION

There was a brief discussion on the definition of vulnerable children and whether this aligns with the Kahungunu definition and goals for Oranga Tamariki. The question of 'how will Toiora provide support to vulnerable children aside from removing them from risk' was discussed.

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 Thursday 7 September 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.	09 Aug 17	**Te Ara Whakawaiora - Mental Health (National And Local Indicators)** Mental Health Services to develop proposal, including whānau and community groups, to have greater input into whole of sector approaches, i.e. the Intersectorial Forum.	Allison Stevenson / Simon Shaw	TBA	**IN PROGRESS**
2.	9 Aug 17	**Te Ara Whakapiri Hawke's Bay (Last Days Of Life)** 2.1 Support Leigh to make amendments to the care plan with reflection of Māori, including spiritual aspects to support whānau beliefs and empowering staff around spiritual values.	Patrick Le Geyt / Sharon Mason	Nov	**IN PROGRESS** 28/08/17 Leigh White (Portfolio Manager, Long Term Conditions advised the development team met and discussed the issues raised at MRB. Please refer to Item 2.1.2. on page 3.
		2.2 Align Dr James Graham (Senior Advisor Cultural Competency) and Laurie Te Nahu (Programme Administrator) to work with Leigh White to ensure this plan is appropriate.	Patrick Le Geyt	Nov	**IN PROGRESS** 28/08/17 Leigh White is on annual leave returning 30/10/17.
		2.3 Coordinate with Leigh to present the updated plan to Kaumatua in Wairoa for feedback.	Hine Flood	Nov	**IN PROGRESS** 28/08/17 Leigh White is on annual leave returning 30/10/17 and will coordinate with Hine on her return.
3.	12 July 17	**Māori representatives in the workforce** Additional column to be inserted into Māori Staff Representation at HBDHB. Graph to include statistics of the users of the service.	Kate Coley	Aug	**COMPLETE** Additional column inserted. Refer to Item 3.1 on page 3. The graph, shared with the Board, shows these figures against HBDHB workforce and HB Population.

Action No	Date Issue first Entered	Action to be Taken	By Whom	Month	Status
4.	12 July17	**MRB Special Meeting** Special meeting to present a brief summary paper of the NUKA model and identify benefits for the region of Hawke's Bay	Patrick Le Geyt	10 Aug 17	**COMPLETE** MRB Special Meeting was held 10 Aug 2017.
5.	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.
6.	10 May 17	**Upgrade plan** Present the upgrade plan of the Tower Block and reconfiguration of Level 2 Corporate Administration Building	Trent Fairey	Oct 2017	**IN PROGRESS** Scheduled to present to MRB on 11 October 2017
7.	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.	Patrick Le Geyt / Chrissie Hape L Aitcheson-Johnson	May 2017	**IN PROGRESS** 09/08/17 Ngahiwi requested a date to be finalised before the end of MRB hui. 12/07/17 Finalise date for this workshop. 12/04/17 L Aitcheson-Johnson and N Tomoana to meet and discuss L Aitcheson-Johnson presenting to NKII
8.	14 Sep 16	**HBDHBs MRB hosting the next Te Whiti ki te Uru:** a) Develop the agenda and discussions b) Agree future MRB representation to TWKTU.	NKII	2 Oct 2017	**IN PROGRESS** 09/08/17 Tatiana will remain MRB representative until a replacement is appointed. 14/06/17 seeking registrations of interest to replace Tatiana Cowan-Greening as MRB representative.
9.	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 2017	**IN PROGRESS** **NKII Review on HOLD** 09/08/17 Chrissie Hape and Ngahiwi Tomoana will bring a paper to MRB in September for the Toiora Board.
10.	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

Item 2.1.2. The following detail was provided by Portfolio Manager Long Term Conditions:

- A meeting for November has been booked with multi others to assist with further planning and with the emphasis of viewing the Te Ara Whakapiri Care Plan and Toolkit through a cultural lens and can this tool be used in our communities (people dying in their homes).

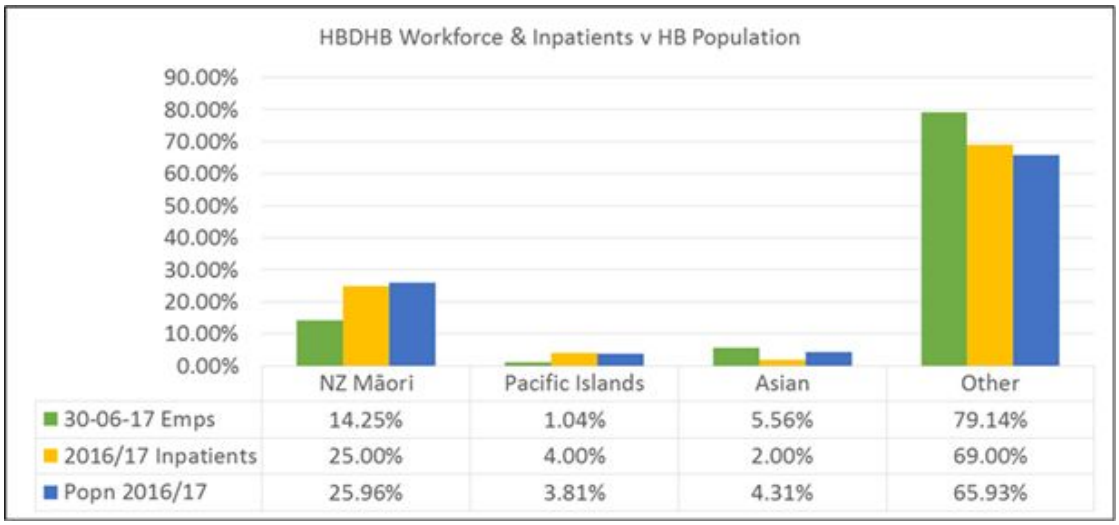
- Discussed the issues raised about people dying in Ballayntne House. Leigh has been informed that renal/palliative teams are keen to formalise a process around formalising links between the dialysis unit, hospital, GP and hospice for end-of-life patients/dialysis withdrawal patients. Some of this work would be around symptom management, assisting with advance care planning separate from the discussions already happening in the renal unit and exploring the option of a 'renal supportive care clinic' which may be helpful for patients who might be ambivalent about even starting dialysis.

Item 3.1. The following detail was provided by Executive Director of People & Quality:

2016/17	Maori	Pacific Peoples	Asian	Other
Hawke's Bay Regional Hospital				
Total Inpatients	25%	4%	2%	69%
Paediatric Medical Inpatients	44%	8%	4%	44%
ED Patients *	31%	6%	3%	60%
Maternity Inpatients	39%	6%	5%	49%
Wairoa Health Centre				
Total Inpatients	60%	1%	1%	38%
Central Hawkes Bay Health Centre				
Total Inpatients	12%	1%	0%	86%
All Facility TOTAL Inpatients	26%	4%	2%	68%
* Calendar year 2016				

Please note:

- The % of patient by ethnicity differs by site and Service.
- Children services such as Paediatric Medical have a higher % of Māori as does the Maternity Service.
- Wairoa Health Centre also has a higher % of Māori due to the high proportion of Maori in the Wairoa population
- A total % for all inpatients across all facilities in the bottom line.



MĀORI RELATIONSHIP BOARD

WORKPLAN SEPTEMBER 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
6 SEPT	***Hawke's Bay Health Leadership Forum, 8.30-3.00pm, East Pier, Napier***			
7 Sep	Position on Reducing Alcohol Related Harm – progress Consumer Experience Feedback Q4 Report Te Ara Whakawaiora: Heathly Weight (National Indicator)	Tracee Te Huia Kate Coley Tracee Te Huia	Metabolic (Bariatric) Survery - in the context of a Healthy Weight Strategy for Adults	Tracee Te Huia
11 Oct	Establishing Health and Social Care Localities Update Te Ara Whakawaiora: Culturally Competent Workforce (Local Indicator) Ka Aronui Ki Te Kounga / Focussed on Quality (final)	Tracee Te Huia Kate Coley Kate Coley	Implementing the Consumer Engagement Strategy Social Inclusion (to Committees)	Kate Coley 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
	Quality Accounts Final deferred. Date to be confirmed.	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:	September 2017
Consideration:	For Information

8

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 to be had at the Board meeting which will be held on Wednesday 30 August 2017 pertaining to Māori health.

INTRODUCTION

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

- Ministerial Targets
- The Big Listen and Clinical Services Plan
- Ngātahi Vulnerable Children's Project
- Human Resources KPIs Quarter Four
- Transform And Sustain Strategic Dashboard
- Te Ara Whakawaiora – Mental Health

MINISTERIAL TARGETS

For the month of July, Shorter Stays in Emergency Departments achieved 91.8 target. High levels of inpatient occupancy and record ED presentations compromised the Health Target performance.

The Elective Health target plan for 2017/18 has been agreed, with phasing in the final stages of the agreement.

Faster Cancer Treatment target of 77.1 percent was an achievement against the previous 85 percent target. However the target has been increased to 90 percent by the Ministry of Health (MoH) as of 1 July.

Better Help for Smokers to Quit – Primary Care remains steady at 90 percent.

THE BIG LISTEN AND CLINICAL SERVICES PLAN

The Big Listen has been launched across the sector, providing an opportunity through surveys and listening workshops for staff and consumers to feedback on their experiences as staff in the sector or as a patient being cared for in the sector. The Big Listen is an approach to listen to staff and patient journeys to identify opportunities to align behaviours with values and opportunities to make the HBDHB a better place to work and be cared for.

The Clinical Services Plan (CSP) is underway and on schedule. Initial engagement has involved general practice, various DHB and PHO committees, pharmacy, aged residential care and DHB health services. Engagement with more NGOs and health services is planned for the coming weeks. To date there has been a good level of engagement with some valuable feedback gathered.

A presentation on the Big Listen and CSP will be provided to the Board at the meeting.

NGĀTAHI VULNERABLE CHILDREN'S PROJECT

A competency framework for the Ngātahi development project for the vulnerable children's workforce in Hawke's Bay has been agreed by 24 agencies and will map existing competencies and development needs for the workforce. This phase will be completed by the end of September. The mapping will then be used to develop a training programme over 2018 and 2019.

HUMAN RESOURCES KPIs QUARTER FOUR

Māori representation in the workforce was above target for 2016/17 with 14.25 percent employees identifying as Māori at 30 June 2017. Overall staff turnover for the year was slightly above the annual benchmark, at 10.28 percent. The three main reasons for staff leaving were retirements, staff relocating outside Hawke's Bay and staff moving to employment outside HBDHB. While these reasons give no particular cause for concern, the HBDHB are reviewing the exit interview process across the organisation to identify the issues and reasons for people leaving while identifying areas for improvement.

TRANSFORM AND SUSTAIN STRATEGIC DASHBOARD

The Transform and Sustain Dashboard continues to identify areas where progress is being made as well as highlighting areas where focus is still required. Progress and improvement is being made in Faster Cancer Treatment. Results are moving further away from target for Māori women smoking during pregnancy, this remains an area of focus. There are a number of activities being run to address the high smoking rate.

TE ARA WHAKAWAIORA – MENTAL HEALTH

The Te Ara Whakawaiora report recognised that reducing inequity for Māori in Mental Health requires a sector and system wide approach with the knowledge that improved quality and outcomes for Māori improves outcomes for all.

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:	September 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 August 2017.

INTRODUCTION

In this months report contains an update about the following:

- Nuka System of Care Workshop
- Pregnancy and Parenting Information and Education Programme RFP
- 0-4 Yrs ASH Rates - Respiratory Care Pathways
- GA dental pathways
- Engaging Effectively with Māori (EEM)
- Hawke's Bay District Health Board, Implementation of Bowel Screening Programme
- Roles and Functions of the HBBSP Advisory Group;
- Rapai Pohe Māori Nursing Student Scholarship Recipients
- Diversity Workforce Plan Update
- Operations Research Priorities in Population Health

Nuka System of Care Workshop

On Thursday 10 August 2017 MRB held a workshop to discuss The Nuka System of Care[1], developed by South Central Foundation in Alaska, USA, and how this relates to HBDHB and, in particular, Māori.

A briefing paper was developed that provided background on South Central Foundation and key features about the Nuka System of Care. Each workshop participant shared their thoughts on the Nuka system and key themes, challenges and transferrable features that could possibly be adopted in the Hawkes Bay context.

The initial focus of the discussion was based on the 'tribally owned' provider system of Alaska Natives and their community led model of 'customer ownership' where users 'drive the system' and take greater self-responsibility of their own wellbeing and that of the community in general. MRB viewed self-responsibility, enhanced within a cultural context, as a key enabler for change.

[1] Nuka is an Alaskan Native word for 'strong, giant structures and living things'.

Comparisons and differences between the different contexts in which Alaska Natives and NZ Māori both live and engage with their respective health systems were acknowledged. Tribal ownership and customer owners were also identified, from a Māori perspective, as a key advantage and discussions were centred around, how, or if, this could be realised within a HB context. It was agreed that this is not the approach Hawkes Bay should take but that we should continue to work on the integration model between Maori health providers and GP Practices. Post Settlement Group Entities (PSGEs) were identified as enablers of whānau/hapū input into future service design specific to Māori. MRB recommended that HBDHB and NKII lead a project and work with PSGEs to define a preferred model of care.

MRB agreed their main role was to ensure that HBDHB was being responsive to Māori whānau/hapū/iwi health needs and were moving towards a whānau centred approach in service design and delivery. Discussions were then centred on how the learnings from the Nuka System could be adopted within HBDHB and Māori community context. MRB recommended that the Nuka System aspects of greater engagement with community, consumer/whanau partnership centred care, integrated care teams, behavioural therapy, and traditional Māori approaches to wellbeing and healing be included in the whānau centred approach.

Congratulations to Ngahiwi Tomoana

Ngahiwi was awarded the Te Taniwha o Te Kīngitanga by Kīngi Tūheitia Pōtatau Te Wherowhero VII in recognition of his services to Ngāti Kahungunu, Takitimu waka and Te Mana Motuhake o te iwi Māori. There have only been three other recipients of this award to date including Tīmoti Kāretu, Kara Puketapu and Koro Wētere. In retrospect, the Archbishop Brown Turei was presented this award as well as Rāhui Papa. On behalf of the HBDHB, we would like to acknowledge and congratulate Ngahiwi. This award is a distinguished honour and well deserved.

Pregnancy and Parenting Information and Education Programme RFP

On 25 August 2017, HBDHB Māori Health released the Pregnancy and Parenting Information and Education Programme for tender on GETS. The closing date for the tender is Thursday 14 September 2017.

The Pregnancy and Parenting Information and Education Programme is an integral part of HBDHB's commitment to maternal health and well-being and to reduce maternal and child health inequalities. Māori mothers experience disproportionate rates of poor pregnancy outcomes including maternal and perinatal mortality, pre-term birth, and low birth weight compared to non-Māori mothers. To contribute to improved maternal health outcomes, we are enhancing and improving access to information and education during pregnancy and early parenthood.

A number of quality improvement activities have been carried out, such as rebranding of the programme, improving the time and location of the classes, use of social median etc. but it is evident that the programme is still being under-utilised by priority groups such as Māori and Pacific whānau, and young mothers, Given that low attendance is a historical issue, it could be estimated that more than 70% of all Māori and Pacific mothers could have benefited from, but did not receive ante-natal advice and support. A HBDHB review of current ante-natal programmes and whether they meet the Ministry of Health service specification requirements identified a number of inequities in access to ante-natal care. The content and context within which the programmes are being delivered, and a lack of cultural significance embedded within the programmes demonstrate an inadequate 'degree of fit' and are contributors to the low participation rates of vulnerable groups.

In 2014, 64.9% or 1207 of women who used maternity services in Hawkes Bay lived in deciles 8 – 10. A disproportionately high number of these mothers were Māori and Pacific. In addition, there is an increased need for and expectation to ensure pregnancy and early parenting programmes adequately address their social, maternal mental health needs, women who are geographically isolated, and parents with limited comprehension of the English language.
Improving the design and delivery of pregnancy and parenting information and education so that it is tailored to the cultural and social needs of the population will help facilitate access to those women and whānau/families that might not otherwise know how to navigate and access services.

We want women and their whānau in our community to feel assured and confident that they will receive a high quality, culturally responsive, pregnancy and early parenting programme. For this purpose, HBDHB seeks to fund a Pregnancy and Parenting Information and Education programme that aligns with the National Service Specifications, to help prepare mothers and fathers-to-be and their families, for pregnancy, childbirth, and parenting, and to make informed choices.

Key Outcomes and Objectives:
The key outcomes that we want to achieve from this Programme are:

- A quality Programme that aligns with the National Service Specifications
- A Programme that is accessible and responsive to disadvantaged and vulnerable whānau
- Strong linkages in the community to meet whānau/families unmet maternal health and social needs

The objectives of the Programme are:

- To provide pregnant women and their whānau with pregnancy, and parenting information, education, and support to help prepare them for pregnancy, childbirth, and parenthood and make informed choices
- To provide whānau/families the opportunity to share their experiences and form and strengthen relationships with other whānau/families, as well as health and social networks

In addition, HBDHB expect the Programme to:

- Provide an innovative, interactive approach to engage participants
- Prioritise the needs of Māori, Pacific, and vulnerable pregnant women

- Develop and maintain essential linkages with appropriate Māori and non-Māori communities to promote awareness and access to the programme, and
- Provide and maintain an effective electronic registration system, database, and IT solutions that appropriate meet the needs of whānau/families.

0-4 Yrs ASH Rates - Respiratory Care Pathways

An investigation of the respiratory care pathways for tamariki 0 – 4 years presenting to the Emergency Department for a ASH respiratory event has been completed. The project has involved a case file audit, a review of primary and secondary care pathways, an in-depth analysis of the ASH data, and interviews with respiratory nurses and Māori and Pacific whānau.

A summary report was produced and identified four main areas for improvement:

1. Improving data quality
2. Respiratory care pathways
3. Service delivery
4. Improving service responsiveness to Māori and Pacific whānau.

Some of the findings from the report include:

- Tamariki Māori are bearing the burden of respiratory illness in Hawkes Bay with disproportionate representation in every district, as well as type of respiratory condition. Tamariki in Flaxmere are especially vulnerable.
- The respiratory care pathway does not have a standardised follow up procedure in all primary care practices that provides clear processes and systems for following up tamariki and their whānau post presentation to ED
- Of the 14 whānau interviewed, all but one received a follow up review by a respiratory nurse champion post presentation to ED
- In delivering respiratory advice and support, there is no considered approach for working with Māori or Pacific whānau.

The Working Group has reviewed the recommendations, and has developed agreed areas of actions and responsibility. The Group will continue to meet monthly to progress the actions, and report improvements.

General Anaesthetic dental 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. The review involves:

- An analysis of ASH dental data
- A case file audit
- A review of the ASH dental care pathway and processes (including booking and FSA processes)
- Interviews with whānau of tamariki who underwent a GA procedure within the last 6 months.

The protocols and approach for the case file audit and interviews has been finalised. The audit tools and interview schedules are in development. We are in the process of identifying and extracting ASH dental data. The review will include a specific focus on Wairoa as GA procedures and pathways are carried out separately from HBDHB processes and services. We are working with the Ministry and the contracted Mobile Surgical Bus Services to gather this information.

Engaging Effectively with Māori (EEWM)

There have been a further three mandatory workshops in the month of August, all based here at the hospital with great, positive feedback that is being utilised to assist in the review and delivery process of EEWM.

There are four workshops scheduled for September, two for the general workforce, one specifically for the SMOs and one to be delivered to the Wairoa workforce (one workshop has already been completed for the first lot of staff).

Hawke's Bay District Health Board, Implementation of Bowel Screening Programme

The Māori Health Services is represented on the HBDHB Bowel Screening Steering Group, to support the establishment of a National Bowel Screening Programme (NBSP). Budget 2016 provided $39.3 million over four years to begin implementation of the NBSP. This will cover the design, planning and set-up phases. Additional funding has also been set aside for work that will support the IT needed for a national programme[2]. A screening pilot was launched in 2011 in Waitemata DHB, which will now provide support and 'national coordination' functions to the tranche one DHBs (Hutt Valley/Wairarapa) whilst a national programme is established.

A national coordination centre will be established by 2018 to manage and send screening invitations and to coordinate the processing, analysis and management of completed bowel screening test results. Hutt Valley has been assessed as the preferred provider for our central region and work is currently underway with development and readiness for other DHBs. Hawke's Bay (HB) will need to be ready for roll out in July 2018, with systems and processes: delivering colonoscopies; clinical leadership; ensuring patients have been notified of results; workforce; quality management; equity focus and, of course, the "bigger picture" impact on surgical, primary care and community services.

The HBBSP Advisory Group is accountable to the Boards of HB and Health Hawke's Bay (HHB) reporting through to Clinical Council, Māori Relationship Board and PHO Clinical Advisory Group.

Roles and Functions of the HBBSP Advisory Group;

- Provide strategic leadership (advice and support) in the development, implementation and sustainability of HBBSP
- Review data and recommend actions to ensure that the aims of the HBBSP are achieved
- Provide oversight of the capacity, capability and quality of the programme to deliver services along the screening pathway in accordance with the BSP Quality Standards, Ministry, Māori and Pacific expectations
- Approve changes to Operating Policy, Quality Standards or Service Delivery model to better achieve the goals of the Programme, e.g. assist in promotion of a culture change
- Regularly review risks and barriers to the successful delivery of the Programme and ensure that appropriate strategies and actions are being taken in response
- Monitor the programme budget and expenditure

Principles

The Advisory Group will:

- Operate in accordance with the Treaty of Waitangi principles of Partnership, Participation and Protection
- Have a Māori, Pacific and population perspective with an understanding of the principles of screening programmes
- Have a commitment to ensuring that all aspects of the programme are of high quality and are safe

Composition

The Advisory Group will be comprised of representatives of impacted services:

- Clinical Director, Gastroenterology (Malcom Arnold)
- Executive Leadership (Andrew Phillips)

[2] Ministry of Health: National Bowel Screening

- Executive Director Quality and Risk (Kate Coley)
- Chief Information Officer (Anne Speden)
- Acting Head of Strategic Services (Paul Malan)
- Nursing Director (Chris McKenna)
- HHB PHO representative (General Practitioner, Practice Nurse)
- Manager of Population Health (Jenny Cawston)
- Manager of Medical Directorate (Paula Jones)
- Manager of Surgical Directorate (Rika Hentschel)
- Manager of Community Directorate (Claire Caddie)
- Manager of Cancer Services (Mandy Robertson)
- Māori representation (Laurie Te Nahu/Patrick LeGeyt)
- Pacific representation (Talalelei Taufale)
- Pharmacy and Laboratory Portfolio Manager (Di Vicary)
- Administration support (Julie Charlton, Corporate Services)

Rapai Pohe Māori Nursing Student Scholarship Recipients

Dayna Porter and April Papuni-Hohepa were the successful recipients of the Rapai Pohe scholarship for 2017. This scholarship is given in honour of the significant contribution made by Rapai Pohe to Māori Health. With the support of Rapai's whanau, the School of Nursing and the Tūruki Māori Workforce Development fund offer the Māori Nursing Student Scholarship for Bachelor of Nursing Year 1. The scholarship consists of one-half of the enrolment fee for the first year of the Bachelor of Nursing Degree shared between EIT and HBDHB. Māori students who have completed the Certificate in Health Science Level Four and have been accepted for the Bachelor of Nursing Degree can apply.

Left to right: Claire Mclean-Hokianga (2014) now working in B2 Medical, HBDHB; Kathy Kupenga (2014) also working in B2, HBDHB; April Papunui-Hohepa (2017); Dayna Porter

(2017); Jamee Waenga (2016) Bachelor of Nursing Year 2; Shannon O'Neil (2016) Bachelor of Nursing Year 2; Tiara Williams (2011) working in B1 cardiology, HBDHB.

Diversity Workforce Plan Update

The work plan for Tūruki 2017-2018 has been approved. The plan includes an objective to support the development of the HBDHB Diversity Workforce Plan. The Recruitment Team Leader will provide updates to the Tūruki Steering Group on progress in this area. Furthermore, Tūruki is working in partnership with the Pacific Health Development Manager to provide key linkages with stakeholders such as EIT. For example, Tūruki invited the Pacific health team to the Rapai Pohe ceremony which was progressed to a strategic meeting with the Deputy CEO, EIT. An outcome of this engagement is an invitation to the team to become a member of the Nursing Education Advisory Committee at EIT. By leveraging from Tūruki programmes and stakeholder engagement processes, the goal of increasing the diversity of the workforce can be achieved.

Operations Research Priorities in Population Health

Māori Health Services submitted a paper titled ***"Operations Research Priorities in Population Health"*** to the HBDHB Clinical Research Committee to be tabled in the upcoming meeting in August. The purpose of the paper was to highlight areas of intervention within the HBDHB Annual Plan which have had poor progress along with tentative questions that might need some answers through "operations research" to improve better health outcomes for Māori and reduce health inequality between Māori and non-Māori. The Clinical Research Committee is expected to:

i.) Review the paper and endorse the proposed tentative "qualitative studies" aimed at informing better planning and implementation of the HBDHB Annual District Health Plans to address equity issue within the health priorities of HBDHB.

ii.) Encourage internal and external researchers to carry out "qualitative studies" yet to be identified on health equity to inform programme planning and implementation at HBDHB.

The paper was based on information collected through consultation meetings with selected key action plan leads which focused on areas of planning and implementation of the Annual District Plan that might benefit from further information through small scale "operations research".

HAWKE'S BAY District Health Board Whakawāteatia	**Metabolic (Bariatric) Surgery in the context of a Healthy Weight Strategy for Adults** Addendum to paper presented 30 May 2017
	For the attention of: **Māori Relationship Board, HB Clinical Council and HB Health Consumer Council**
Document Owner:	Tracee Te Huia, ED Strategy and Health Improvement
Document Author:	Jill Garrett Strategic Services Primary Care[1]
Reviewed by:	Paul Malan Acting Strategic Services Manager; Rob Leikis Physician - Endocrinologist HBDHB; Mark Petersen – CMO Primary Care HBDHB; Lisa Jones Business Intelligence Team Leader and the Executive Management Team
Month:	August 2017
For:	Discussion

RECOMMENDATION

That MRB, HB Clinical Council and HB Health Consumer Council:

For consideration for future investment.

Feedback from Rob Leikis;
No specific recommendations for changing the document

General comments: *The cost savings for type 2 diabetes will not add up in the NZ context because we do not have any of the modern and more expensive diabetes drugs funded by pharmacy. We have a lot of patients self-funding but they are not our obese population thereby increasing inequities further. Most obese patients are actually avoiding treating their diabetes due to the fact that most funded medicine in NZ cause weight gain.*

I am still very much in the dark why we do not provide surgery locally. When we did a couple of years ago the surgical element went fairly smoothly but we had a substantial holdup with psychology services. The Wellington service limits patients to 160 kg whereas local surgery had the limit at 180 kg. The Wellington service provide extremely little communication, seems similar across a number of Wellington surgical services.

Finally the Wellington service have this obsession that the patient must lose weight prior to being accepted for surgery, (this does not include the pre op diet). This is supposedly to show commitment but I think it is just cruel and demonstrates a poor understanding of weight physiology by the staff concerned. The patients have invariably been trying their whole life to lose weight and put a lot more effort in than the population who have a BMI of 30 whom dietary change can make a considerable difference.

Finally the benefits stated are improving diabetes hypertension sleep apnoea etc., no mention is made of the fact that post surgery the patient can leave the house, get in a car and stand on the side-line to watch their child play school sport, to the patient this is way more important than their diabetes management. This aspect is grossly understated in nearly all documentation.

Cheers Rob

[1] Original author of the paper was Mary Wills Head of Strategic Services. This paper is a revised version.

The Inclusion of Bariatric Surgery in Healthy Weight Management Strategies
"Although additional studies are needed to further demonstrate long-term benefits, there is sufficient clinical and mechanistic evidence to support inclusion of metabolic surgery among anti diabetes interventions for people with T2D and obesity (as defined as Class III Obesity). To date, the DSS-II guidelines have been formally endorsed by 45 worldwide medical and scientific societies. Health care regulators should introduce appropriate reimbursement policies." *Diabetes Care volume 39-June 2016*[2]

Class III Obesity is defined as persons who have a Body Mass Index that equates to ≥40kg/m2 Māori and ≥30kg/m2 Asian. Currently there is no measure for Pasifika.

Guidelines - UK
In the UK, guidelines were updated in 2014 based on research reviewed or conducted by NICE. Specifically, due to the significant cost and projected growth in type 2 diabetes, bariatric surgery was identified as a cost saving strategy in the context of obesity AND early onset diabetes. The guidelines for bariatric surgery were amended and are reflected in the current New Zealand Guidelines.

Guidelines - New Zealand Ministry of Health
The MoH clinical guidelines for Weight Management in NZ Adults[3] discusses the efficacy of bariatric surgery and recommends that, if all appropriate non-surgical measures have been tried but failed, bariatric surgery should be considered for:

- People with a BMI of 40kg/m^2 or more (Class III Obesity); or
- People with a BMI of 35-40kg/m^2 (Class II Obesity) if they have another significant disease (e.g. type 2 diabetes, sleep apnoea, high blood pressure, or arthritis requiring joint replacement).

Current Hawke's Bay Position
Considering the above, in 2002/03 the estimated population of Hawke's Bay with Class III obesity was 3095 of which 1707(55%) were Māori and 215 (7%) Pasifika. *(See Appendix One – EMT Paper pg8 for more detail).* These figures were based on 2002/03 Health Survey data. Today the picture has changed considerably. The prevalence rate of Class III obesity is not calculated at a DHB level, however based on the same prevalence rates experienced nationally the following calculations have been applied to the population of Hawke's Bay using the health survey data of 2014/15

Table 1.0 – Hawke's Bay population 15+ years classified as having Class III Obesity

	Māori	Pasifika	Asian	Other
Hawke's Bay	2798	833	60	3944
Prevalence	10.0%	20.1%	1.1%	4.4%

Estimated total number Class III Obesity (15+)
6,851

Based on prevalence rates experienced nationally 2014/15 and applied to the 2017 population (Lisa Jones Business Intelligence)

This equates to 5.3% of the total Hawke's Bay 15+ adult population being eligible for bariatric surgery[4]. In the UK it is 5.4%. Providing surgery at this level is not feasible in Hawke's Bay.

Studies in a number of countries have shown that the number of bariatric surgeries delivered is much lower than the guideline and that there is a multitude of factors that influence this. This is certainly the case in Hawke's Bay to date.

[2] Metabolic (Bariatric) surgery in the treatment algorithm of Type 2 Diabetes: A joint statement by International Diabetes Organisations. Diabetes Care 2016;39:861-877 | DOI: 10.2337/dc16-0236
[3] Ministry of Health, Clinical Trials Research Unit. 2009. *Clinical Guidelines for Weight Management in New Zealand Adults*. Wellington: Ministry of Health
[4] If this were to be funded at an average cost of 12,800 per tertiary intervention the cost would be $95m

Background to Current Referral Numbers: (Detail is provided in Appendix Two)
The Diabetes Service is currently responsible to generate referrals for Bariatric Surgery. This is endorsed by the CMO primary as the pathway that should be followed for referrals into the service from general practice. It was previously managed by surgical services. Applying best practice guidelines and individual patient risk factors the number of referrals are greatly reduced.

In 2016-17;

- 37 referrals were made
- 28 declined.
- A total of 9 patients were fit for surgery.
  The actual results of those 9 referrals are as follows
  - x 1- received surgery
  - x 1- shifted out of the area
  - x 1- delayed for surgery due to anticipated post op complications (dietary management)[5]
  - x 2- failed to be marijuana free
  - x 2- will be completed in July[6]

  + 2 additional referrals still awaiting outcome

Clinical Risk Management:
The clinical guidelines for bariatric surgery are clearly outlined in the documentation provided by the tertiary provider - http://hawkesbay.health.nz/assets/Bariatric-Surgery/1.-Referral-for-FSA-for-Bariatric-Surgery-Template.pdf and provided in Appendix Three. HBDHB have seen the benefit of providing the non-surgical components of the service locally as a way of enhancing clinical outcomes and success of referral for the patient and whanau. This has been recognised by CCDHB as a component that needs to be included for all DHBs operating in the lower North Island.

Endorsing best practice is a high priority of HBDHB. Decision making regarding eligibility that sits outside of these guidelines would not be recommended.

Equity:
There are no published data on bariatric surgery in Māori. Only the Wakefield Gastroenterology Centre appears to be regularly publishing New Zealand outcome data (Dhabuwala et al 2000, He and Stubbs 2004, White et al 2005, Wickremesekera et al 2005, Stubbs et al 2006), but it does not publish data about the ethnicity of the patients. Data from the New Zealand Health Information Service suggest a disparity in access to publicly funded bariatric procedures between Māori and the combined New Zealand European and Other group.

To contribute to the pragmatic implementation of the Treaty of Waitangi and Māori development, while working within the parameters of He Korowai Oranga: The Māori Health Strategy, three strategic actions for Māori have been identified in the area of weight management for Māori.

- Accelerate the development of a culturally competent sector that understands the lived realities of Māori and the importance of mana-enhancing relationships.
- Ensure effective health services for Māori are provided by non–Māori-led and Māori led providers.
- Promote the ongoing development of Māori-led providers and the Māori workforce.[7]

Benchmarking how many we should do.

[5] Once the dietary management is in place the patient will be reviewed again for surgery.
[6] Due to time and processing of referral
[7] MoH NZ Weight Management Adult Guidelines

The current NHS benchmark for a bariatric surgical service at 5 years is 0.01% of the population per year.[13] In 2007, this was more than threefold the estimated rate of NHS commissioned bariatric surgery.[13] The NICE topic-specific advisory group admit this is not the optimum rate of procedures required and that rates 'may need to increase beyond this'.

Total HB population 162,900
0.01% = 16
Currently 7 patients are funded for bariatric surgery in Hawke's Bay
(0.05% of total population)

Financial Modelling:

- Surgical costs per individual person are $12,714
- Costs in addition to surgery are estimated at $5,000 per person
  - These include coordination of referrals, pre and post op psychology and dietetic support.
  - Patients not eligible for surgery at the time of presentation may also be offered in part these services to prepare them for surgery.
  - cost per patient $18,000
- Total cost x 7 patients $124,000
- Total cost x 16 patients $288,000
- Total new investment required $164,000

Cost-effectiveness
Studies[8] have demonstrated benefits that include; Sustained weight-control; Improved blood pressure, Improved or resolved diabetes, Improved hyper-lipidemia, Improved sleep apnoea, Improved insulin sensitivity.

Recommendations

- Advocate to up hold our obligations to Te Tiriti o Waitangi through supporting He Korowai Oranga and the three strategic actions identified in the area of weight management for Māori.
- Apply the New Zealand and UK guidelines to identify our priority populations
- Apply the 0.01% to the total population as a means to identify eligible numbers (Increasing numbers eligible from 7 to 16)
- Utilise existing funding to support the pre-and post-surgery pathway
- Fund all surgery through the normal IDF process, which will remove the anxiety over the "funded number" and allow a health promotion/secondary prevention approach to be taken
- Identify savings in type 2 diabetes costs (ongoing) to offset the increased cost of potential increases in bariatric surgery volumes.

EMT comments and follow up

- Agree to proposed volumes and funding through IDFs
- Seek confirmation from Capital and Coast to manage the increase from 7-16
  - *Provider has indicated they can manage increased volumes*
- Develop a robust pathway (currently in draft).
  - *The diabetes team are working actively with all stakeholders to ensure the pathway is robust and communicated to primary care*

[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3695555/

    - *The pathway will then be trialled for 12 months and then integrated into MoM*[9]
- Support effective information communication with primary care
    - The PHO are involved in the pathway development and in charge of communication with general practice
- Actively monitory referrals into the service and patient outcomes
    - Referrals from general practice - currently 35 YTD
    - Central point of contact at HBDHB managing referrals

[9] Map of Medicine

Appendix One:
Metabolic (Bariatric) Surgery in the context of a Healthy Weight Strategy for Adults

Presented EMT May 30th

Executive Summary: The management of obesity will continually require a strong preventative and early intervention element. Healthy weight strategies for both children and adults need to be modelled on strengthening whole of population lifestyle intervention programs, shown to cut obesity and prevent diabetes[1].

Using behavioral approaches for those with class III obesity is ineffective and not a recommended use of resources. The place of bariatric surgery is and should remain a last resort for the management of class III obesity[2].

Currently an estimated 7% of the population of Hawke's Bay (refer table 1.1 below for demographic distribution) will need to rely on bariatric intervention for the management of class III obesity. This equates to ~ 3000 persons.

Economic modelling[3] suggests that investment in bariatric surgery could be reduced to only 3% of the population within a 9 year period through: investment in whole of population prevention and early intervention programs. In addition to the population reduction, the evolution of operative techniques will result in more cost effective bariatric interventions being available, resulting in lessened costs (of this intervention) and reduction in % of the population who meet the threshold.

Robust evaluation pertaining to ethnic, gender and or age specific outcomes for weight management programs in the New Zealand and Hawke's Bay context are lacking. We do know however that behavioural type interventions do not work in those that have reached obesity levels and are therefore poorly placed with the class III obesity management options.

Evaluation of the efficacy of metabolic surgery over a protracted period of time is poorly documented both nationally and internationally post 3 years of intervention. Demonstrating the effectiveness of programs and or interventions included in any healthy weight strategy for HBDHB is needed in order to justify the economic investment being made.

Summary comment:

The length of time and degree to which bariatric surgery is relied upon as an intervention within the context of healthy weight management will depend on;

- Investment in whole of population, prevention and early intervention approaches to healthy weight management for both children and adults.
- Prevention and early intervention being the key focus areas of any healthy weight strategy.
- Ensuring all ethnicities, ages and genders have access to programs/interventions that work for them, enabled through access to robust evaluation findings.

Recommendations:

- The (Clinical) efficacy of Metabolic (Bariatric) Surgery[4] is proven and appropriate for class III[5] obesity treatment and should be included in the options strategy for the management of;
  - healthy weight in the adult population of Hawke's Bay; and
  - Type 2 Diabetes with Class III Obesity / Poor Glycaemic control.

- Metabolic surgery is supported as a medium term intervention for Class III Obesity but should not be supported as treatment for less obese.

[1] UK Select Committee

[2] Class III Obesity equates to ≥40kg/m2 Māori and ≥30kg/m2 Asian. Currently there is no measure for Pasifika.

[3] Bariatric surgery - can we afford to do it or deny doing it? https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3695555/

[4] Metabolic Surgery options can include the following;

[5] Class III Obesity equates to ≥40kg/m2 Māori and ≥30kg/m2 Asian.

- Criteria and clinical indicators aligned to this intervention are in place and should be adhered to in the provision of this service.

- Current utilisation of this tertiary intervention is below the recommended 7 p.a. for the district.[6] Closer monitoring of the referral pathway and follow-up post intervention is currently in place to ensure referrals made using agreed clinical guidelines result in surgical intervention.

  An investment of 200k (subject to funding) would provide up to 16 surgeries p.a. Our current tertiary provider is positioning itself as the regional provider. Exploring options to increase referral numbers to Capital and Coast would be required. The provider indicates they have the capacity to do so.

- Obesity prevalence in Māori is 47% and Pasifika 66%. Of which 77% and 7% are classified as having class III Obesity respectively. Currently the intervention is not accessed by Pasifika and only 2 Maori in 2015/16. Strategies to achieve equity for Māori and Pasifika need to be put in place. (refer table 1.0 & 1.1 below)

- Strengthening programs that are focused on early intervention, prevention and environmental change will over time lessen the demand on last resort preventative measures such as bariatric surgery. Obesity is an equity issue related to deprivation. It needs to be approached from both an environmental as well as a clinical standpoint.

- Combining the work of the health and social sectors is a realistic approach to addressing health inequities. Systematically identifying commonalities between programs in addressing high level health outcomes should form part of a comprehensive evaluation framework that supports a healthy weight strategy.

  NB. *"The UK Select Committee regarded it as "inexplicable and unacceptable" that the NHS is now spending more on bariatric surgery for obesity than on lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes over a decade ago."*

Figure 1.0 – Stratification of Healthy Weight Management Initiatives – Hawke's Bay

7%	Tertiary Provision –Metabolic (Bariatric) Surgery
26%	Intensive Management
35%	Behaviourist approaches – models of care transformation Health Coaching – Green Prescription Nutritionist / Dietician Services Weight Management Programs Self-management programs
32%	Healthy Lifestyles Iron Maori Patu School programs Sport Hawke's Bay Key messages – sit less, small change Promoting water, breastfeeding Healthy eating policies – DHB-Schools -Workplaces

Appendix One: **The Current Hawke's Bay Position**

Appendix Two: **New Zealand and International Context**

Appendix Three: **Primary Prevention**

[6] Despite fortnightly conferencing with tertiary provider it was only latterly discovered that referrals for surgery had been rejected with no follow up provision made. This has now been rectified and the person managing referrals is clinical personal

Appendix One - The Current Hawke's Bay Position:

Hawke's Bay DHB currently funds 7 patients per year for bariatric surgery from Capital & Coast DHB as a last resort for people with Class III Obesity. It is estimated that up to 3000 individuals within the Hawke's Bay population would be classified with Class III Obesity (Morbidly Obese).

Obesity is not just a clinical issue. Fixing the clinical issue goes only partway to addressing a condition brought about by high levels of deprivation and environmental influences. People living in the most deprived areas are 1.7 times as likely to be obese as adults living in the least deprived area. Obesity requires strategies that address both.

Table 1.0 – Summary of Class III Obesity (Morbidly Obese)

NZ Extreme Obesity	Female			Male			Total	Overall Prevalence		Total
	Māori	Pasifika	Other	Māori	Pasifika	Other		Female	Male	
Northland	1,095	38	753	1,158	52	311	3,407	3.6%	3.0%	3.3 %
Waitemata	1,036	764	3,265	1,179	833	1,318	8,395	2.8%	1.9 %	2.3 %
Tairawhiti	498	16	165	524	21	69	1,293	4.3%	4.1%	4.2 %
Hawke's Bay	829	89	835	878	126	338	3,095	3.3%	2.6%	2.9 %

**Source based on 2002/03 NZ Health Survey, BMI ≥40kg/m2 – pg 90-96 MoH publication (Dec 04) tracking the Obesity Epidemic: NZ 1977-2003*

Table 1.1 – Summary of Class III Obesity (Morbidly Obese) in Hawke's Bay

	Māori	Pasifika	Other	Total
Hawke's Bay	1707	215	1173	3095
%	55%	7%	38%	

**Estimated values based on table 1.0*

The number of publicly funded bariatric surgeries in HBDHB have ranged from 3 in 2014/15 to 7 in 2015/16. Two Maori received services in 2015/16. No Pasifika have received surgery. This is consistent with other areas where Pasifika populations have been less likely to access surgery. Funding is $89,000 per annum for up to 7 surgeries.

Hawkes Bay DHB has a Healthy Weight Strategy which prioritises investment in the early years, identifying the following enablers to effectuate the strategy; Leadership, Prevention, Early intervention and Environment. Four interlinking objectives are being implemented via HBDHB's *Best Start Healthy Eating and Activity: A Plan (2016-2020)*:

1) Increasing healthy eating and activity environments

2) Develop and deliver prevention programmes

3) Intervention to support children to have healthy weight

4) Provide leadership in healthy eating

With the strategy having longer term vision to generate lifestyle and environmental change over time through its younger generation focus, direction and investment is also required now to manage the current adult obesity burden as per figure 2.0 below.

Figure 2.0 – Exert from HBDHB Healthy Weight Strategy

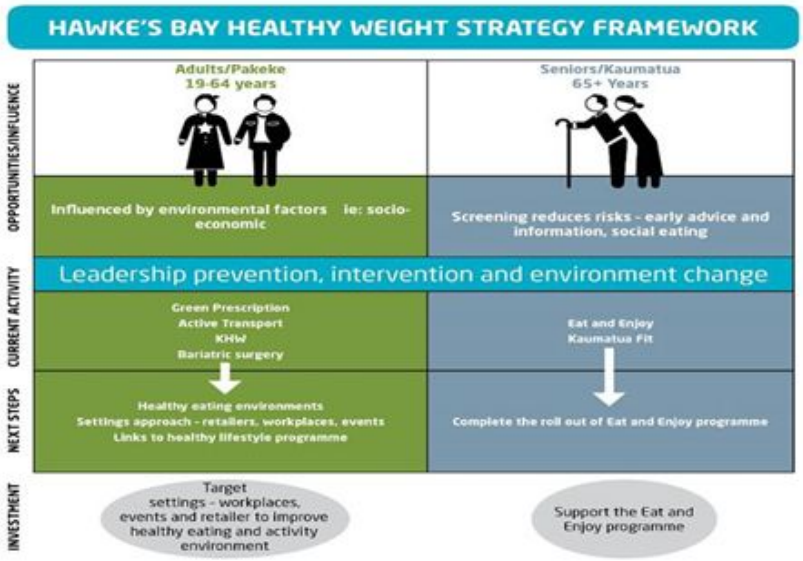


Table 1.3 – Programs currently in place across the sector (refer figure 1.0 above)

Interventions	**Programmes**	**Targeted population**	**Investment of $200,000**		**Effectiveness (sustained >3yrs)**
			Cost per person	**Volumes**	
Primary	Healthy environments Health literacy Healthy workplaces School Programs Workforce development-LMCs Well Child Breastfeeding support and promotion	Whole of population	$100	2000+	Low - med
Secondary	Weight management Green Prescription Kahungunu Hikoi Whenua Stanford Self - Management services Green Prescription Patu Iron Maori Pipi Program Weight management programmes Sport HB Healthy Conversations and whānau plan	Pre-diabetes Diabetes Obese	$200	1000	Low – Med *Small changes in weight can lead to significant health benefits
Tertiary[7]	Metabolic Surgery	Class III Obesity	$12,714	≥16	High

[7] Provided by Capital and Coast and currently only accessed by 7 patients.

For the adult population, the strongest evidence base for effective interventions in the estimated 3% of people in our population with Class III Obesity is metabolic (bariatric) surgery.

Running concurrently to this approach is the need to support and strengthen effective primary care programmes which targets 66% of the population who are currently overweight or obese.

Population-level interventions (increasing exercise, reducing unhealthy foods, health literacy, supporting healthy environments, and weight management programmes) are essential components to a healthy weight strategy that is promoting healthy environments. The correct place for these types of programs are universal approaches to healthy populations.

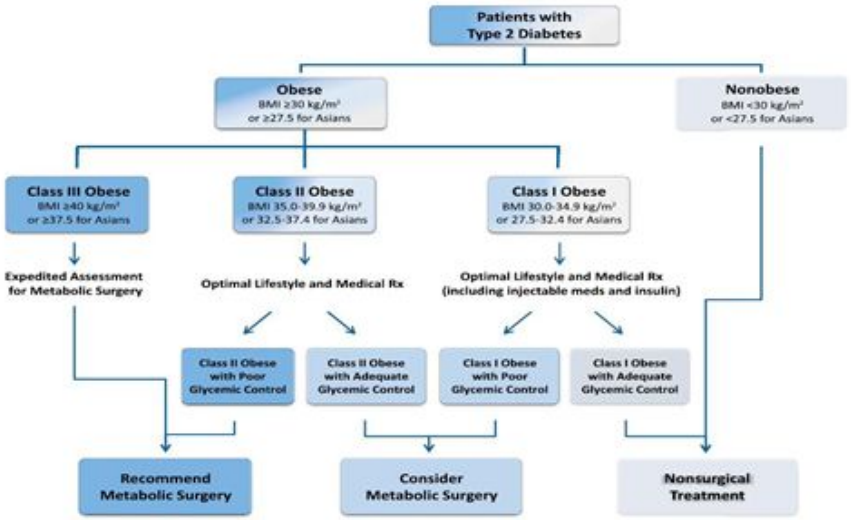
They are effective when placed correctly within this sphere of influence. When used as corrective measures – their efficacy is low to medium. More intensive management and influence is required to change existing behaviours that have led to poor health outcomes.

11.1

To meet the needs of our population requires a pathway for weight management. This would include[123] appropriate health and social investment in programs designed fit for purpose for;

- Universal prevention;
- Intervention for those overweight;
- Specialist multi-disciplinary teams including psychological and assessment or co-morbidities; and
- Metabolic (Bariatric) surgery with appropriate follow up is fit for purpose for those with Class III Obesity. Of note there is no agreed BMI ratio for Pasifika with all modelling being based on BMI ≥40kg/m2 and ≥37kg/m2 for Asian; and class Type 2 Diabetes with Class III Obesity / poor glycaemic control

Figure 3 – Metabolic (Bariatric) Surgery as indicated for the treatment of T2 Diabetes – Class III Obesity[8]



Intervention modelling

- Efficacy of intervention (prevention of morbidity)-HIGH
- Effective management of Class III Obesity / Type 2 Poor glycaemic controlled Diabetes-HIGH

[8] *Source- Metabolic Surgery in the treatment algorithm of Type 2 Diabetes: A joint statement by International Diabetes Organisations – Diabetes Bare 2016;39:861-877| DOI:10.2337/dc16-0236*

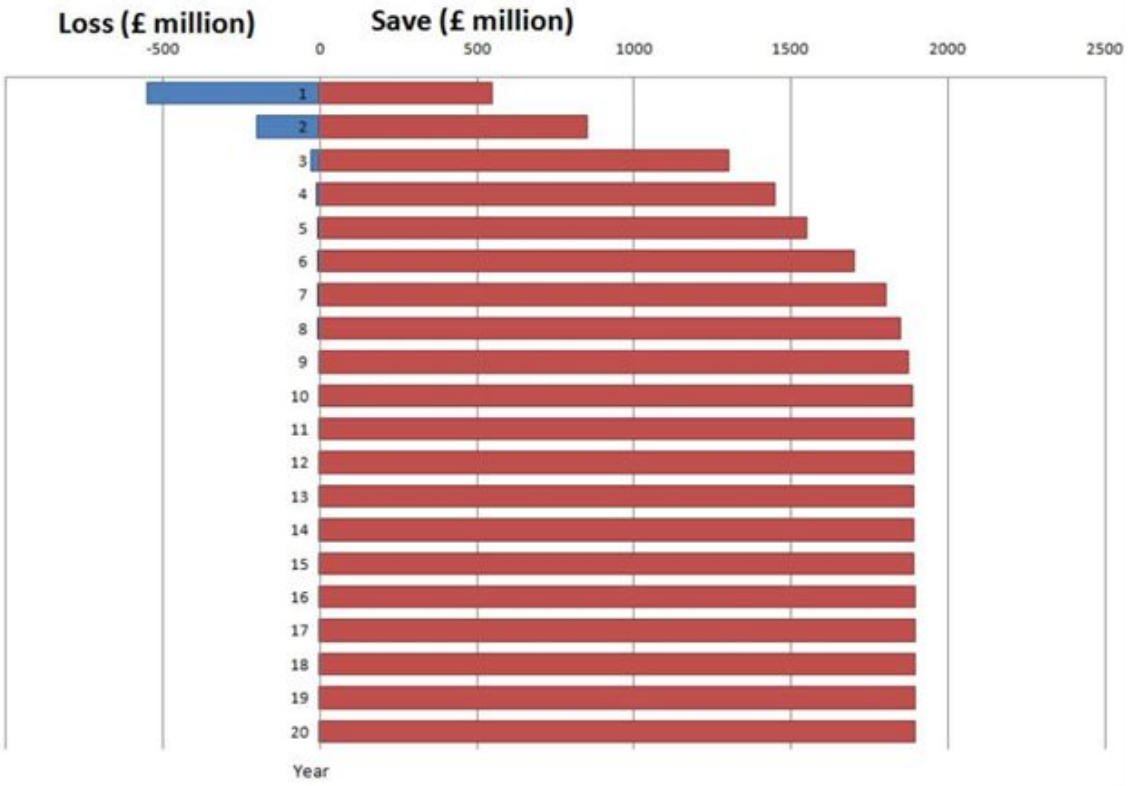
- The level of additional investment being considered for metabolic (bariatric) surgery is $200k

- Cost of surgery is $13k per person with a proposed volume of 16 patients p.a. (refer table 1.3 above). The capacity exists within our tertiary provider to manage an increase in patient volumes. Exploring the increase of referrals that meet the clinical criteria and indicators is recommended

- Greater investment in whole of population prevention and early intervention will have a positive impact on spend related to obesity over time by maintaining or reducing weight for people in the overweight and obese categories. Also in the long term increasing the healthy weight population.

  "The future for the management of obesity will continually require a strong preventative element; nevertheless bariatric surgery can increasingly offer successful disease resolution and cost-benefit for an increasing proportion of obese, overweight and metabolically disordered patients. This will most likely increase in view of the continual evolution of operative techniques. The cost-effectiveness of bariatric surgery can result in an increased number of cases with commensurate cost-savings (Fig 4) The length of time for which bariatric procedures can be favoured will however depend on our ability to develop safer, cheaper and more efficacious anti-obesity alternatives"[9]

Figure 4 - Hypothetical projection of the cost-benefit of bariatric surgery to UK society over 20 years.



Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3695555/

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3695555/

Appendix Two - New Zealand and International Context

Obesity is New Zealand's leading modifiable risk factor for health loss. A number of diseases, including type 2 diabetes, ischaemic heart disease, stroke, some cancers, and poor maternal, foetal and neonatal outcomes, are associated with excess body weight. Life expectancy for the extremely obese is shortened by 8 to 10 years.[4] High BMI (overweight or obese) accounted for approximately 9% of all illness, disability and premature mortality in 2013, making it the leading modifiable risk to health, equal with smoking.[5]

New Zealand, along with most developed countries, is experiencing an obesity pandemic. Obesity is evident across all age groups, ethnicities, socioeconomic groups and genders in New Zealand[6]. A third of the New Zealand adult population is obese with higher rates in the Māori, Pasifika and Asian Indian populations.

Obesity equates to a BMI ≥30 kg/m2. Class III Obesity is defined as a BMI of ≥40 kg/m2 or more for adults 19 years and older. Class III obesity is an indicator for surgical intervention.

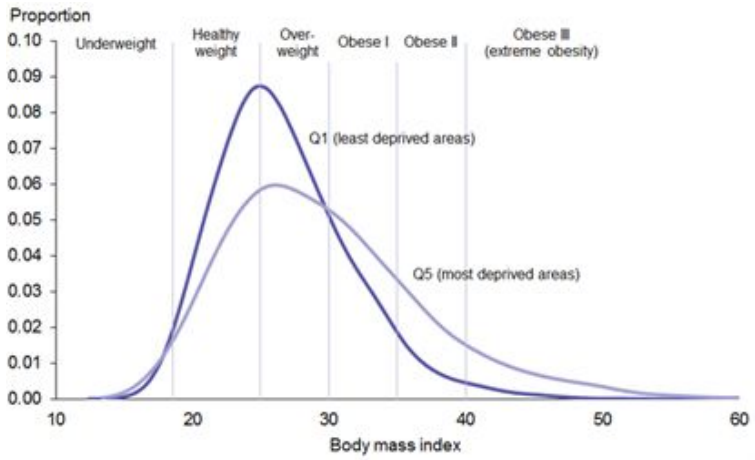
The New Zealand Health Survey found that:

- almost one in three adults (aged 15 years and over) were obese (31%)
- a further 35% of adults were overweight but not obese
- 47% of Māori adults were obese
- 66% of Pacific adults were obese
- adults living in the most deprived areas were 1.7 times as likely to be obese as adults living in the least deprived areas
- the adult obesity rate increased from 27% in 2006/07 to 31% in 2014/15[7].
- Class III obesity rates increased from 3.4% in 2006/07 to 5.3% in 2014/15
- One in nine children aged 2-14 years are obese

Obesity rates are strongly linked to socioeconomic deprivation. The obesity rate for children living in the most deprived neighbourhoods is five times that of those living in the least deprived neighbourhoods; and for adults the equivalent rate ratio is 1.7 times, after adjusting for age, sex and ethnic differences.

Over the last 15 years there has been an increase in BMI across the whole adult population. Adults living in the most deprived areas are more likely to have a high BMI.

Figure 2 - Body mass index distribution in adults, by deprivation, 2011–2013[8]



The increasing prevalence of obesity has occurred despite increased knowledge, awareness and education about nutrition, physical activity and obesity. The potential reasons for the recent increase in obesity are complex. Swinburn attributes the increase to the increasingly obesogenic environment in which we live[9]. The last three decades have seen a much greater availability and promotion of cheap, energy-dense, nutrient-poor foods, together with a reduction in physical activity levels.

Government recognises the health consequences of increasing obesity and has published a multi-level strategy that aims to reduce obesity. While the strategy has strengths (increasing exercise, supporting industry to re-formulate products to reduce sugar and fat) it has been criticised for not addressing

mechanisms of price, supply or marketing of high-sugar, high-fat foods. Strong criticism was levelled at the Minister's choice to make referrals of children for obesity a health target, rather than rates of obesity.

Obesity prevention and treatment

The recommended management of Class III obesity (metabolic / bariatric surgery) in many countries contrasts strongly with the actual approach to the management of obesity (largely preventive). The World Health Organisation (WHO) has noted the ineffectiveness of a range of counselling, behavioural and lifestyle interventions to address physical inactivity and poor diet amongst the morbidly obese. According to the WHO the only effective treatment for this group is metabolic / bariatric surgery.

This apparent paradox is explained by the conflict in values between these approaches. For example, the UK Select Committee regarded it as "inexplicable and unacceptable" that the NHS is now spending more on bariatric surgery for obesity than on lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes over a decade ago.

They recommended that all tiers of weight management services should be universally available and individual clinicians should use every opportunity to help their patients to recognise and address the problems caused by obesity and poor diet, and to promote the benefits of physical activity. In 2015 the U.K. Health Select Committee on the impact of physical activity and diet concluded, that there is compelling evidence that physical activity in its own right has health benefits independent of a person's weight. The importance of this—regardless of weight, age, gender or other factors—needs to be clearly communicated. They recommended interventions focused on supporting individuals with behavioural change with regard to diet and physical activity needing to be underpinned by broader, population-level measures that impact on far greater numbers than could ever benefit from individual interventions.

Appendix Three: Primary Prevention

A NICE[10] review of effective interventions for individuals:

Interventions that provide advice on nutrition, increased physical activity and behavioural strategies to overweight and obese individuals can result in an average weight loss of about 5 kg after 12 months. However, in controlled studies, interventions which had either less time with participants, fewer follow-up sessions or deviated from suggested guidelines had less success. After 1-2 years the effect of the interventions tended to decrease and often were only minimal after five years.

There was no evidence found that a single, brief intervention by health professionals (like that for tobacco) would result in sustained weight loss.

Conclusion: population-level interventions can lead to weight reduction if implemented with fidelity. Any effective approach to obesity is likely to be multi-faceted, comprehensive and involve a whole of society approach. "We must aim to make the healthy choice the easy choice".

Health Hawke's Bay PIP (Prediabetes Intervention Primary Care) study[10]

Patients were responsive to practice nurses in busy primary care practice providing structured dietary advice to patients with pre-diabetes. The intervention group lost 1.3kg weight at 6 months, which is comparable to other international studies. Primary care advice on weight loss appears to have a significant impact on patient attempts to change behaviours related to their weight[11].

Conclusion: Providers should address weight loss with their overweight and obese patients.

HBDHB Investment in Prevention

HBDHB directly invests $580,000 in support to more than 2,000 adults per year. This includes funding through the Ministry of Health for Adult Green Prescription, Active Families, Iron Maori and Health Promotion. Additional funding is provided within other programmes for healthy lifestyles and health promotion including obesity prevention.

HBDHB works with local Councils to support healthy environments through cycle ways, safe walking areas, playgrounds and parks.

Conclusion: Evaluation data is showing that 80% of people involved in these programmes have made improvements in healthy weight behaviour such as increased physical activity and increased amount of fruit and vegetables eaten. The number of people covered in prevention/promotion programmes are significantly higher.

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[9] Swinburn B. Obesity prevention: the role of policies, laws and regulations. Australia and New Zealand Health Policy 5(1): 12 2008
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[11] Physician weight loss advice and patient weight loss behaviour change: a literature review and meta-analysis of survey data International Journal of Obesity 37: 118-128 2013

Appendix Two – Bariatric Surgery Report
Communities Women and Children Directorate

June 2017

OVERVIEW

This report wished to advise on behalf of Communities, Women and Children the outcome and reasons why HBDHB did not achieve Bariatric volumes for 16/17. This report will also outline the plan for 17/18 to achieve the volumes.

BACKGROUND

Since 2011, HBDHB has been providing publically funded bariatric surgery. Appendix 1 outlines the MoH expectations regarding bariatric surgical volumes per annum. These volumes have proved difficult to achieve for a variety of reasons so in 2015 approval was sought and given to have the service provided by the Central Regional Bariatric Service through CCDHB from July 2016. Until then, Hawke's Bay DHB had been the only DHB in the Central Region opting to do this surgery in-house. Expectations regarding the volumes to be achieved also increased in 2015-16 from 6 to 7 volumes.

CCDHB had been operating a pathway that required patients to attend multiple pre-operative appointments at CCDHB, irrespective of where they were domiciled. CCDHB were willing to consider developing a new pathway that would localise the non-surgical components of the pathway and ensure the bulk of this service was delivered closer to the patient's home.

Key points to note:

- There were significant differences in criteria for acceptance of referrals onto the new pathway
- Referrals would continue to be received and coordinated locally through the Endocrine Service at the HBDHB.
- The criteria for FSA was also different than what we had in place with clear expectations of client/patient responsibility to show ongoing weight loss leading up to and prior to surgery. The pathway was agreed to Attachment 1 and process began for 16/17. Implementing the new pathway has highlighted where processes/communications need to be improved at both CCDHB and HBDHB and where gaps need to be addressed.

The process involved 6 weekly meetings with the respective teams in CCDHB and HBDHB with referrals following the pathway. From HBDHB's point of view we were meeting all the requirements and criteria for CCDHB and we had not had any notification from CCDHB to believe otherwise. January 2017 MoH advised HBDHB COO Sharon Mason that no surgery had been achieved for HBDHB.

This subsequently highlighted a major disconnect between teams within the Surgical services in CCDHB where in fact our 5 referrals we had sent over the 6 months had been declined with no notification being issued to HBDHB therefore an inability for HBDHB to follow up patient and whanau to work through the reasons for the decline.

The timelines of meeting changed to 2 weekly meetings and modification of the pathway and some leniency in weight criteria was agreed to. This was still not clearly defined as even with agreement from both surgeon and management of CCDHB the agreed pathway was not often followed so created further delays. COO of CCDHB, COO of HBDHB and MoH all became actively involved.

Outcome 16/17

The following outcomes have been achieved in this past year.

Referral 1 Referral sent to CCDHB on 27/7/16. Surgery done 30/5/17

Referral 2	Referral sent to CCDHB 4/11/16. Pre FSA psychology report identified that post surgery support would be required. This has been set up but surgery will not be achieved/discharged before end of June 17
Referral 3	Referral sent to CCDHB 23/11/16. Requires 6 months (not 3 months) for patients to be smoke free and or marijuana free. We have 2 months to meet that criteria and then this patient will be placed for surgery
Referral 4	As above
Referral 5	Referral sent to CCDHB Aug 16. Patient relocated to Wellington in April 17 so no longer considered as HB referral
Referral 6	July surgery planned
Referral 7	July surgery planned

5 further referrals in progress

Learning outcomes	Communication of the pathway and criteria to GPs. to ensure identification of appropriate candidates
Plan	Working with PHO to advise GP's of criteria for referral
Learning Outcomes	The referrals and pre assessment is very client driven and in order for us try to meet volumes has created significant administration for Endocrine Service who receive the referrals and coordinate the local provision of services. We are doing the assessment with them rather than the patient choosing to do this in a timely manner.
Plan	The learnings from this year sees that the pathway is time intensive and in fact can take a long period before acceptance to FSA is achieved. CCDHB advised it can take up to 18 months for a referral to progress through to successful surgery.
Learning Outcome	To reduce family/whanau travel has meant again significant clinical and admin time. With the appropriate support, much of this could be managed by General Practice, not HBDHB.
Plan	Re-evaluating the pathway with CCDHB August 2017 Planning and Funding have allocated funds from within the contract to acknowledge the FTE resource needed should this remains predominately DHB managed.
Learning Outcome	A medical service (Endocrine) is managing a surgical process. This would be more appropriately led by HBDHB Surgical services and CCDHB surgical services.
Plan	To follow the revised pathways for one more year with handover 2018/19. CCDHB are keen to persist with this pathway and implement this across other DHBs in the Central region (Whanganui, MidCentral, Wairarapa etc.). Meeting in August with CCDHB staff attending to confirm revised pathway.

Conclusions

HBDHB will not achieve planned volumes for 16/17. This is very disappointing both for the Endocrine team and surgical services in CCDHB and for the population of HB. MoH will not allow this to be accrued into 17/18 as ring fenced funding each year. It is however still the right thing to do clinically and opportunities to work collaboratively together is a positive. CCDHB like our dietetic and psychology assessment and see opportunities to modify their own intensive counselling process. CCDHB believe what HBDHB does regionally to support the whanau and patient is something to be considered for other DHBs in the lower North Island.

Group information sessions were successful and when the CCDHB team visit in August 17, the aim is to utilise the opportunity to provide a group session here to further reduce the travel for whanau.

We have not achieved the best outcome for the population of HB in achieving access to bariatric services. We have however developed a good pathway, developed stronger links to CCDHB and remain convinced this is the right process for Bariatric surgery in HBDHB.

It does highlight that while we do have many people who may fit the criteria for bariatric surgery, acceptance and changes for the patient and whanau remains the most critical factor in successful progression through the pathway.

FINANCIAL IMPLICATIONS OR OTHER KEY ISSUES AS REQUIRED

Appendix Three

Referral for FSA Bariatric Surgery Capital and Coast

REFERRAL FOR FSA FOR **BARIATRIC SURGERY**

REMINDER CHECK LIST FOR REFERRERS

- Discuss with the patient :
  - obesity factors
  - bariatric surgery, including risks and impact on life
  - commitment to long-term behaviour change
  - readiness for surgery
- Note smoking status
- Note previous weight loss attempts by any other non-surgical means; successfully losing 5% of body weight. (even if not sustained)
- Complete the referral including the information from the template. Note this information is essential for access.
- Include all relevant clinical information, reports, including recent bloods (HbA1C, Lipids etc)

REFERRAL AND PRIORITISATION FOR **BARIATRIC SURGERY**

Name		Weight (kg)	
NHI		Height (m)	
Age		BMI (kg/m2)	
Gender		Ethnicity	
Referrer			

Exclusion Criteria	Y	N		Y	N
Weight > 160kg or BMI > 55			ASA score of 4 or above		
End stage irreversible conditions or active cancer			Uncontrolled psychiatric conditions (psychosis, severe neurosis or addiction)		
Current Smoker					
Past Medical History					
Pulmonary embolus includes history of superficial or deep vein thrombosis or previous PE			Coagulation abnormalities		
Use of oral contraceptive					

Please tick any of the following areas of impact that the patient is actively being treated for and provide relevant clinical information including blood tests* (eg HbA1C)

A: Impact on Life		✓			✓
Lifestyle*	1		Obstetric / Gynaecological issues	3	
Hypertension**	1		Renal (Including hyper filtration)	3	
Dyslipidaemia**	1		Infertility	4	
Urology (eg Stress incontinence)	2		Obstructive sleep apnoea (OSA)**	4	
Gastrointestinal reflux disease (GRD)**	2		Diabetes (IGGT)	2	
Mild Arthritis****	2		Diabetes (Diet or oral meds)	6	
Arthritis with significant limitation	3		Diabetes (Insulin)	10	
Non alcoholic steatohepatitis (NASH)	3				

Please tick most relevant indicator

B: Likelihood of achieving maximum benefit with respect to control of diabetes	✓
No Diabetes	
Insulin > 7years,HbA1C>7	
Insulin > 7years,HbA1C<7	
Insulin 4-7 years, Diet or oral meds > 7years, HbA1C>7	
Insulin 4-7 years, Diet or Oral meds > 7years, HbA1C <7	
Insulin < 4years, Diet or Oral meds 4 – 7 years, HbA1C <7	
IGGT,Diet or Oral meds< 4years	

HAWKE'S BAY District Health Board Whakawāteatia	**Position on Reducing Alcohol Related Harm – progress report**
	For the attention of: **Maori Relationship Board (MRB), HB Clinical Council and HB Health Consumer Council**
Document Owner:	Tracee Te Huia, ED Strategy and Health Improvement
Document Author:	Dr Rachel Eyre, Medical Officer of Health
Reviewed by:	Executive Management Team
Month:	September 2017
Consideration:	For Information and Decision

RECOMMENDATION

That MRB, Clinical and Consumer Council:

1. **Accept** this progress report on the Alcohol Harm Reduction Position Statement to go to the Board (at 27 September Board meeting)
2. **Support** and mandate the establishment of a Steering Group with wide DHB representation to provide oversight to the alcohol harm reduction activities across the DHB and report to the Clinical Council (and/or other groups as advised) on a regular basis (as referenced in Appendix 1: Terms of Reference for an Alcohol Harm Reduction Steering Group).
3. **Endorse** the Strategic Framework and Priorities to be considered and accepted by the HBDHB Board at their September meeting (as referenced in Appendix 2: 'Tackling Alcohol Harm in Hawke's Bay' *Draft* Strategy).

Additionally, that Clinical Council :

4. **Agree** to the proposal that Clinical Council adopt the clinical governance role (at its 13 September Clinical Council meeting).

OVERVIEW

In November 2016 the HBDHB Board adopted a Position on Reducing Alcohol Related Harm and requested a progress report after six months. The Position effectively acknowledged that alcohol is a priority health and equity issue for our DHB as evidenced by the earlier Health Equity report (2014). The Position includes a vision, principles for engagement and the outcomes we seek to achieve. In addition there are 'next steps' for action with linkages to key relevant strategies, policies and plans (both from our DHB and nationally as per the National Drug Policy).

In adopting the position statement the Board sought assurance that *all building blocks, operational and governance structures would be in place,* noting that *the work was not being done in isolation but in collaboration with other agencies within Hawke's Bay.*

This document reports on progress with each of the steps endorsed by the Board and in particular reports on progress in establishing building blocks, operational and governance structures.

PROGRESS REPORT ON THE POSITION'S 7 'NEXT STEPS'

1. Identify the appropriate capacity and resource to lead the development of an Alcohol Harm Reduction Strategy and Implementation Plan

Prior to June this year the Population Health Service took responsibility for operationalising the 'next steps' and building blocks agreed to by the Board. Some steps, such as those linked to the delivery of Medical Officer of Health regulatory responsibilities under the Sale and Supply of Alcohol Act 2012, are best operationalised by Population Health. Other steps are linked to the community based work of the SHI Directorate and in particular the Health Promotion team.

The role to establish DHB wide support structures or the provision of services and interventions within clinical settings will be managed by clinical services. These services will lead the work to identify and address any gaps in addiction services and to promulgate screening and brief intervention.

During May and June an external contractor worked with the author and a stakeholder group to undertake some initial scoping work. This involved a stocktake of programmes, services and health sector consultation. A DHB-led health sector workshop was held on 5 July to report back findings, agree priorities and to agree an outline strategic framework. This culminated in the *Draft Strategy* report 'Tackling Alcohol Harm in Hawkes Bay' (see Appendix 2).

At the EMT meeting on 27 June, the CEO formally allocated responsibilities across the two DHB Directorates with the Executive Director SHI to take responsibility for external (or population) focused work involving collaboration with external agencies and to the Executive Director Provider Services to lead internally (personal health) focused work across primary and secondary care. EMT also requested a report on how the work was to be led and managed prior to this paper going to the other committees and then to the Board.

On 2 August a meeting was held to agree a coordinated steering and delivery structure for the DHB's Alcohol Harm Reduction Strategy. The Terms of Reference were agreed subsequent to this meeting (see Appendix 1).

2. Identify a governance and management structure to guide and provide an accountability mechanism for the Coordination and Strategy/Plan delivery

Feedback from the May/June stakeholder consultation recommended that the Clinical Council provide clinical governance for both strategy and plan delivery. In particular it was thought that the Council can provide assurance that quality evidence-based strategies will be advanced to achieve the outcomes consistent with the National Drug Policy and the DHB's position. This will give a stronger sense of ownership by clinical teams to the work that is required of them to address alcohol-related harm, akin to the cultural change efforts required across the sector to address smoking.

Higher level governance for the cross sector efforts and leadership has yet to be fully determined. However this work could be driven by the Board and potentially the Social Inclusion Strategy could provide an overarching framework for this work given alcohol is a priority issue for Hawke's Bay. There are also other possibilities for example, through working with broader cross sector Family Harm governance structures.

At the operational level, the Steering Group will drive this work across the different departments. This group will guide and assist those who are charged to deliver on the Implementation Plan, once developed by the clinical services. The responsibility for delivery will be allocated to those departments in which the activity sits. There will be no new resource allocated so it will require a shift in resources and inclusion in workplans. The challenge will also be to ensure there is good coordination of interventions and connections made to create mutually reinforcing activities and momentum. The programme coordination function, provided by Population Health, will service the Steering Group and take responsibility for planning, monitoring and reporting of the delegated actions.

The Steering Group, via the Programme Coordinator, is anticipated to report to the Clinical Council on a regular basis as a high level accountability mechanism.

3. **Support high-level Champions within our health system and in the community to act as spokespersons and be credible role models to help influence staff, community, whānau, family and individual attitudes to reduce harmful alcohol consumption**

   A number of Champions have already been identified both within the health sector and in the community. An example is the Māori Relationship Board requesting that the DHB cease making alcohol available at the Hawke's Bay Health Awards. However the Implementation Plan would specify the support provided to Champions to help deliver key messages in strategic ways.

   Relevant Champions would assist to deliver key messages to target audiences e.g. Samoan Rugby Club Team members to Pasifika around FASD.

4. **Identify the best way to input into the review and delivery of the Napier City and Hastings District Councils' Joint Alcohol Strategy to limit availability and promote safe, responsible drinking**

   The HBDHB has been a key player in the Joint Alcohol Strategy (JAS) (Napier City Council and Hastings District Council) since 2011. The JAS has recently been reviewed by Councils and has been forwarded to our DHB for feedback. The Council's priority groups are very similar to our own with the exception of including specific target groups of Men and Māori, and obviously excluding a focus on health services. Collaborative regulatory and non-regulatory activities sit under this Strategy and the role of the DHB is acknowledged in both these areas. Leadership is similarly identified as a Council priority. The JAS has included the DHB's position as an appendix to show how the Council and DHB activity will partner one another to achieve their Strategy. Clearly there is an opportunity for both the Council and DHB to work together and support each other's leadership role, whether that be through role modelling healthy events, encouraging community to be 'active citizens' when it comes to having a say around licensing decisions, or protecting the most vulnerable in society, such as children (by reducing exposure to alcohol) and helping those with addictions, by provision of clear pathways for support.

   Whilst the Napier/Hastings and Central Hawke's Bay 'Local Alcohol Policies' are currently subject to appeal, the Wairoa District 'Local Alcohol Policy (LAP)' is currently being drafted for community consultation later this year. There is potential for community to use the Wairoa LAP process to have more voice around licensing and availability of alcohol in their community.

   NB. A specific request from a Board member that greater visibility be given to health and alcohol advocacy to local authorities is an opportunity we must take.

5. **Establish the best method to engage the relevant departments across the DHB and PHO, and to engage with Iwi, Pasifika, young people and community (building on existing groups - Safer Communities, Māori NGOs etc.), to develop appropriate strategies and to provide support**

   There has been some initial consultation in developing the Strategic Framework and priorities, however as an effective way to develop Iwi and community-led initiatives, a more comprehensive communication and engagement plan will be a key approach to be outlined within the Implementation Plan during its development.

6. **Consider the development of a local Alcohol Coalition of NGOs and other agencies, akin to the Hawke's Bay Smokefree Coalition to build support at a community level**

   There is support for this concept but forming such a group will require resources and time not just for the DHB but for other agencies too. Other coalitions could potentially pick up on alcohol too. For example, Safer Communities, fora around Family Harm, locality groups, and the Health and Social Care Localities. Whether the community interest in other drugs is interested in tackling alcohol harm, which is more widely prevalent but more widely tolerated, remains to be tested.

7. Identify service gaps and priority objectives for local DHB action to include:

- Improved systems for health data collection/screening and brief intervention (e.g. in the Emergency Department, Maternity and Primary Care)
- Appropriate clinical referral pathways and treatment services
- Support for strong, effective and consistent health messaging (such as no drinking during pregnancy)

The Emergency Department (ED) has begun last month to screen all presentations to the ED to ascertain whether alcohol is involved or not, directly or indirectly. This data is now mandatory required by the Ministry of Health. This provides a unique opportunity to monitor the extent to which alcohol is a contributor to the burden on our ED, and to monitor the harm in our communities and the cost to our health system. This data collection also allows for the development of further brief intervention and treatment pathways and targeted initiatives e.g. to under 18s, frequent attenders, etc. This data collection could also be useful for advocacy to influence alcohol licencing decisions.

The support for strong consistent health messaging is a key action that has come out of the initial consultation. Within the FASD Discussion Document (2016) there is a commitment by our DHB to increase community knowledge and awareness about FASD with resulting behaviour change and to reduce the number of pregnant women who drink whilst pregnant. Limited progress has been made in the FASD prevention area to date however the Population Health team has now made this a priority within their annual plan.

Consultation to date

The 5 July workshop was open to all stakeholders involved in an initial consultation and stocktake exercise, led by Jessica O'Sullivan (DHB-contractor)[1]. The purpose of the workshop, which was opened by Dr Kevin Snee, was to gain agreement across our health sector around a strategic framework and priorities, and how we can initiate some traction in these areas within existing resource. There was widespread agreement around the priorities and an outcome of this meeting was the Draft Strategy document (see Appendix 2).

Consultation with other groups such as Police, Councils and community groups is essential but is anticipated will occur at a later stage. The main purpose of the work to date has been to secure the commitment and agreement from within our health services first, before moving wider into the community. The stakeholders who could potentially have a voice around alcohol harm are very broad as the problems and solutions extend well beyond those people who have an alcohol problem. It is important that as a Health sector we recognise alcohol as a significant health issue first and that we understand the culture change required and to counter any resistance from within before expecting wider societal change.

Final Comments

There is much to do, the position statement has clearly established priorities that have been supported by stakeholder consultation and formalised into the current draft strategy which is for five years (2017-2022).

There is good evidence for what works for reducing alcohol related harm, which shows that there is a place for both population health and targeted approaches. While current national policy settings are relatively weak, changing cultural norms through leadership and role modelling, and providing brief intervention in a range of settings with improved treatment services, are the areas where we can make a difference to improve the health and equity of our Hawke's Bay population. The new Steering Group will be able to draw on an extensive literature in this area and join the dots with other addictions and related areas so that the work is not siloed.

[1] (See attached)

APPENDIX 1

Terms of Reference
HBDHB Alcohol Harm Reduction Strategy Steering Group

AIM

Overall: To enable the Strategy vision, *"Healthy communities, family, and whānau living free from alcohol-related harm and inequity"* to be achieved.

The Alcohol Harm Reduction Strategy Steering Group (referred to the 'AHR Steering group') reports to the Clinical Council (who has overall governance responsibility) and delegates to the Health-sector Programme Working Groups, namely the Clinical Service Programme Working Groups and Population Health Programme Working Groups (these are referred to as 'PWGs'). The AHR Steering group will be expected to take a leadership role in relation to alcohol related harm issues.

The Steering Group is predominantly responsible for initiating and monitoring progress of the Health-sector PWGs and for resolving issues that may compromise the successful delivery of the Strategy overall. The PWGs will address the priority action areas outlined in the Strategy i.e. 'health services', 'youth' and 'unborn babies'.

The external facing work on 'youth' and 'unborn' babies that needs to engage with community, Iwi and other agencies such as Councils and Police may in time develop a separate 'governance' mechanism outside of the DHB. In the meantime the ED SHI Directorate, will be the conduit for the communication around the broader population health and community development approaches adopted in partnership with non-DHB entities (these wide-ranging activities already report in the main to Population Health). However the initial role of the AHR Steering group will be to *mobilise the health workforce to address alcohol harm as a health issue* within and across clinical services. The Steering Group may wish to identify Health-sector Champions to help gain profile for this work.

PRINCIPLES AND VALUES

The Steering Group will be most successful in achieving the aims by:

- Demonstrating leadership
- Fostering a culture of collaboration and mutual respect for each other's contributions
- Being responsive to Māori and applying an equity lens on all projects
- Ensuring culturally and age appropriate strategies
- Being evidence-informed
- Considering a consumer perspective for all projects
- Regular information sharing and establishing an outcome measurement framework to report on to the Clinical Council
- Keeping the workforce and community informed regularly around alcohol-related harm in Hawke's Bay and the health system response
- Using other relevant fora to highlight and respond to the issues – e.g. NCC and HDC Joint Alcohol Strategy group, 'DHB-Police Partnership', Intersectoral forum, Safer Community groups, Wairoa and CHB Health and Social Care Localities groups
- Being systematic and coordinated in our approach and making change sustainable

RESPONSIBILITIES

The Steering Group will:

- Ensure that projects are 'set up to succeed' (realistic timeframes and appropriate resources)
- Identify and support lead staff of PWGs and provide overall guidance and direction to the projects as required, ensuring they remain viable and within agreed constraints
- Approve changes to the PWGs (within delegations/tolerances)
- Ensure that risks, issues and dependencies to the projects are being managed effectively and make decisions & clear roadblocks as required
- Manage communications to internal and external stakeholders regarding the Strategy and projects via a Communications Plan
- Provide assurance that the Strategy and projects are being delivered satisfactorily
- Escalate issues to the appropriate GM or ED, that cannot be adequately resolved by the AHR Steering Group

- Undertake periodic reviews of the overall Strategy achievement and the effectiveness of the project/s and take appropriate action where required

ACCOUNTABILITY
The HBDHB Clinical Council will receive a six-monthly report on progress on the Steering Group's workplan and Strategy progress.

MEMBERSHIP
Membership will be based on a formal membership process including representation from:
- Clinical Council representation
- ED SHI Directorate (Tracee Te Huia)
- EDPS (Sharon Mason)
- ED Primary Care (Chris Ash)
- Service Director for Community, Women and Children (Claire Caddie)
- Emergency Department Clinical representative
- Primary Care Clinical Representative (Primary Care) lead
- Mental Health and Addiction Services Clinician (Mental Health) lead
- Public Health Advisor / Strategy (Public Health) lead
- Consumer representation
- Communications expertise
- (IS support* - for data collection, screening and brief intervention tools and referral processes)

*On an as required basis

CHAIRPERSON
The Chair will, in the first instance, be the ED SHI Directorate whilst the structures, processes and initial workplan are developed. The Chair will be reviewed after six months to reflect the workplan (anticipating that a priority will be the establishment of a Health Services Screening and Brief Intervention project).

QUORUM
Six members (half of total) must be present for confirmation of decisions.

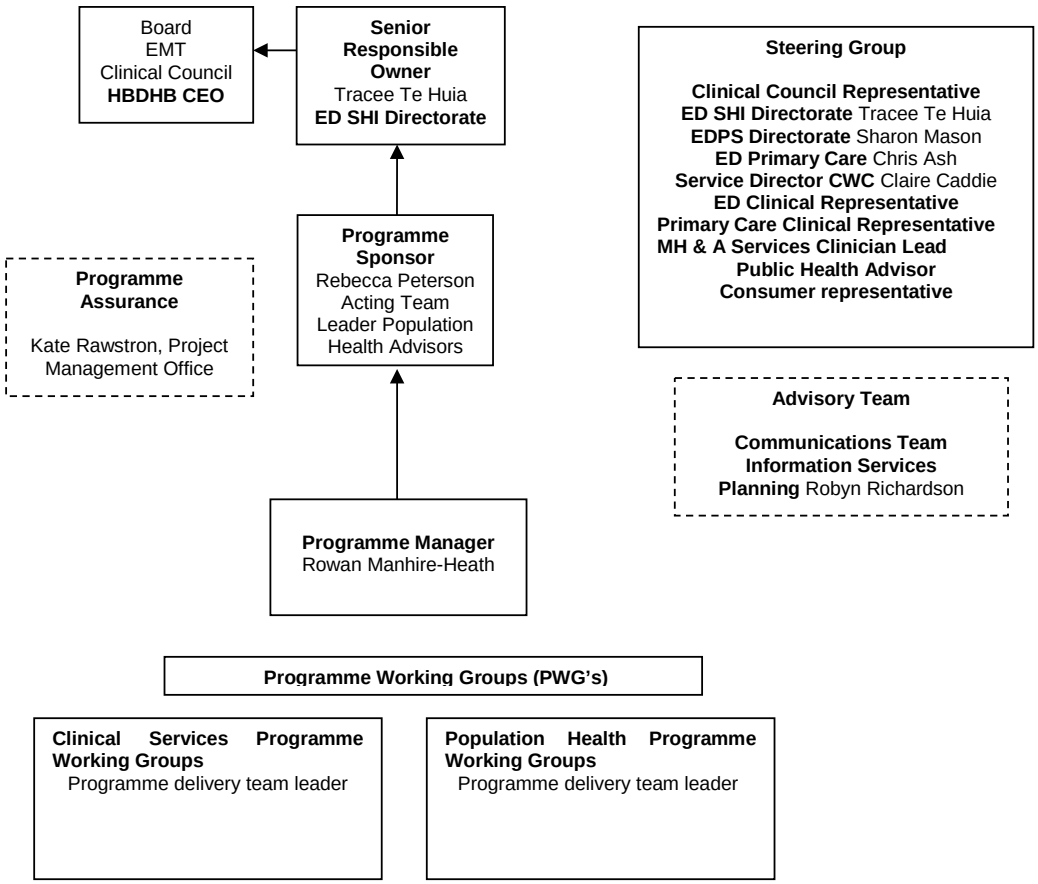
MEETINGS
A minimum of 6 meetings a year (approximately every 2 months)
Meetings will be time-tabled for the entire year by administration support

AGENDA
A written agenda will be developed and approved by the Chair and circulated 5 days prior to the meeting by admin support. Members will send any agenda items to the Chair prior to the meeting.

MINUTES
Minutes will be recorded by administration support and be approved in the first instance by the Chair. These draft minutes will be circulated to all members for final approval at the next meeting. Administration services will be provided by the SHI Directorate for the first six months.

REVIEW
These Terms of Reference and project structure will be reviewed after 6-12 months, as required.

PROGRAMME MANAGEMENT TEAM STRUCTURE



ROLE DESCRIPTIONS

Senior Responsible Owner

- EMT Conduit and support for Programme Sponsor
- Provides active support and leadership if required
- Resolves issues at Executive level

Programme Sponsor

- ACCOUNTABLE for project delivery
- Acts as line manager for the Programme Manager in relation to the programme
- Escalates issues to the Senior Responsible Owner so no surprises
- Ensures expectation for delivery and outcomes are translated into the programme plan
- Enables resources for the programme/s
- Ensures resolution of barriers to progress

Steering Group

- Represents those who will use the deliverables of the project to realise the benefits after the project is complete
- Works together with the Programme Sponsor to resolve strategic and directional issues within the programme which need the input and agreement of senior stakeholders to ensure the progress of the programme.

Advisory Team

- Provide expertise at specific points of programme development and implementation

Consumer Rep

- TBC based on specific programme consumer engagement

Programme Manager

- Plan, delegate, monitor and control all aspects of the programme
- Motivation of those involved to achieve the project objectives within the expected performance targets for time, cost, quality, scope , benefits and risks

Programme Delivery Team Leader

- Coordinates Completion of tasks and effective management of resources
- Works to agreed timeframes
- Report progress and elevates issues to the Programme Manager in a timely way

Programme Working Groups

- Completes tasks as required
- Works to agreed timeframes
- Report progress and elevates issues in a timely way
- Effective team member demonstrating pro-active and constructive problem solving

Project Management Office

- Provides pro-active project *assurance input* to support the programme to use best practice processes to create the deliverables and appropriately follow the programme management processes

HAWKE'S BAY
District Health Board
Whakawāteatia

WAIOHA PRIMARY BIRTHING UNIT BENEFITS REALISATION

13

Presentation

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Healthy Weight (national indicator)**
	For the attention of: **Māori Relationship Board (MRB), HB Clinical Council and HB Health Consumer Council**
Document Owner:	Tracee Te Huia, ED – Strategy & Health Improvement
Document Author:	Shari Tidswell, Intersector Development Manager
Reviewed by:	Patrick Le Geyt and Executive Management Team
Month:	September 2017
Consideration:	Monitoring

RECOMMENDATION

That MRB, Clinical and Consumer Council

Note the contents of this report

OVERVIEW

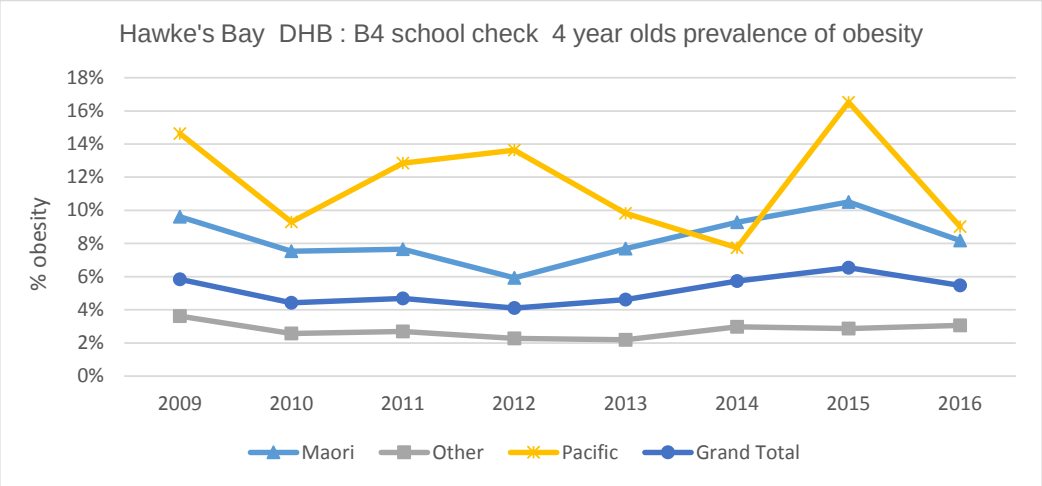
Te Ara Whakawaiora (TAW) is an exception based report, drawn from Annual Maori Health Plan (AMHP) quarterly reporting, and led by TAW Champions. Specific non-performing indicators are identified by the Māori Health Service which are then scheduled for reporting on progress from committees through to Board. The intention of the programme is to gain traction on performance and for the Board to get visibility on what is being done to accelerate the performance against Māori health targets. Part of that TAW programme is to provide the Board with a report each month from one of the champions. This report is from July 2016 to July 2017, Champion for the Indicators is Tracee Te Huia.

UPCOMING REPORTS

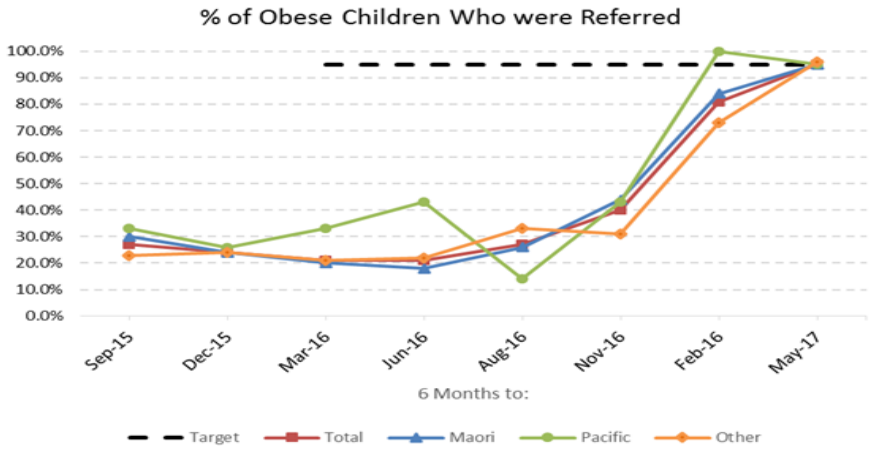
Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
Obesity *National Target*	B4SC 4 year olds identified as obese are referred for clinical support and provided with whānau lifestyle change support	95 %	Tracee Te Huia	Shari Tidswell	October 2017

MĀORI HEALTH PLAN INDICATOR:

Below are tables tracking obesity rates and the national target data. From 2014 to 2016 rate for Māori dropped from 9.3% to 8.2% in 2017 and Other have stayed static around 3%. The gap is reducing slowly.



The national target "Raising Healthy Kids" -95% of children attending a B4 School Check and identified as obese (BMI 98th percentile) are referred to a health professional and given whānau based lifestyle support. Table below show the tracking for the target, note the new Target did not start until July 2016.



Key Performance Measures	Baseline [1]	Previous result [2]	Actual to Date [3]	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%	▲

The Raising Healthy Kids target has been achieved for Hawke's Bay quarter four- 95 %4. This is ahead of the Ministry's timeline by 6 months. This includes equitable referral rates across ethnicities and 100% referral acknowledgement rate. Also all whānau were provided with a healthy weight plan.

1 6 months to September 2015

2 6 months to February 2017

3 6 months to May 2017

4 The table above are the reported data to the Ministry of Health for quarter 4

WHY IS THIS INDICATOR IMPORTANT?

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

We are seeing the start of a slow decrease in 4 year old obesity rates and the response for whānau of obese children is equitable with 95% of Māori whānau being referred to a general practitioner for clinical assessment and 100% developing a whānau healthy eating plan with their B4 School Check nurse.

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

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

Delivered activity to support healthy weight under-fives:

Activity	Outcomes
Mama Aroha training and resource provided to key community workers to support and all wāhine delivering pepe.	Mama Aroha programme delivered and resources distributed to providers and wāhine.
Maternal Green Prescription (GRx) delivered- target of 160 referrals with 50% of these being Māori or Pasifika.	Referrals met targets.
Gestation Diabetes management- 100% of pregnant women with gestational diabetes are screened and 75% engaged with support.	Screening targets have been met and the support exceeded 94%.
"Health First Foods" programme delivered via Well child and Tamariki Ora providers.	120 whānau engaged in the sessions (66% Māori). Recipes cards have been developed and are being distributed
Active Families Programme, target of 40 referrals and 50% of these being Māori or Pasifika.	Targets exceeded.
Healthy Conversation Tool developed and trialled in B4 School Checks	Implemented, including whānau input into design and training for nurses to implement. Initial feedback is very positive.
Insector forum establish to support healthy weight leadership and activity across sectors	Forum is established, member are implementing activities to be role models as employers. Map developed to provide oversight of current impact and delivery. Also an advisory group has been establish to support the healthy sector implementation of the Best Start Plan.

Next steps:

- Increase the volumes for Active Families under 5 to meet demand created via the national Target and support earlier engagement (2 and 3 year olds) in Active Families.
- Complete evaluations and work with Advisory Group to action recommendations

- Engage with early childhood education (ECE) sector to design resources to support healthy weight environment and learning for whānau engaged in ECE.
- Find further opportunities to support healthy weight messages via services with existing relationships with whānau
- Continue to monitor contract targets and national Target
- Continue to develop the intersector relationships

RECOMMENDATIONS FROM TARGET CHAMPION

Key Recommendation	Description	Responsible	Timeframe
Complete the evaluations and action based on recommendations	Take the recommendations to the Best Start Advisory Group to develop actions for improvement	Shari Tidswell	Dec 2017
Complete variations to contract to increase the volumes for Active Families Under 5	Secure additional funding from MoH Complete a contract variation	Shari Tidswell	Sept 2017

CONCLUSION

We will continue to work and ensure the Target is met. This will be supported by the work delivered under the Best Start Plan, particularly implementing recommendations for the evaluations currently underway - which will provide guidance for improvements and development.